

**Implementing LGBTQIA+ Curriculum in Pre-licensure Nursing Programs: a
Phenomenological Study**

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DAVID JENSEN

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Abstract

The problem addressed in this study is that patients who identify as lesbian, gay, bisexual, transgender, queer, intersex, or asexual are at risk for inadequate nursing care because nursing graduates are not prepared to provide affirming care. The purpose of this qualitative phenomenological study was to document the lived experiences of nursing educators implementing inclusive health education in pre-licensure nursing curricula, guided by Transformative Learning Theory. Open-ended virtual interviews were conducted with 10 nurse educators in the United States who held a master's degree in nursing and taught in pre-licensure nursing programs. Participants were recruited through a social media group for nurse educators. Data were analyzed using thematic analysis integrated with interpretative phenomenological analysis to identify patterns and themes. Key findings indicated that nurse educators experience multiple barriers when integrating inclusive health content into pre-licensure nursing curricula, including limited collegial, leadership, and institutional support, competing curriculum priorities, and regional influences. Implications from the findings suggest that nurse educators may require intentional self-reflection and preparation before implementing LGBTQIA+ health content into the curriculum. Findings also indicated that successful curriculum integration was influenced by educators' intentions and the level of professional and institutional support available. Implications of these findings suggest that institutional leadership can influence LGBTQIA+ health content integration by providing or limiting training, guidance, and curricular resources. These findings contribute to nursing education practice by identifying structural and interpersonal factors that influence curriculum implementation and highlight the need for institutional and leadership support to promote inclusive, patient-centered nursing education.

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Section 1: Foundation

The lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) community often report not trusting or being discriminated against by healthcare professionals (Gedzyk-Nieman & Hand, 2023). Although some articles use acronyms such as LGBT, LGBTQ, or LGBTQ+ all are acknowledged as part of the inclusive LGBTQIA+ community. To remain consistent, this study documents use of LGBTQIA+ to represent members of the community. For example, members of the LGBTQIA+ community have reported higher incidences of conditions such as depression, anxiety, substance abuse, smoking, and sexually transmitted diseases, including HIV. These health disparities are further perpetuated by the discriminatory practices of nurses toward the LGBTQIA+ population when seeking healthcare (Sherman et al., 2023). Due to the increased incidences of discrimination that the LGBTQIA+ community faces when seeking healthcare, organizations such as the American Nurses Association (ANA) have recommended that nursing programs include LGBTQIA+ health-related concerns in the curriculum (Gedzyk-Nieman & Hand, 2023).

Although the ANA has recommended implementing LGBTQIA+ curriculum in pre-licensure nursing programs, many institutions across the United States have not made the necessary changes (Sherman et al., 2023). A survey conducted in the United States showed that approximately 17% of associate degree Nursing (ADN) and Bachelor of Science in Nursing (BSN) programs in the United States, implemented curriculum changes regarding LGBTQIA+ health-related topics (Gedzyk-Nieman & Hand, 2023; Web & Zablocki, 2022). Web and Zablocki (2022) found that the median time spent in BSN programs throughout the program on LGBTQIA+ health-related topics is only 2.12 hours. One of the gaps in nursing education is

related to inadequate LGBTQIA+ education in pre-licensure nursing programs and requires a further look into the lack of support provided to the nurse educator.

There are multiple challenges to implementing LGBTQIA+ health topics into pre-licensure nursing programs throughout the United States. One challenge is related to the required textbooks in nursing programs because they do not contain LGBTQIA+ health-related topics or have incorrect information (Klepper et al., 2023). For nursing instructors dedicated to implementing a curriculum that ensures LGBTQIA+ health-related topics are addressed, this can result in a time constraint barrier because of the need to search for appropriate supplemental materials.

Nurse educators have also identified a lack of institutional support as a barrier to implementing curricular changes to include LGBTQIA+ health-related topics (Webb & Zablocki, 2022). Without institutional support, time constraints are exacerbated because the nurse educator is not provided additional time to dedicate to implementing LGBTQIA+ health-related issues into the curriculum. Another factor identified by nurse educators is their lack of knowledge regarding LGBTQIA+ health-related issues and the need for additional training and resources from the institution (Webb & Zablocki, 2022).

Because the National Council of State Boards of Nursing - Registered Nursing (NCLEX-RN), the examination body responsible for testing and giving licenses to nursing graduates, does not include LGBTQIA+ health-related issues as a required topic on their text plan, many nurse educators feel they do not have the time to implement curriculum changes due to the amount of required content. Other barriers included conservative and religious factors of the institution or nursing instructor, which reduced the likelihood of implementing curriculum changes to include LGBTQIA+ health topics in the pre-licensure nursing program (Sherman et al., 2023). Although

the lack of LGBTQIA+ information in nursing textbooks is a major issue, addressing challenges within the institution that hinder the necessary curriculum changes will help identify additional areas of concern.

Graduate nurses must provide patient-centered care for all members of society. About 4.5% of the population in the United States identify as a member of the LGBTQIA+ community (Sherman et al., 2023). Without training and education regarding LGBTQIA+ health-related topics, many new graduate nurses will not have the information and tools to provide patient-centered care. For example, 25% of nursing students surveyed do not believe that a suicide assessment is a necessary evaluation tool for the LGBTQIA+ population (Sherman et al., 2023). However, many members of the LGBTQIA+ community report mental health issues such as depression and suicidal ideations and do not seek treatment due to discrimination and stigmatization. Studies have shown that members of the LGBTQIA+ community have limited access to healthcare and, when seeking healthcare, have a reduced quality of care due to discrimination and lack of knowledge by the healthcare professional. Nursing faculty face many institutional challenges, such as lack of support and training, leading to feeling unprepared to provide instruction to nursing students about LGBTQIA+ health-related topics, which can impact the graduate nurses' ability to provide patient-centered care.

Nurse educators are the cornerstone for implementing curriculum changes in nursing programs that will impact patient care (Hassmiller & Wakefield, 2022). Pre-licensure nursing programs must ensure that the required textbooks include LGBTQIA+ health-related topics or supplemental resources for their students (Klepper et al., 2023). Ensuring textbooks have the needed information can reduce the impact of time constraints identified by many nurse

educators. Institutions must provide additional training and resources to nurse educators (Hassmiller & Wakefield, 2022).

Webb and Zablocki (2022) discussed that many nurse educators do not have adequate knowledge about LGBTQIA+ health topics and do not feel comfortable discussing the issues with their students. Nurse educators sometimes feel there is too much information to cover, including LGBTQIA+ health topics. However, threading the health topics in each course rather than trying to discuss them in one course, such as mental health, will provide exposure to LGBTQIA+ health topics throughout the nursing program (Brown et al., 2023). Including small group activities and clinical skills, scenarios will ensure that LGBTQIA+ content is included, and the graduate nurse after graduation and licensure will be prepared to care for all members of society.

Nursing programs are not required to obtain certification through accrediting bodies; some can gain approval from the state boards of nursing. An example of an accrediting body for nursing programs is the American Association of Colleges of Nursing (AACN), which now requires nursing programs to address health disparities as part of their accreditation standards (Mueller-Burke et al., 2024). One way to ensure that all nursing programs throughout the United States include LGBTQIA+ content is to include it in the NCLEX – RN test plan. This study explored barriers and challenges nurse educators face with LGBTQIA+ curriculum integration in pre-licensure nursing education programs.

Statement of the Problem

The problem addressed in this study is that LGBTQIA+ patients are at risk for inadequate nursing care, because nursing instructors are not required to include LGBTQIA+ curriculum in pre-licensure nursing programs (Sherman et al., 2023). Graduate nurses must be able to provide

patient centered affirming care to all patients, including the LGBTQIA+ population (Wadsworth et al., 2022). Barriers identified by nursing faculty for LGBTQIA+ curriculum integration in nursing programs are a lack of confidence with LGBTQIA+ health related content, time constraints, inadequate materials, and religion constraints (Klepper et al., 2023; Sherman et al., 2022). When nurse educators receive training and can implement LGBTQIA+ curriculum graduate nurses will be equipped with the tools to provide patient centered care to the LGBTQIA+ population (Hassmiller & Wakefield, 2022).

Klepper et al. (2023) found that 16% of nurse educators surveyed in the United States believed their graduates possessed the knowledge and skill required to provide adequate care to the LGBTQIA+ population. However, members of the LGBTQIA+ population report mistreatment and denial of healthcare from nurses (Sherman et al., 2023). Further, in a review of pre-licensure nursing textbooks many had inappropriate terminology or misrepresented the health disparities in the LGBTQIA+ population (Klepper et al., 2023). The lack of education to provide care to the LGBTQIA+ population in pre-licensure nursing programs is already resulting in subpar care for the LGBTQIA+ population (Sherman et al., 2022). If this problem is not addressed, the LGBTQIA+ population will continue to receive subpar care. Because many nurse educators are not knowledgeable or comfortable about LGBTQIA+ health related concerns, new graduate nurses are not prepared to provide care to the LGBTQIA+ population and graduate nurses surveyed reported having negative or neutral thoughts about the population (Huges et al., 2022).

Purpose of the Study

The purpose of this qualitative phenomenological study was to document the lived experiences of nursing educators in implementing LGBTQIA+ education in the pre-licensure

curriculum. This study is a logical research response to the stated problem and the research questions because if research isn't conducted on implementing LGBTQIA+ health content into pre-licensure nursing curricula, the LGBTQIA+ population will continue to receive subpar medical care. The population is all U.S. nursing educators. A purposeful sampling of eight to 10 participants was needed with the inclusion criteria of having a master's degree or higher in nursing education, and one year or more teaching experience, full or part time, in a U.S. pre-licensure nursing program. A Facebook nursing educator group was utilized to recruit interested nurse educators. Nurse educators were invited for a virtual interview using semi-structured questions. Demographic variables collected included age, race, gender, and region of the country to provide the reader with context for the findings. This study contributes to the literature, highlighting nurse educators' lived experiences of barriers faced when implementing LGBTQIA+ health content into pre-licensure nursing curricula.

Research Questions

Overarching RQ1

What are the lived experiences of nursing educators implementing LGBTQIA+ education into course curricula in pre-licensure nursing programs, including how geographical region, institutional leadership, and peer educator attitudes impacts implementation?

Sub Questions

RQ1a

How do nurse educators describe their experiences when attempting to include LGBTQIA+ health topics in the nursing curriculum?

RQ1b

How does institutional leadership and peer educator attitudes impact the integration of LGBTQIA+ health content into the nursing curriculum?

RQ1c

How does geographic region of the United States impact the lived experiences of nurse educators in implementing LGBTQIA+ health content into the nursing curriculum?

Theoretical Framework

Integrating LGBTQIA+ health content in nursing education is essential to ensure graduate nurses are prepared to provide patient-centered care to LGBTQIA+ individuals (Sherman et al., 2023). Building on Transformative Learning Theory (TLT) principles, such as freedom from oppression and political liberation, this study allows educators to share their experiences and perspectives on LGBTQIA+ curriculum development (Dirkx, 1998; Muzari et al., 2022). TLT, developed by Jack Mezirow in the 1970s, has been expanded by scholars such as Larry Daloz (1986) and Dirkx (1998), who added emotional depth. Mezirow (1998) defines TLT as a process where the educator helps the learner examine and challenge their assumptions through reflection. In the context of LGBTQIA+ curriculum development, nurse educators must also reflect critically on their beliefs and biases before integrating inclusive content (Ryan et al., 2022). Self-reflection is the key to reshaping how content is developed and delivered, ensuring students are guided to provide affirming, inclusive care.

Although Nye and Dillard-Wright's (2023) study does not directly reference TLT, their article explored overlapping themes such as heteronormative language, critical reflection, and the importance of challenging embedded heteronormative assumptions in nursing education. Klepper et al. (2023) highlighted that nursing textbooks either use inappropriate terminology or entirely

lack LGBTQIA+ content. Connecting this to TLT, these gaps in foundational materials may lead educators to confront inconsistencies in what they have been using or teaching, which can result in a dilemma that prompts them to reflect, question, and adapt their approach to teaching.

Definitions of Key Terms

Barriers

For this study, barriers are defined as lack of knowledge, limited resources, and religious or personal beliefs that can hinder nurse educators from integrating LGBTQIA+ health-related content into the curriculum (Gedzyk-Nieman & Hand, 2023; Sherman et al., 2023).

Curriculum Integration

For this study, curriculum integration is defined as embedding LGBTQIA+ health content across nursing courses to ensure consistent exposure and competence development (Gedzyk-Nieman & Hand, 2023).

Health Disparities

For this study, health disparities are defined as when healthcare needs of the LGBTQIA+ community are not adequately met due to provider bias, lack of knowledge, and discriminatory practices (Eickhoff, 2021).

LGBTQIA+

LGBTQIA+ is an acronym for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other sexual and gender minorities (Burton et al., 2021).

Review of the Literature

The problem addressed in this study is that the LGBTQIA+ patients are at risk for inadequate nursing care, because there is no specific national LGBTQIA+ curriculum required for pre-licensure nursing programs (Sherman et al., 2023). The purpose of this qualitative

phenomenological study was to document the lived experiences of nursing educators in implementing LGBTQIA+ education in the pre-licensure curriculum. The literature search revealed current emerging themes, which included: (a) discrimination in healthcare, (b) challenges that nurse educators experience when implementing LGBTQIA+ health-related content, (c) lack of accreditation requirements from the NCLEX-RN, and (d) the regional and institutional influences that affect integration of LGBTQIA+ curriculum.

The National University Navigator provides access to multiple databases, including CINAHL, ProQuest, EBSCOhost, and ScienceDirect. Additionally, Google Scholar was used to identify peer-reviewed research that was not in institutional databases. Search parameters utilized the following limiters of full-text peer-reviewed academic journals, English language, and between 2022-2025 to search for relevant research articles related to LGBTQIA+ pre-licensure curriculum. The following three searches were conducted utilizing the same limiters and Boolean operators (e.g., AND) to refine results: (a) LGBTQIA+ AND nursing programs that yielded 16 results, (b) LGBTQIA+ AND education AND U.S.A that yielded 22 results, and (c) LGBTQIA+ AND education AND health care programs that yielded 22 results. Using the search terms and including AND helped to narrow the results into meaningful and manageable information.

LGBTQIA+ Discrimination in Healthcare

The LGBTQIA+ population faces stigmatization and discrimination when seeking healthcare, leading to poor healthcare outcomes (Day et al., 2023; Gedzyk-Nieman & Hand, 2023; Sherman et al., 2023). As a result of the negative experiences when seeking healthcare, many of the LGBTQIA+ population report not seeking healthcare (Sherman et al., 2023). Still today, throughout the United States, many of the LGBTQIA+ population continue to experience trauma, discrimination, and violence (Fontenot et al., 2023). Overall, the LGBTQIA+ population

receives less preventative care education and has less access to quality healthcare (Klepper et al., 2023). Providing equitable care to diverse patient populations is an essential competency for nursing graduates (Dobkin et al., 2024).

The National Institutes of Health (NIH) identifies sexual and gender minorities as a population with significant health disparities and there is a high prevalence of psychiatric conditions within this group, including depression, eating disorders, substance use disorders, and suicide (Hughes et al., 2022). Ensuring that preventive care is patient-centered and affirming is essential (Brown et al., 2023; Wadsworth et al., 2022). Lesbian women experience higher rates of obesity, arthritis, asthma, and overall poor physical health compared to heterosexual women (Bloompott et al., 2023). At the same time, gay men have higher incidences of cancer, chronic obstructive pulmonary disease, and HIV. Transgender and lesbian women also report disproportionately high rates of unmet mental health needs compared to their heterosexual counterparts (Bloompott et al., 2023).

The LGBTQIA+ population is discussed as one community. However, some subpopulations have different healthcare needs (Brown et al., 2023; Burton et al., 2021). Identifying the various subpopulations is necessary to understand the various needs within the population. Sexual identity refers to how an individual defines their emotional, romantic, or sexual attraction to others, which may include identities such as lesbian, gay, bisexual, or heterosexual (Burton et al., 2021). Gender identity is distinct from sexual identity; for example, a transgender person's gender identity does not align with the sex assigned at birth. Sexual and gender identities can coexist and intersect; for example, a transgender women may identify as a lesbian and also use the term queer to describe her sexual orientation.

The identities of individuals within the LGBTQIA+ population are also shaped by factors such as culture, political views, age, socioeconomic status, ethnicity, and religion (Burton et al., 2021). In a survey, 30.8% of transgender people report delaying or not seeking healthcare due to discrimination (Jewell & Petty, 2024). Graduate nurses must understand the diverse factors that influence LGBTQIA+ health, including unique needs of subpopulations such as transgender individuals, and recognize the importance of providing patient-centered, affirming care (Elertson & McNiel, 2021).

Roy and Clark (2024) conducted a cross-sectional survey of pre-licensure nursing students in the northeastern United States who had completed at least one clinical rotation or graduate nurses with less than two years of work experience. Seventy-three participants completed the survey, and 90% were enrolled in a pre-licensure nursing program. Fifty-four percent of nursing students reported observing stigmatizing behaviors toward the LGBTQIA+ patient population from their clinical instructor, nurses on the floor, or nursing assistants. Forty percent of nursing students reported observed stigmatizing behavior towards members of the LGBTQIA+ patient population by doctors or nurse practitioners. Further, 31.5% of participants reported they had personally demonstrated stigmatizing behavior toward an LGBTQIA+ patient, with the most commonly reported stigmatization being misgendering. Jewell and Petty (2024) reported that 70.1% of transgender, nonbinary, and gender expansive individuals had experienced an interaction with a healthcare provider that was negative. Roy and Clark (2024) believe that stigmatization begins in nursing school and follows the new graduate nurse into the professional role through role-modeling behaviors. These findings suggest that stigmatizing behaviors are not only observed but also carried forward into clinical practice, reinforcing the need for intentional curriculum reform that promotes affirming care for LGBTQIA+ individuals.

Challenges in Implementing LGBTQIA+ Curriculum

Because stigmatization role-modeling behaviors begin in pre-licensure nursing programs, implementing curriculum changes that include LGBTQIA+ health-related content is essential (Sherman et al., 2023). Some barriers identified by nurse educators include a lack of knowledge and confidence to discuss LGBTQIA+ health-related topics, holding negative views of the LGBTQIA+ population, and difficulty finding evidence-based teaching resources (Bloompott et al., 2023; Day et al., 2023; Eickhoff, 2021; Webb & Zablocki, 2022).

Eickhoff's (2021) descriptive cross-sectional research surveyed nurse educators from 294 pre-licensure nursing programs throughout the United States and received the following challenges identified from the nurse educators who participated where able to select multiple challenges and barriers identifying (a) 66.9% reported time constraints, (b) 15.4% reported that the nursing faculty was not interested in teaching LGBTQI+ content, (c) 53.7% were unsure of where to include LGBTQIA+ content, (d) 55.1% felt they did not have the knowledge required to teach LGBTQIA+ health-related content, (e) 3.7% the nursing program did not want LGBTQIA+ taught in the program, and (f) 1.5% of educators reported the topic had not come up. Eickhoff's (2021) study highlighted nurse educators' experiences, challenges and barriers when implementing LGBTQIA+ health-related curricula.

Bloompott et al. (2023) conducted a quantitative, cross-sectional, comparative descriptive study of 142 pre-licensure program deans and directors in the United States with an online email survey to determine the amount of LGBTQIA+ health-related content included in the curriculum. SPSS using ANOVA was utilized to analyze the data and the average time spent across the entire program was on average 4.5 hours, throughout the United States. The study highlighted that associate degree nursing programs had more LGBTQIA+ topics in their curriculum than

bachelor's degree nursing programs and that geographical location has a role in the amount of LGBTQIA+ health topics included in the curriculum. This study also identified barriers nurse educators report with LGBTQIA+ curriculum integration: (a) 27.2% knowledge and comfort, (b) 21.4% not enough time, (c) 6.8% religious beliefs of the school or faculty member, and (d) 21.4% reported no barriers.

Priddle et al. (2023) conducted an international scoping review to examine the inclusion and representation of LGBTQIA+ health-related content in undergraduate nursing education. The review included 30 peer-reviewed empirical studies involving undergraduate nursing students, nurse educators, faculty, and nursing school administrators. Studies not in English, on graduate programs, or involving non-nursing students were excluded. Thematic analysis revealed six major themes: (a) level of knowledge regarding LGBTQIA+ people and their specific health needs, (b) comfort and preparedness in providing care to LGBTQIA+ individuals, (c) attitudes toward LGBTQIA+ people, (d) inclusion of LGBTQIA+ educational content, (e) framing of LGBTQIA+ educational content, and (f) pedagogical strategies used to incorporate LGBTQIA+ content. A significant knowledge deficit among students and educators was identified as a major contributor to inadequate care and persistent disparities (Priddle et al., 2023).

Priddle et al. (2023) also found that many nursing students felt unprepared to care for LGBTQIA+ patients and reported that their nursing programs inadequately addressed these topics. When LGBTQIA+ content was included, it was often limited to topics such as HIV, STIs, or mental health, reinforcing stigmatizing narratives. Textbook analyses revealed framing of heterosexuality as the norm and LGBTQIA+ individuals as "deviating from normal" or included only under general terms like "vulnerable populations." The review acknowledged limitations, including the medium quality of many studies and the lack of intersectional analysis. Priddle et

al. (2023) recommended the integration of comprehensive, affirming LGBTQIA+ health content throughout nursing curricula using inclusive pedagogical approaches.

Highlighting the multiple challenges nurse educators identify as barriers to implementing LGBTQIA+ health content into the curriculum, Klepper et al. (2023) conducted a qualitative descriptive analysis to address the lack of LGBTQIA+ content in the required textbooks in pre-licensure nursing programs. During the analysis of the 14 required textbooks from a pre-licensure nursing program, there were omissions, incorrect terminology, and negative portrayals of the LGBTQIA+ population. Of the 14 required textbooks, four completely omitted LGBTQIA+ health-related content. Lack of LGBTQIA+ health-related topics results in nurse educators omitting LGBTQIA+ topics due to time constraints to teach NCLEX-RN required content (Klepper et al., 2023).

Nurse educators often lack access to standardized continuing education on LGBTQIA+ health, which is frequently cited as a major barrier to integrating LGBTQIA+ topics into nursing curricula (Gedzyk-Nieman & Hand, 2023; Murray et al., 2024; Web & Zablocki, 2022). While many nursing instructors report being unprepared to teach LGBTQIA+ content, most states and institutions do not require participation in related LGBTQIA+ professional development (Gedzyk-Nieman & Hand, 2023). The literature describes the barriers to LGBTQIA+ continuing education and the lack of knowledge by nurse educators (Eickhoff, 2021; Murray et al., 2024).

One example of an educational initiative designed to address these gaps is the LGBTQIA+ Health Initiative developed by the Johns Hopkins School of Nursing (Sherman et al., 2021). This resource aimed to improve nurse educators' knowledge, confidence, and access to evidence-based materials and is readily available to support the integration of LGBTQIA+ health content into nursing curricula. Without institutional mandates or accreditation incentives,

continuing education remains an untapped resource for overcoming faculty knowledge gaps (Eickhoff, 2021; Gedzyk-Nieman & Hand, 2023; Murray et al., 2024). The lack of required LGBTQIA+ continuing education sustains inequities in both content delivery and student competency (Eickhoff, 2021; Murray et al., 2024).

Another reason nurse educators cite the lack of LGBTQIA+ health content in pre-licensure nursing curricula is the lack of available resources (Bloompott et al., 2023; Klepper et al., 2023; Priddle et al., 2023). In a study conducted by Klepper et al. (2023), most required nursing textbooks were found to either omit LGBTQIA+ content entirely or use incorrect terminology. Due to these limitations, nurse educators who attempt to integrate LGBTQIA+ health topics must often spend significant time locating and evaluating supplemental, evidence-based materials. Priddle et al. (2023) also found that when LGBTQIA+ content is included, it is often grouped with other minority populations or presented in superficial ways. The most common topics where LGBTQIA+ health is addressed include HIV, sexually transmitted infections, mental health, and youth issues; reinforcing heteronormative frameworks within nursing education (Bloompott et al., 2023; Priddle et al., 2023). These findings emphasize that when LGBTQIA+ content is not integrated into standard textbooks, nurse educators must independently locate and evaluate supplemental materials adding to their already significant time constraints and further discouraging integration.

The various studies highlighted common challenges nurse educators face when implementing or attempting to implement LGBTQIA+ health content into the curriculum. Nurse educators report a lack of training, minimal institutional support, conflicting cultural or religious beliefs, time constraints, and exclusion of LGBTQIA+ topics in required resources and the national licensure examination (Bloompott et al., 2023; Eickhoff, 2021; Klepper et al., 2023;

Priddle et al., 2023; Sherman et al., 2023; Web & Zablocki, 2022). These challenges highlight the complexity of implementing inclusive education and the importance of understanding how nurse educators experience and respond to these barriers.

Lack of LGBTQIA+ Content in NCLEX and Accreditation Standards

The ANA, NIH, and the National Academy of Medicine believe there must be a national standard for training healthcare professionals to provide patient-centered care to the LGBTQIA+ population (Sherman et al., 2023). The LGBTQIA+ population continues to experience high incidences of discrimination when seeking healthcare, resulting in health disparities such as increased risk of depression, anxiety, substance abuse, and sexually transmitted diseases (Gedzyk-Nieman & Hand, 2023; Sherman et al., 2023). The ANA recommends including LGBTQIA+ health content in pre-licensure nursing curricula; however, significant curricular changes have not been adopted across the U.S. (Sherman et al., 2023). Each nursing program designs its curriculum, and each state board approves it. Due to the extensive content required for licensure preparation, nurse educators often omit LGBTQIA+ topics in favor of content included in the NCLEX-RN test plan (Webb & Zablocki, 2022). Although research continues to highlight gaps and systemic barriers, without formal accreditation or licensing mandates, LGBTQIA+ curriculum integration remains inconsistent. Although nursing and medical organizations recommend that curricula include LGBTQIA+ health-related topics, nursing curricula remain inconsistent throughout the United States (Sherman et al., 2023).

Each nursing program is responsible for developing appropriate curricula based on the state board of nursing requirements (Bloompott et al., 2023). Because there is no standardized curriculum, each program has varying amounts of LGBTQIA+ health-related content. Many nurse educators report that they do not have enough time to implement LGBTQIA+ content.

Because the content is not included in the NCLEX-RN test plan, some nurse educators do not believe it is important to include LGBTQIA+ health-related topics in the curriculum (Webb & Zablocki, 2022). Although some higher education institutions offer continuing education nurse educators are not required to participate in LGBTQIA+ continuing education (Gedzyk-Nieman & Hand, 2023).

Murray et al. (2024) conducted an exploratory Qualtrics online survey of 38 nurses and allied health educators to determine the educator's knowledge of LGBTQIA+ health inequities. The study utilized paired-sample t-tests to analyze the educator's knowledge, self-efficacy, and inclusion of LGBTQIA+ health content, comparing LGB and T+ scales. The study found that faculty's knowledge of LGBTQIA+ health content was low to moderate, with especially low T+ health knowledge reported. While self-efficacy was higher than previous studies, 75% of educators continue to report not feeling confident discussing LGBTQIA+ health topics (Murray et al., 2024). The study's limitations were reported as having a small, homogenous (white), heterosexual, and cisgender sample. Clinical experience is a required element of pre-licensure nursing programs, and often, there is little or no direct interaction or patient care with members of the LGBTQIA+ population (Sherman et al., 2023). Providing care during learning experiences to members of the LGBTQIA+ population improves student learning and empathy (Murray et al., 2024).

In response to the evolving healthcare landscape, Mueller-Burke et al. (2024) described how nursing education is transitioning from a knowledge-based model to a competency-based education (CBE) framework. This approach aligns with the AACN's 2021 Essentials and emphasizes the integration of population health, social determinants of health, health equity, structural bias, ethical decision-making, and advocacy into nursing curricula. Nursing graduates

must demonstrate broad competencies across knowledge, skills, and attitudes to care for a diverse patient population effectively. Successful implementation of these curricular reforms requires strong collaboration across departments, including curriculum committees and diversity, equity, and inclusion (DEI) leadership. While the AACN Essentials promote equitable care principles, they do not mandate the inclusion of LGBTQIA+-specific health content, leaving its integration at the discretion of individual nursing programs (Mueller-Burke et al., 2024).

This qualitative phenomenological study highlighted the lived experiences of nurse educators implementing LGBTQIA+ health-related content into pre-licensure curricula. Bloompott et al. (2023) and Eickhoff (2021) discussed the multiple challenges nurse educators face when implementing LGBTQIA+ health curriculum, and both highlight the same two main challenges: knowledge and comfort, and time constraints. At the same time, Bloompott et al. (2023) reported that 21.4% of participants reported no barriers to implementing LGBTQIA+ health-related content, and Eickhoff (2021) did not find any participants who reported barriers. Klepper et al. (2023) found that required pre-licensure nursing textbooks either omitted LGBTQIA+ health-related content or had incorrect terminology, highlighting the need for the nurse educator to spend additional time preparing lessons. Web and Zablocki (2022) discussed that because the NCLEX-RN test plan does not include LGBTQIA+ health content, many nurse educators do not make the time to include it in their lessons. The study conducted by Murry et al. (2024) focused on health educators' knowledge and self-efficacy, which showed a need for higher education institutions to include LGBTQIA+ health education for educators training future nurses. This study raises awareness of current issues that nurse educators experience with implementing LGBTQIA+ health content into pre-licensure nursing curricula.

Regional and Institutional Influences on LGBTQIA+ Curriculum Integration

Dobkin et al. (2024) found that smaller pre-licensure nursing programs were more likely to include terms such as health equity, underserved populations, and anti-racism in their mission statements; 100% of programs with fewer than 100 students included these themes, compared to just 56% of larger programs. Interestingly, in states where anti-DEI legislation failed or was vetoed, a higher percentage of students only spoke English. On the other hand, states where DEI legislation passed had more faculty engaged in community health programs. Public institutions stood out, with 82% including public health content in their curriculum, compared to 33% of private schools. Lastly, associate degree nursing programs demonstrated stronger performance on social mission indicators than bachelor's programs, including strategic planning and community engagement (Dobkin et al., 2024).

Sherman et al. (2023) found that nursing faculty in U.S. regions characterized by intense religiosity and conservative political views reported higher levels of homophobia and transphobia, along with decreased interactions with LGBTQIA+ populations. In many of these institutions, LGBTQIA+ content is only addressed in a single course or elective rather than being integrated throughout the nursing curriculum. A frequently cited barrier among nurse educators was a lack of time for curriculum reform. One contributing factor is that faculty often do not have sufficient time for educational research or curriculum development, resulting in a relatively limited body of scholarly work on LGBTQIA+ curriculum integration (Sherman et al., 2023).

Wadsworth et al. (2022) found that 79.2% of LGBTQIA+ self-identified faculty and students believed their heterosexual and cisgender counterparts lacked competency in caring for LGBTQIA+ patients. In contrast, 53.5% of heterosexual and cisgender faculty and staff felt they had received adequate training to provide affirming care. Faculty in some institutions are further

constrained by rigid curriculum guidelines, which limit their ability to include LGBTQIA+ content. This highlights the ongoing absence of consistent, nationally mandated curriculum standards (Wadsworth et al., 2022).

To address ongoing barriers to equitable care, nurses must be prepared to lead and engage in health equity initiatives (Hassmiller & Wakefield, 2022). The Robert Wood Johnson Foundation (RWJF; n.d.) and the National Academy of Sciences, Engineering, and Medicine (NASEM, 2021) recommended that nursing organizations develop a shared strategic framework to tackle social determinants of health and improve population-level outcomes. By 2030, an estimated 1.2 million nurses will retire, potentially creating a significant knowledge gap (Hassmiller & Wakefield, 2022). In response, many nursing programs are shifting curricula to prepare students for evolving healthcare, technology, and policy roles (Hassmiller & Wakefield, 2022).

The NASEM (2021) report emphasizes the need to integrate health equity education into nursing curricula, expand the number of PhD-prepared nurses, and ensure that graduates are equipped to serve increasingly diverse populations. However, social determinants of health and health inequities remain inconsistently embedded across pre-licensure nursing education (Sherman et al., 2023). To ensure competence upon graduation, students must actively engage in experiential learning supporting culturally responsive and equity-focused care. Moreover, increasing the number of PhD-prepared faculty with expertise in health equity is critical to building a curriculum that adequately addresses these themes (NASEM, 2021).

Despite multiple calls for a representative workforce, nursing remains 80% white and female, even as this group makes up only 60% of the U.S. population. Institutions must dismantle structural racism by reforming policies, courses, content, and clinical placements

(Hassmiller & Wakefield, 2022). The recommended changes by RWJF and NASEM to improve workforce diversity, equity, and inclusion begin within nursing education. These changes include eliminating discriminatory academic content and policies, enhancing academic access for socioeconomically and geographically disadvantaged students, and recruiting diverse faculty prepared to deliver education on health equity (Hassmiller & Wakefield, 2022).

In 12 states across the United States, a qualitative descriptive study, using semi-structured interviews, was conducted to examine how nurse leaders in hospitals define LGBTQIA+ inclusive practices and identify approaches they consider practical for implementation (Yu et al., 2024). The study included 21 participants in senior leadership roles, such as chief nurse executive, chief nursing officer, or nurse director, representing institutions ranging from public health systems to children's hospitals. Geographically, institutions from the South, Northeast, Midwest, and West were represented, with 42.9% of organizations participating in the Human Rights Campaign's Health Equality Index. Like barriers seen in academic settings, participants highlighted the lack of comprehensive guidance from accrediting and regulatory bodies – such as the Joint Commission and Centers for Medicare & Medicaid Services – as a challenge to establishing system-wide LGBTQIA+ equity standards. A limitation of the study was the use of purposive snowball sampling, which may have favored institutions already invested in LGBTQIA+ inclusion, potentially limiting perspectives from less progressive regions (Yu et al., 2024).

Student Outcomes

Patients often interact with nurses before any other healthcare professional, which shapes their initial healthcare experience and perceptions (Elertson & McNiel, 2021). Due to the lack of knowledge and comfort about LGBTQIA+ curriculum, expressed by many nurse educators,

graduate nurses are often not adequately prepared to deliver patient-centered, affirming care to the LGBTQIA+ community (Hughes et al., 2022). This lack of preparation results in graduate nurses demonstrating poor cultural competence in critical areas such as cancer screening, reproductive health, gender-affirming care, and assessment of sexual orientation and gender identity. Alarming, an estimated one-third to one-half of nursing students surveyed reported discomfort when caring for LGBTQIA+ individuals, contributing to continued healthcare discrimination and negative experiences for this population (Roy & Clark, 2024).

Transgender and gender-diverse patients often report they must educate their healthcare providers about their own health needs, highlighting a significant gap in pre-licensure training (Elertson & McNiel, 2021). In response to this gap, Elertson and McNiel (2021) implemented an educational intervention for 33 senior nursing students using a six-member volunteer panel representing diverse identities within the LGBTQIA+ community. Following the panel discussion, 88% of students reported increased awareness of health disparities affecting LGBTQIA+ individuals, and 67% stated they had developed at least one actionable strategy to improve their care for this population. These findings suggest that targeted educational interventions can enhance student preparedness and support culturally competent, affirming nursing care (Elertson & McNiel, 2021).

Priddle et al. (2023) found that approximately 40% of nursing students nearing the end of their programs reported feeling unprepared to provide affirming care to LGBTQIA+ patients, citing a lack of communication skills and specific knowledge as contributing factors; those who felt prepared or somewhat prepared often credit personal experiences or knowledge gained outside their nursing education. Notably, a positive association was observed between students' preparedness and the frequency of LGBTQIA+ content integrated throughout their coursework.

Simulation-based learning has emerged as an effective strategy to increase students' competence and confidence; however, nearly all simulations reviewed by Priddle et al. (2023) involved transgender patients in mental health scenarios, indicating a limited scope. Bloompott et al. (2023) found that LGBTQIA+ content was mostly delivered through lectures (36.1%) and case studies (17.6%), with only one participating program reporting adequate coverage of LGBTQIA+ health topics. These findings emphasize that limited or uneven LGBTQIA+ content within nursing curricula may not adequately prepare students to deliver inclusive care, highlighting the need for consistent, well-integrated educational strategies.

Integrating LGBTQIA+ Health into Pre-Licensure Nursing Curricula: Best Practices

Organizations such as the National LGBTQIA+ Health Education Center (n.d.) were developed to improve health equity for LGBTQIA+ populations by addressing specific health disparities and enhancing the overall quality of care. The Center designs evidence-based curricular resources that can be integrated into healthcare and academic settings. These resources emphasize creating inclusive, respectful, and identity-affirming environments for LGBTQIA+ patients, students, and staff. The National LGBTQIA+ Health Education Center partners with several key organizations, including (a) Health Resources and Services Administration (HRSA) partners, (b) National Cooperative Agreements, (c) AIDS Education and Training Centers, (d) LGBTQIA+ and sexual health-focused organizations, and (e) academic institutions such as Harvard Medical School and the Center for Health Impact (National LGBTQIA+ Health Education Center, n.d.).

A wide range of free educational materials are available through the Center, including self-paced online learning modules that evaluate institutional impact, serve as change agents, and integrate sexual and gender minority health content into course or clerkship syllabi (National

LGBTQIA+ Health Education Center, n.d.). Additionally, the Center offers recorded webinars addressing diverse aspects of LGBTQIA+ health, including topics like advancing health equity for sexual minority women. For nurse educators, a teaching module developed in collaboration with Harvard Medical School provides training on effective instructional strategies and delivers affirming, culturally responsive care to LGBTQIA+ populations. All resources are free to participants, making them highly accessible to educators and clinicians alike (National LGBTQIA+ Health Education Center, n.d.).

Another national organization, The GLMA: Health Professionals Advancing LGBTQIA+ Equality promotes LGBTQIA+ health equity by providing education, advocacy, and professional development opportunities for health professionals (GLMA, n.d.). GLMA offers high-impact continuing education and accessible resources to inform clinicians and support LGBTQIA+ individuals in making informed healthcare decisions. One of its notable programs, Health Professionals in Training (HPiT), connects LGBTQIA+ learners and early-career practitioners to share experiences, access advocacy training, and participate in academic opportunities such as webinars, conference sessions, and poster presentations. HPiT participants may serve in leadership roles as co-chairs, where they help develop programming, coordinate working groups, and represent the organization in leadership forums such as GLMA board discussions. A central focus of HPiT is curriculum reform, supported by an open-access committee that welcomes students across all health disciplines, including residents and postdoctoral fellows. This committee evaluates LGBTQIA+ content in health education and creates tools to foster culturally responsive teaching. Another leadership initiative is the GLMA Health Trainee Fellowship, which engages members in developing initiatives to strengthen LGBTQIA+ health advocacy

knowledge, leadership competencies, and professional involvement within the HPiT community (GLMA, n.d.).

Also, the Stanford School of Medicine offers an educational course focused on teaching LGBTQIA+ health, specifically designed for health professions educators (Stanford Medicine, n.d.). The course enhances participants' knowledge, instructional strategies, and cultural responsiveness related to the care of LGBTQIA+ patients. This free program is accessible to any health educator interested in integrating LGBTQIA+ content into their curriculum. Course content includes foundational teaching principles and real-world case scenarios that support practical application. Upon completion, participants receive a certificate of completion (Stanford Medicine, n.d.).

Ethical Assurances

This study received approval from National University's Institutional Review Board (IRB) and permission from Facebook nurse educator groups administrators before recruitment begins. The study presents minimal risk to participants. Anonymity and confidentiality were maintained through pseudonyms, and any identifiable data is accessible only to me. Data is stored on a password-protected external drive that is kept in a locked cabinet and retained for three years per IRB policy, after which it will be securely deleted.

I identify as a member of the LGBTQIA+ community and as a nurse educator with experience in curriculum development. Given this positionality, I acknowledge assumptions such as the belief that time constraints, institutional priorities, or personal beliefs may influence faculty resistance to implementing LGBTQIA+ content. To address potential bias, I maintained a reflexive journal throughout the study to reflect critically on my personal assumptions. Member

checking was conducted to verify that the codes and themes developed accurately reflect the participants' lived experiences.

Summary

Despite national recommendations, the absence of a required LGBTQIA+ curriculum in pre-licensure nursing programs continues to place LGBTQIA+ individuals at risk for discrimination in healthcare settings (Sherman et al., 2023). This qualitative phenomenological study documented the lived experience of nurse educators implementing LGBTQIA+ health-related curricula in U.S. pre-licensure nursing programs. Understanding these experiences is essential to identifying barriers and supporting curriculum reform that promotes affirming, patient-centered care for LGBTQIA+ individuals (Sherman et al., 2023).

Participants were recruited from a Facebook group for nurse educators using purposeful sampling, with inclusion criteria requiring a master's degree or higher in nursing education and at least one year of teaching experience. One-on-one, semi-structured interviews (12-18 minutes) were conducted to collect data (Eatough & Smith, 2017). Using IPA, this study explored how each educator interprets their experience (Bloomberg, 2023). Data were analyzed using Braun and Clarke's (2006) six-step thematic analysis, and the four elements of trustworthiness (credibility, transferability, dependability, and confirmability) were addressed (Guba, 1981). TLT underpins the study, guiding critical reflection on institutional norms, personal beliefs, and curriculum reform (Dirkx, 1998; Mezirow, 1998; Muzari et al., 2022).

The LGBTQIA+ population in the U.S. continues to experience trauma, violence, and discrimination that contribute to health disparities (Fontenot et al., 2023). Many avoid healthcare due to prior negative experiences (Day et al., 2023; Sherman et al., 2023). Inclusive education is vital because nursing students model behaviors from instructors and clinical settings (Roy &

Clark, 2024). However, many nurse educators report insufficient knowledge, lack of confidence, and difficulty finding evidence-based resources (Bloompott et al., 2023; Eickhoff, 2021). In addition, the NCLEX-RN licensure exam does not include LGBTQIA+ health content, contributing to the perception that LGBTQIA+ nursing care is not important. (Sherman et al., 2023).

Studies continue to show that graduate nurses often lack the competence to care for LGBTQIA+ patients (Hughes et al., 2022). Nursing students report discomfort and uncertainty when caring for LGBTQIA+ individuals (Roy & Clark, 2024). However, accessible educational resources are available to support nurse educators. For example, the National LGBTQIA+ Health Education Center and Stanford School of Medicine offer free, evidence-based tools and instructional modules to enhance LGBTQIA+ curriculum integration (NSAEM, n.d.; Stanford Medicine, n.d.). By highlighting the lived experiences of nurse educators, this study aimed to outline common challenges and identify practical strategies to improve LGBTQIA+ curriculum implementation. These findings may support other pre-licensure programs across the U.S. in integrating inclusive content that prepares nursing graduates to deliver affirming, equitable care.

Section 2: Methodology and Design

The problem addressed in this study is that LGBTQIA+ patients are at risk for inadequate nursing care, because nursing instructors are not required to include LGBTQIA+ curriculum in pre-licensure nursing programs (Sherman et al., 2023). The purpose of this qualitative phenomenological study was to document the lived experiences of nursing educators in implementing LGBTQIA+ education in the pre-licensure curriculum. Section two outlines the research design and methodology, including materials, population and sample, and data collection and analysis procedures. This section also addresses the study's assumptions, limitations, and delimitations and concludes with a summary.

Design and Method

This study used a qualitative method and a phenomenological design with open-ended interviews to understand the nursing educators lived experiences of implementing LGBTQIA+ health content into pre-licensure nursing curricula. Through the interview process (Monaro et al., 2022). Qualitative research explores complex and underexamined experiences, such as nurse educators integrating LGBTQIA+ health content, by focusing on how participants interpret experiences within their real-life contexts (Larkin et al., 2019). Phenomenological research is appropriate for examining how individuals perceive and interpret their lived experiences as they appear in consciousness, aiming to understand the essence of those experiences without imposing external assumptions (Tuffour, 2017). Qualitative, phenomenological research is appropriate for this study to address the study problem, purpose and research questions.

Other types of research were considered but not selected for this study. The quantitative research method uses numerical information and random sampling to generalize findings, which would not be appropriate for this research study (Salkind, 2010). I did not choose the case study

design because this study aimed to understand the lived experiences of nurse educators as they describe them rather than to analyze a bounded system or specific program (Bloomberg, 2023). Ethnography, which is used to compare and interpret cultural patterns over time, was not selected because this study does not seek to examine cultural groups or their evolution. Grounded theory was also considered but ruled out, as the aim is not to generate a new theory but to gain a deeper understanding of nurse educators lived experiences related to implementing the LGBTQIA+ curriculum. A phenomenological design is most appropriate, as it explores how individuals make meaning of a shared experience, in this case, the integration of LGBTQIA+ content in pre-licensure nursing education (Bloomberg, 2023).

Researcher reflexivity must be transparent throughout the research (Bloomberg, 2023). My perspectives and assumptions are based on being a member of the LGBTQIA+ community and a nurse educator in a pre-licensure nursing program. One assumption is that nurse educators often do not attempt to incorporate LGBTQIA+ health-related content due to time constraints and the large amount of content already required to cover in pre-licensure nursing programs. I ensured that I did not guide interviewees towards my assumptions about why LGBTQIA+ content may be excluded. However, nurse educators must ensure that graduate nurses are prepared to provide patient-centered care to all members of society. I utilized a social constructivism paradigm approach to understand each nurse educator's experiences as they describe them when implementing LGBTQIA+ health-related content (Bloomberg, 2023). As previously discussed, participants were selected using purposeful sampling with inclusion criteria of teaching full or part-time in the classroom for a pre-licensure nursing program in the United States and having a master's degree or higher in nursing education.

Population and Sample

The population for this study was U.S. nurse educators. The National League for Nursing (2022) found 10,657 full-time nurse educators across all ranks in the United States during the 2020-2021 academic year. However, data distinguishing part-time faculty and differentiating pre-licensure from post-licensure programs (such as RN-to-BSN, MSN, or doctoral programs) were not provided (National League for Nursing, 2022). The population pool was larger because this phenomenological study included full-time and part-time nurse educators who teach in pre-licensure nursing programs. This broader pool increased the likelihood of recruiting an adequate number of participants for the study. Selecting nurse educators to provide examples of their lived experiences aligns with the IPA approach, which focuses on exploring how individuals experience and describe significant events in their own words (Eatough & Smith, 2017).

Using purposeful sampling, participants were selected through a Facebook group for nurse educators. This study included 10 participants, which is appropriate for a phenomenological study (Eatough & Smith, 2017). This sample size allows for a detailed exploration of individual experiences while supporting data saturation. Larger samples could dilute the unique perspectives of each participant, which goes against the purpose of IPA. No additional educators were recruited because data saturation was reached with 10 participants. IPA focuses on how individuals reflect on and make sense of life events, which can lead to new insights or areas to explore. Semi-structured interviews allowed for flexible, conversational dialogue and give participants space to share their experiences in depth (Eatough & Smith, 2017).

This sampling strategy aligns with IPA's focus on deeply understanding participant's lived experiences by utilizing a small, purposively selected sample (Eatough & Smith, 2017).

The goal was to explore the complexity of each nurse educator's lived experience integrating LGBTQIA+ health content into the curriculum. Data saturation is reached in IPA when no new themes or significant variations emerge from interviews (Van Manen, 2014). Because participants may find it challenging to share sensitive experiences, rich details may continue to emerge throughout the interview phase, potentially requiring additional participants to ensure saturation is achieved.

Materials/Instrumentation

This study utilized semi-structured open-ended questions (Appendix A) to collect data from participants about their lived experiences when implementing LGBTQIA+ health content into pre-licensure nursing curricula. These types of questions allowed the participants to respond in depth while allowing me to ask follow-up questions for clarification. The questions were developed based on prior literature, my professional experiences as a nurse educator, and my perspective as a member of the LGBTQIA+ community. The study's research questions were used as a guide, I ensured that the interview items address key elements relevant to the study's purpose.

The study conducted by Bloompott et al. (2023) served as a model for question development and content validation. That study included four key sections: (a) geographic and demographic items related to nursing programs, (b) a table of 15 LGBTQIA+ health topics covered in curricula, (c) a list of nine pedagogical strategies, and (d) three open-ended questions inviting participants to comment on LGBTQIA+ health integration. Nursing and LGBTQIA+ content experts reviewed their instruments to establish content validity. I utilized the format from the Bloompott et al. (2023) study to support the development of my question. A field test of my interview guide was conducted to support the trustworthiness of my instrument, utilizing two

nurse educators, who were not part of my sample. They reviewed the questions for clarity and alignment with the research purpose, based on their feedback minor adjustments to verbiage was made. In addition, I conducted a pilot test with two eligible nurse educators who met the inclusion criteria, they were not included in the final study. The pilot helped me to evaluate the clarity, flow, and appropriateness of the interview questions and procedures. No adjustments were needed after conducting the pilot test. These steps support the study's trustworthiness as outlined by Guba (1981), particularly in ensuring credibility and confirmability through careful instrument design and review.

Data Collection and Analysis

Approval from the Institutional Review Board (IRB) at National University was obtained prior to the commencement of any interviews or data collection. Data were collected through one-on-one, semi-structured virtual interviews that lasted 18-30 minutes, allowing participants to openly share their perspectives (Eatough & Smith, 2017). Participants were offered flexible scheduling options for virtual interviews and selected a date and time that best suited their availability. Each participant received a \$30 Amazon gift card as a token of appreciation for their time and contribution to the study. Each interview began with a brief introduction of myself and the purpose of the study (Appendix A). I then proceeded with semi-structured open-ended questions designed to explore participants lived experiences with integrating LGBTQIA+ health content into pre-licensure nursing curricula. With participants' consent, the interviews were audio-recorded and transcribed for analysis. All responses remain confidential, and participants were assigned pseudonyms to protect their identities. Before the interview, participants reviewed the informed consent form that outlined the study's purpose, procedures, voluntary nature, and

confidentiality measures. Research participants were recruited via an online Facebook nurse educator group. I received permission from the group administrator prior to recruitment.

Interpretative Phenomenological Analysis (IPA) was used to examine the lived experiences of nurse educators as they describe the barriers and challenges to implementing LGBTQIA+ health-related content into pre-licensure nursing curricula. This approach centers on the meaning of nurse educators' experiences and beliefs, which may influence their curricular decisions (Alase, 2017). After transcribing the interviews, Braun and Clarke's (2006) thematic analysis process was integrated with IPA to help organize the data and develop themes that reflected the data (Bloomberg, 2023), using the six-step thematic analysis approach with elements of IPA. IPA was used to understand each research participant's experiences as they described them. Then, inductive thematic analysis helped develop codes and themes across all participants' accounts. Thematic analysis includes (a) becoming familiar with the data through multiple readings to understand how participants describe their experiences implementing LGBTQIA+ health-related content, (b) developing initial codes based on the data, (c) after the initial codes are developed, grouping them to search for themes, (d) reviewing the codes and themes to ensure there is enough data, (e) after reviewing explaining the meaning of each theme in detail, and (f) after the themes are developed and defined the data was analyzed and written in narrative form to report the findings (Braun & Clarke, 2006; Creswell & Poth, 2016).

IPA aligns with the philosophical foundations of phenomenology, emphasizing the researcher's role in interpreting how participants make sense of their experiences. As Van Manen (2014) highlights, bracketing, or setting aside personal assumptions, is essential for remaining open to participants' perspectives. Beck (2023) further explains that bracketing allows the researcher to pause judgment and remain attentive to how meaning is constructed by participants.

Throughout data collection and analysis, I engaged in reflexive bracketing to critically examine my own positionality and interpretations. In line with IPA, this reflexivity supports the double hermeneutic process, in which participants interpret their own lived experiences, and I, as the researcher, interpret those interpretations to understand how meaning is constructed (Larkin et al., 2019). After the interviews were completed and transcribed, they were uploaded into NVivo, a qualitative data analysis software used to organize, manage, and code textual data (Elliott-Mainwaring, 2021). The program enabled me to develop codes and themes through an iterative process. It provides visualization tools such as word clouds, clusters, and coding trees to assist in identifying patterns and relationships within the data. As a novice user, I initially utilized NVivo's built-in tutorials and external training resources to become proficient in its application, as suggested by Elliott-Mainwaring (2021), who noted its accessibility for new users. NVivo software was initially used to begin organizing codes and themes, but due to functionality and workflow, I completed the remainder of the coding manually. Manually coding allowed closer engagement with the data and stronger alignment with the IPA approach.

Assumptions

Guba (1981) notes that assumptions in qualitative research must be contextually grounded and aligned with the study's interpretive framework, particularly when exploring individuals' perceptions and interpretations of their experiences. Guiding this study, the following assumptions are made. It was assumed that the nurse educators participating in the study were able to offer reflective insight based on their lived experiences with LGBTQIA+ curriculum integration. These participants were also expected to have personal and professional experiences with LGBTQIA+ topics that were directly relevant to the focus of this study. Virtual interviews are assumed to be effective in facilitating rapport-building and enabling the collection

of rich, in-depth data. It was assumed that qualitative phenomenology was best suited for this study because it involves a homogeneous sample of nurse educators, allowing for the exploration of their shared experiences with implementing LGBTQIA+ health content into the curriculum (Larkin et al., 2019). This research design supported an in-depth understanding of the lived experiences of participants, aligning with the study's aim to capture personal meaning and interpretation. Finally, it was assumed that participants were able to recall and articulate their experiences with sufficient depth and clarity to support phenomenological interpretation.

Limitations

IPA studies typically seek a homogeneous participant sample to ensure depth of understanding within shared experience (Larkin et al., 2019). For this study, the homogeneous sample included nurse educators with a minimum of a master's degree in nursing. A potential limitation was the small sample size standard in qualitative research, which may affect transferability (Larkin et al., 2019). This study included 10 participants for in-depth interviews to explore nurse educators lived experiences with integrating LGBTQIA+ health content into pre-licensure nursing curricula.

Using a Facebook-based nurse educator group to recruit participants may have affected transferability (Guba, 1981). Although there were some regional variations among participants, most were located along the East Coast, with a few located in the Midwest and the West. The distribution may have influenced the perspectives represented in the data. In addition, all participants were African American, and most identified as members of the LGBTQIA+ community, which may also impact the transferability of the findings. Another limitation related to transferability is the lack of diversity in nursing education. According to the National League

for Nursing (2022), most nurse educators are heterosexual, Caucasian females, which may limit the range of viewpoints represented.

Participants may have experienced some discomfort discussing sensitive topics, such as LGBTQIA+ health content (Frechette et al., 2020). To minimize this limitation, I avoided casual conversations and relied on open-ended, probing questions to help participants express underlying meaning in their responses (Frechette et al., 2020). Additionally, the participant's age may influence openness to discussing LGBTQIA+ topics. Research suggests that some older educators may lack confidence or feel discomfort integrating inclusive content into instruction, potentially making younger educators more likely to engage with these topics in their teaching practices (Day et al., 2023). These limitations, while present, are typical of qualitative research and do not undermine the value of the study. Instead, they help frame the context of the findings and contribute to trustworthiness through transparency and reflection (Guba, 1981).

Delimitations

Delimitations of this study include selecting a homogeneous population of nurse educators in the U.S. to participate in interviews about their lived experiences with implementing LGBTQIA+ health content (Larkin et al., 2019). Transformative learning theory (TLT) guided the development of semi-structured interview questions to explore educators' critical reflections on their beliefs and biases, thereby helping to uncover perceived barriers to integration (Mezirow, 1998). Participants were recruited from anywhere in the U.S., provided they could participate in the virtual interview (e.g., via Zoom). This study focused on integrating LGBTQIA+ health content into pre-licensure nursing curricula.

Klepper et al. (2023) found a lack of LGBTQIA+ content in required textbooks across U.S. nursing programs. Similarly, Bloompott et al. (2023) found that nurse educators identified

barriers to integration, including lack of knowledge or comfort, time constraints, and religious beliefs held by individuals or institutions. While the literature review discusses student outcomes to highlight the importance of curriculum integration, this study does not include student interviews or perceptions.

Summary

The purpose of this qualitative phenomenological study was to document the lived experiences of nursing educators in implementing LGBTQIA+ education in pre-licensure nursing curricula. I ensured that my position as a nurse educator and a member of the LGBTQIA+ community was transparent to participants. The population and sampling pool include nurse educators across the U.S. who hold a minimum of a master's degree in nursing and have at least one year of full-time or part-time teaching experience in pre-licensure programs.

A pilot test was conducted with two nurse educators who were not be part of the sample to enhance the trustworthiness of the interview protocol (Guba, 1981). After receiving permission from the administrator of a Facebook group for nurse educators, 10 participants were recruited for semi-structured interviews conducted virtually. This sample size aligns with IPA, which emphasizes a deep understanding of participant's lived experiences (Eatough & Smith, 2017). Participants were offered flexible scheduling and asked follow-up questions for clarification during the interview.

Following transcription, interviews were analyzed using Braun and Clarke's (2006) thematic analysis framework in conjunction with IPA to develop codes and themes. Nvivo software was initially used to assist in organizing and managing the large volume of qualitative data (Elliott-Mainwaring, 2021). However, the remainder of the coding was completed manually to allow deeper engagement with the transcripts and closer alignment with the IPA approach.

The study assumes that the participants can effectively reflect on and communicate their experiences.

Possible limitations include a lack of diversity among participants or overrepresentation from specific geographic regions, which may impact transferability (Guba, 1981). Another potential limitation, as noted by Frechette et al. (2020), was that the participants may have been hesitant to fully disclose sensitive information. Transformative Learning Theory guided this study in exploring how nurse educators describe their experiences of integrating LGBTQIA+ content into nursing curricula (Mezirow, 1998).

Section 3: Findings, Implications, and Recommendations

The problem addressed in this study is that LGBTQIA+ patients are at risk for inadequate nursing care because nursing instructors are not required to include LGBTQIA+ curriculum in pre-licensure nursing programs (Sherman et al., 2023). The purpose of this qualitative phenomenological study was to document the lived experiences of nursing educators in implementing LGBTQIA+ education in the pre-licensure curriculum. This section presents the study's findings, evaluates the outcomes related to the research questions, and discusses the implications for future nursing education. Section three concludes with practice recommendations and suggestions for future research.

The limitations of this study included the homogeneity of the participants, because they all hold a master's degree in nursing or higher. The small sample size, along with the fact that all participants were African American and most identified as members of the LGBTQIA+ community, may affect transferability. Because of the sensitive nature of the topic, participants may not have felt comfortable sharing every experience. Another possible limitation was my own experience as a nurse educator and a member of the LGBTQIA+ community, which may have influenced how I interpreted participants' responses despite efforts to maintain reflexivity and bracket personal bias.

Findings

A total of 10 participants took part in this study. Fourteen nurse educators initially expressed interest in participating in the virtual interview. Two did not proceed due to scheduling conflicts, and two did not meet the inclusion criteria based on preliminary screening emails. Table 1 presents the demographic characteristics of the 10 participants, which include age,

gender, sexual orientation, years of teaching experience, and current geographical teaching location.

Table 1

Demographic Information

Participant	Age	Gender	Sexual Orientation	Years of Teaching	State of Employment
P1	32	Male	Gay	5	Florida
P2	28	Female	Straight	1.5	Texas
P3	37	Male	Straight	4	Michigan
P4	30	Male	Straight	3	New York
P5	38	Male	Bisexual	5	California
P6	28	Male	Gay	3	California
P7	38	Male	Straight	2	Texas
P8	35	Male	Bisexual	5	Florida
P9	33	Female	Bisexual	5	Texas
P10	36	Male	Bisexual	7	New York

The sample size for this study consisted of 10 nurse educators with a master's degree in the United States, teaching in pre-licensure nursing programs, who all self-identified as African American. The Facebook group where the sample was recruited from were not primarily African American, but those who chose to participate all identified as African Americans. Participants' ages ranged from 28 to 38, with teaching experience ranging from 1.5 to 7 years. There were eight males and two females. Six of the 10 participants identified as members of the LGBTQIA+ community. The educators taught in multiple regions across the United States represented the East Coast, the South, the Midwest, and the West Coast.

The four areas of trustworthiness were addressed throughout the data collection process. Through reflective bracketing, member checking, the use of open-ended probing questions, and adherence to IPA methods, credibility was supported (Braun & Clarke, 2006). Utilizing detailed descriptions of participants enables transferability by allowing the reader to determine whether

the situation applies to other educational settings (Guba, 1981). Using Braun and Clarke's (2006) framework, an audit trail that included transcripts, notes, and documentation of codes and themes ensured dependability. Lastly, by maintaining a reflective journal and engaging in bracketing to reduce researcher bias, I achieved confirmability (Frechette et al., 2020). The overarching research question that guided this study was: What are the lived experiences of nursing educators implementing LGBTQIA+ education into course curricula in pre-licensure nursing programs, including how geographical region, institutional leadership, and peer education attitudes impact implementation?

RQ1a. How do Nurse Educators Describe their Experiences when Attempting to Include LGBTQIA+ Health Content into the Nursing Curriculum?

Five research questions were asked to gather information for answering RQ1a. The data were analyzed using IPA, while reviewing the transcripts multiple times to support data immersion to identify significant information related to the research questions. The initial coding was completed by assigning descriptive codes to the participants' own words and experiences. The codes were then compared across participants and grouped into preliminary pattern clusters.

As the analysis progressed, clustered codes were refined into categories and developed into overarching themes aligned with the research question. Using an analytic memo during the process helped to document decisions, support reflexivity, and maintain an audit trail. The complete coding schema, code groupings, and representative excerpts are included in Appendix C. The alignment table linking the themes to the research questions is provided in Appendix B. Five themes were deduced from the data, as shown in Table 2.

Table 2*Themes Deduced from the Data for RQ1a*

Themes	1	2	3	4	5	6	7	8	9	10
1. Variety of self-reflection/internal conflict revealed.	X	X	X	X	X	X			X	
2. Multi-level institutional and interpersonal barriers to implementation.	X	X	X	X	X	X	X	X	X	X
3. Support for LGBTQIA+ curriculum integration emerged from multiple sources.	X	X	X	X	X	X	X	X	X	X
4. LGBTQIA+ Curriculum integration was achieved through multiple, intentional teaching strategies	X	X	X	X	X	X	X	X	X	X
5. The integration of LGBTQIA+ curriculum fostered acceptance, awareness, and classroom safety.	X	X	X	X	X	X	X	X	X	X

Theme 1: Variety of Self-reflection/internal Conflict Revealed. Of the ten participants interviewed, seven reported a mix of self-reflection and internal conflict issues before and during LGBTQIA+ curriculum integration. There were religious beliefs about LGBTQIA+, concerns about knowledge gaps, and the possibility of student resistance. P2 and P4 discussed religious beliefs as an internal conflict, with P2 stating, “Because my faith, my religion is actually against LGBTQ.” P3 and P9 expressed concern about their own knowledge gaps, with P9 stating, “Teaching LGBTQIA+ health content made me pause and examine my own assumptions and knowledge gaps.” Four participants (P1, P3, P4, and P9) expressed concern about student resistance to implementing LGBTQIA+ health content into the curriculum. P1 stated, “I considered whether it would be acceptable by the students.” P5 was concerned about being exposed as a member of the LGBTQIA+ community and stated, “I felt like some people were going to find out.” P6 reported colleague resistance, stating, “Conflict with people around me.” Three participants (P7, P8, and P10) reported no internal conflict.

Theme 2: Multi-level Institutional and Interpersonal Barriers to Implementation.

All 10 participants identified barriers to implementing LGBTQIA+ curriculum, with many describing more than one barrier. Five participants identified student resistance as a barrier, with P1 stating, “Discrimination within the student community,” and P4 noting, “the major conflict that we actually had come from some of the students.” Four participants (P3, P4, P6, and P7) identified institutional structure as a barrier. P3 explained, “adding new content means negotiating with the curriculum committee, and it was very slow and resistant to change.” Colleague resistance was discussed by P2, P4, and P7, with P7 stating, “Sometimes faculty discomfort or fear of saying the wrong thing leads to avoidance of the topic.” Leadership was also identified as a barrier by P3, P7, and P10. P10 stated, “leadership... does not prioritize the inclusion of the LGBTQIA+ content.” Finally, P9 identified accreditation guidelines as a barrier, stating, “I think one of the major challenges was that nursing curriculum and accreditation guidelines did not specifically include LGBTQIA+ health competencies.”

Theme 3: Support for LGBTQIA+ Curriculum Integration Emerged from Multiple Sources. The 10 participants described support from various sources, with each often receiving support from more than one source. Leadership emerged as the main source of support for six of the ten participants (P1, P2, P3, P8, P9, and P10), with P10 stating, “The support came from my supervisor, the one directly above me.” Participants P4, P5, P6, and P9 discussed how the institution provided support, with P6 stating, “The institution promotes diversity.” P1, P7, and P8 reported that the community provided a source of support, as noted by P1, “Encouragement from the LGBTQIA+ community.” Students were identified by three Participants (5, 7, and 9) as a source of support, as noted by P7, “Some students are immediately engaged and appreciate the inclusivity.” Two participants (P3 and P4) identified support from their colleagues, with P3

stating, “My biggest support was, it was small, but it came from like, a passionate group of faculty colleagues.”

Theme 4: LGBTQIA+ Curriculum Integration was Achieved Through Multiple, Intentional Teaching Strategies. The 10 participants reported using various strategies to implement LGBTQIA+ curriculum. Five of the ten participants (P2, P4, P6, P7, and P8) noted that classroom discussion was used, stating, “I try to share stories from clinical rotations and see how we can get to discuss.” P1, P4, P8, and P10 discuss orientation to LGBTQIA+ content, with P10 stating, “I implemented introducing the course content.” Four participants (P3, P6, P7, and P9) utilized real-world applications through activities such as simulations, scenarios, and case studies, with P9 stating, “The main strategy I used was incorporating case studies and patient scenarios involving LGBTQIA individuals.” P3 and P7 described using integration to incorporate LGBTQIA+ concepts into the curriculum, with P3 stating, “Instead of creating a separate lecture, I looked for a natural entry point in courses I already taught.” P5 and P10 describe framing LGBTQIA+ health concepts in terms of patient safety, as described by P10 as “advocate for inclusion.” Finally, P4 described peer and group activities as “giving them a room to actually mix with one another... it was not a single-person journey, it’s a group of people, so they come together to form peer groups.”

Theme 5: The Integration of LGBTQIA+ Curriculum Fostered Acceptance, Awareness, and Classroom Safety. Six of the 10 participants noted outcomes related to the integration of LGBTQIA+ curriculum. P2, P4, and P7 reported increased awareness of the students, as noted by P2, who stated, “It actually increased the awareness of the unique health of the LGBTQIA.” P1 and P4 found that student acceptance was evident, with P1 stating that “students are accepting the course.” P3 and P5 described psychological classroom safety as a

positive outcome of the integration, as noted by P3, “I’ve had students approach me privately after class to thank me, some identified as LGBTQIA+ themselves, who said it was like the first time they felt represented in nursing education.” P4 described how students' confidence improved around LGBTQIA+ health topics, stating, “I felt like their comfort tends to increase, and their knowledge actually went up, their confidence was actually boosted.” Four of the ten participants (P6, P8, P9, and P10) noted the continued integration of LGBTQIA+ health content in their discussions of outcomes, reflecting the sustained incorporation of the material into their teaching practices.

RQ1b. How do Institutional Leadership and Peer Educator Attitudes Impact the Integration of LGBTQIA+ Health Content into the Nursing Curriculum?

Participants were asked four questions to identify themes to answer RQ1b. Three themes emerged from the collected data as shown in Table 3.

Table 3

Themes Deduced from the Data for RQ1b

Themes	1	2	3	4	5	6	7	8	9	10
6. Supervisor and institutional support emerged as the most influential source of support for implementing LGBTQIA+ curriculum	X		X	X		X	X		X	X
7. Institutional support shapes LGBTQIA+ curriculum integration	X	X		X						X
8. Institutional training and guidance supported LGBTQIA+ curriculum integration	X			X	X		X	X	X	X

Theme 6: Supervisor and Institutional Support Emerged as the Most Influential Sources of Support for Implementing LGBTQIA+ Curriculum. Highlighting a minor, but important theme, four participants identified direct supervisor support as an encouraging factor in implementing LGBTQIA+ curriculum, with P3 stating, “I also had the support of my program

director who encouraged me to pilot the LGBTQIA+ spaces and models within my course.” Institutional support was identified by P4, P6, P7, and P9 as encouragement for integration of LGBTQIA+ curriculum, with P9 noting, “I also received support from the institution as a whole.” P3 and P8 identified administrative resistance as a barrier to implementing LGBTQIA+ curriculum integration, as noted by P8, “some administrations did not like the idea of us increasing.” P5 described policy-level support, stating, “There were actually policies that supported the implementation... the policies meant to protect the interests of LGBTQIA students and faculty members in the institution.” In contrast, P2 perceived that the institution had no significant impact on implementation, stating, “There wasn’t really any hindrance.”

Theme 7: Institutional Setting Shapes LGBTQIA+ Curriculum Integration. Out of the ten participants, four taught at private institutions and six taught at public institutions. Participants described how the institutional setting influenced the pace, level of support, and overall climate surrounding the integration of LGBTQIA+ curriculum. For example, P1 described working with a religious institution where “several forms of training on LGBTQ” were provided, yet support was mixed at the colleague level, stating “not everyone was in support of the idea,” while also noting strong leadership encouragement, “I got major support from my supervisor.” Similarly, P2 perceived that integration within a private institution “increased learner awareness, stating that the LGBTQIA+ health content “increased the awareness of the unique health of the LGBTQIA.” P4 also perceived a more accepting climate within a private setting, noting, “most private schools actually try their best to make gender accepted.” However, institutional setting did not uniformly accelerate integration, as P10 described an approval process that delayed implementation, citing a “bottleneck” that “delayed the introduction of course content.”

Theme 8: Institutional Training and Guidance Supported LGBTQIA+ Curriculum

Integration. Seven of the ten participants reported receiving institutional training to support the integration of LGBTQIA+ curriculum. For example, P4 stated that the institution “provided support and offered training,” and P9 noted that the institution “organized workshops and sessions. In addition to training, P2 and P8 described the provision of institutional materials and resources to support implementation, with P2 indicating that the institution “provided some standardized test books and materials.”

In contrast, P3 and P6 reported a lack of formal LGBTQIA+ training within their institutions. P6 emphasized the ongoing need for professional development, stating, “There’s still a need for structured training around the topic.” P3 described receiving only general diversity and inclusion training that “wasn’t specific enough for nursing faculty,” highlighting concerns regarding the relevance and specificity of training for clinical LGBTQIA+ care.

RQ1c. How did peer educator attitudes impact the integration of LGBTQIA+ health content into the curriculum?

Two research questions were asked to answer RQ1c. Two themes were developed based on the participants' responses, as shown in Table 3.

Table 3

Themes Deduced from the Data for RQ1c

Themes	1	2	3	4	5	6	7	8	9	10
9. Colleagues' attitudes influenced LGBTQIA+ curriculum integration	X	X	X	X	X	X	X	X	X	X
10. Colleague resistance and discouragement during LGBTQIA+ curriculum integration	X	X			X	X	X	X	X	X

Theme 9: Colleagues' Attitudes Influenced LGBTQIA+ Curriculum Integration.

Participants described colleagues' attitudes in various ways, with an overall perception of limited

support for LGBTQIA+ curriculum integration. P3 stated that “openness has also varied,” and was the only participant who did not explicitly describe negative experiences with colleagues. In contrast, P1 described colleague resistance as emotionally harmful, noting that they “almost thought about dropping the idea” due to the “blackmail” received from colleagues. P5, P6, and P10 also reported experiencing negative perceptions from colleagues, including moral judgment, with P10 stating, “there was this moral judgment.” Additionally, multiple participants described direct opposition to LGBTQIA+ integration, with P4, P6, and P8 perceiving colleagues as being against the content. P4 stated that some colleagues felt it was “against everything that they stand for.”

Theme 10: Colleague Resistance and Discouragement during LGBTQIA+ Curriculum Integration. Of the ten participants, eight noted that their colleagues discouraged the integration of LGBTQIA+ health content into the curriculum. P7 noted that “colleagues see this as a political issue,” and P10 stated that there was “moral judgment, bias.” P9 described colleague resistance as more direct and persistent, stating that a colleague “kept on tormenting and ... reporting,” which was experienced as a major challenge during the integration process. In contrast, P3 discussed feeling supported by a small group of colleagues who “were committed to inclusivity.” P4 did not directly mention discouragement or support from colleagues. Overall, the accounts indicated that collegial discouragement and resistance were common and contributed to challenges in integrating LGBTQIA+ health content into the curriculum.

RQ1d: How did the Geographic Region of the United States Impact the Lived Experiences of Nurse Educators in Implementing LGBTQIA+ Health Content into the Curriculum?

Three research questions were asked to answer RQ1d. One major and one minor theme were developed from the collected data as shown in Table 4.

Table 4*Themes Deduced from the Data for RQ1d*

Themes	1	2	3	4	5	6	7	8	9	10
11. Perceived community support for LGBTQIA+ health content curriculum integration	X				X	X		X	X	X
12. Regional climate varies regarding openness to LGBTQIA+ curriculum integration			X		X		X			X

Theme 11: Perceived Community Support for LGBTQIA+ Health Content

Curriculum Integration. Six of the ten participants described their communities as supportive of integrating LGBTQIA+ health content into the curriculum. P8 noted that the community was “open to the content,” and P9 stated that “the community I live [in]... have a platform where they’re supported.” Conversely, P4 and P7 described limited community support or acceptance. P7 stated that “they stigmatize anybody who openly identifies as part of the community,” suggesting that stigma remained present within the community climate. P2 and P3 did not discuss community support or non-support.

Theme 12: Perceived Regional Climate Shaped Openness to LGBTQIA+

Curriculum Integration. A final minor, but important theme, was that three of the ten participants reported multi-state teaching experiences. P3, who taught in Maryland and Michigan, described regional differences, stating that “in Maryland, I found both students and faculty to be generally receptive” to LGBTQIA+ topics, while reporting that “in Michigan, the response has been more mixed.” P3 also noted that “a few administrators worried that introducing this content might spark complaints.” P7 taught only in Texas, they reported that local biases persisted, leading to discourse during discussion. Similarly, P10, who taught in California and New York, described California as a region where “they are open to everyone...

and nobody is discriminated against,” while noting barriers in New York and stating that implementation “should have been a very straightforward pathway.” P5 reported teaching in California and Washington and noted no perceived regional difference related to openness. Seven of the ten participants did not have experience teaching in multiple states.

Evaluation of the Outcomes

Seven interview questions were asked to answer Research Question 1 and its four sub-questions and identify nurse educators' lived experiences implementing LGBTQIA+ health content in pre-licensure nursing curricula. The method for this research was a qualitative, interpretative phenomenological analysis (IPA). Evaluation of the findings is discussed for each research question and compared with previous research on the topic and with the theoretical framework.

RQ1a Nurse Educators Lived Experiences Attempting or Implementing LGBTQIA+ Health Topics in their Courses.

Findings were that participants had self-reflection or internal conflict related to the integration of LGBTQIA+ curriculum, and multiple barriers, support systems, and strategies related to integrating LGBTQIA+ health content. Further there were reported specific outcomes associated with integration efforts. Collectively, these findings highlight the barriers to implementation of LGBTQIA+ curriculum that were experienced across student, collegial, leadership, and institutional levels, often simultaneously.

These findings concur with prior research, which identifies multiple barriers to implementing LGBTQIA+ health content into pre-licensure nursing curricula, including nurse educators' lack of knowledge and confidence to implementing curriculum changes and time constraints, with 66.9% reporting time as a major barrier (Bloompott et al., 2023; Day et al.,

2023; Eickhoff, 2021; Web & Zablocki, 2022). Furthermore, the outcomes described by participants align with evidence showing that many nursing students report not feeling prepared to provide affirming care to LGBTQIA+ patients; however, competency and confidence improved when simulation-based strategies were utilized (Priddle et al., 2023). The findings suggested that support came from multiple sources; however, encouragement from immediate leadership was a crucial facilitator of LGBTQIA+ curriculum integration. Participants described multiple, overlapping strategies to support LGBTQIA+ curriculum integration, with classroom discussion the most frequently used approach. Together, these findings suggest that although outcomes were discussed less explicitly than strategies, participants perceived meaningful, positive effects on student learning, classroom climate, and ongoing curricular integration.

RQ1b Institutional Leadership Impacts on the Integration of LGBTQIA+ Health Content into the Curriculum.

Findings were that a majority of participants received support from leadership or the institution, including training, guidance, materials, or other institutional support in crafting their curriculum. Collectively, these findings suggest that institutional leadership influenced LGBTQIA+ curriculum integration by providing formal support such as training and implementation resources. Prior research has identified a lack of training and limited institutional support as common barriers, including findings that 55.1% of nurse educators did not know where to include LGBTQIA+ content within the curriculum, and the lack of knowledge and comfort were major barriers to implementation (Bloompott et al., 2023; Eickhoff, 2021). Additionally, nurse educators have reported minimal institutional support and exclusion of LGBTQIA+ content from required resources, which may limit sustainable integration efforts (Bloompott et al., 2023; Eickhoff, 2021; Klepper et al., 2023). These findings partially refute

prior research, as most participants in the current study reported receiving institutional training or guidance to support the integration of LGBTQIA+ curriculum. The participants described support from direct supervisors and institutional structures, including formal policies, that facilitated the implementation of LGBTQIA+ curriculum. The institutional context participants described shaped both facilitators and barriers that influenced the integration and implementation of LGBTQIA+ curriculum. These findings highlight that institutions were often a contributing factor to integration efforts through training, resources, and guidance; however, the availability and specificity of training varied across settings, leaving some educators to seek further professional development opportunities independently.

RQ1c Peer Educator Attitudes' Impacts on the Integration of LGBTQIA+ Health Content into the Curriculum.

All 10 participants (100%) reported peer educator attitudes that ranged from discomfort to negative perceptions of LGBTQIA+ curriculum integration. Eight of the 10 (80%) reported feeling discouraged by colleagues. One participant (10%) described support from a small group of educators, while one participant (10%) did not explicitly discuss colleague attitudes. Collectively, these findings suggest that peer educator attitudes negatively impacted LGBTQIA+ curriculum integration by creating resistance and discouragement that limited faculty willingness to implement or expand LGBTQIA+ content. The literature suggests that conflicting cultural or religious beliefs contribute to implementation barriers (Bloompott et al., 2023; Eickhoff, 2021). Additionally, some regions have more conservative political views and intense religiosity, which results in LGBTQIA+ content being limited to a single course or elective rather than integrated throughout the curriculum (Sherman et al., 2023). These findings concur with the cited research. These findings highlight that unsupportive colleague attitudes, ranging from discomfort and

negative perceptions to moral judgment and resistance, created barriers and emotional strain during the LGBTQIA+ integration process.

RQ1d Geographic Region of the United States Impacts the Lived Experiences of Nurse Educators in Implementing LGBTQI+ Health Content into the Curriculum.

Of the 10 participants, six (60%) described communities as supportive of LGBTQIA+ curriculum integration, while two (20%) reported a non-supportive community environment, and two (20%) did not discuss community support systems. Three of the 10 participants (30%) reported teaching in different states, with two (20%) noting differences across states and one (10%) reporting no differences. Collectively, these findings suggest that geographic region influenced nurse educators' experiences with community support, bias, and the sociopolitical climate surrounding LGBTQIA+ health integration. Prior research supports the role of regional and state-level factors in shaping faculty engagement and curriculum priorities. Dobkin et al. (2024) found that states with DEI legislation were associated with increased faculty engagement in community health programs and differences in curricular inclusion across institution types. Additionally, Sherman et al. (2023) reported that regions with conservative political views and religiosity may contribute to homophobia, transphobia, and limited LGBTQIA+ interactions, resulting in LGBTQIA+ health content being less likely to be integrated across curricula. These findings partially align with the cited research, as participants reported varying levels of community support and regional differences that influenced the integration of LGBTQIA+ curriculum. These accounts indicated that most participants perceived community support as an encouraging factor for integrating LGBTQIA+ health content into the curriculum. These findings highlight that regional climate influenced openness to integrating LGBTQIA+

curriculum, with differences most clearly described by educators with multi-state experience, and one educator noted community-level influences within a single state.

Implications and Recommendations for Practice

The implications and recommendations for practice in this study were derived from the data collected through open-ended, semi-structured interviews with nurse educators. The goal of the study was to explore nurse educators' lived experiences implementing or attempting to implement LGBTQIA+ health content into pre-licensure nursing curricula. The results of this study have implications for nurse educators who implement LGBTQIA+ health content into nursing curricula.

Nurse Educators Lived Experiences Attempting or Implementing LGBTQIA+ Health Topics in their Courses

Most nurse educators experienced internal conflict or required self-reflection before implementing LGBTQIA+ health content into the curriculum, and participants described multiple barriers and supports that influenced their implementation efforts. Thus, there are implications to be addressed from these findings. Implications from the findings suggest that nurse educators may require intentional self-reflection and preparation before implementing LGBTQIA+ health content and may experience barriers such as colleague and student resistance and limited institutional structure to support integration. Nurse educators' self-reflection on beliefs and biases prior to implementation is supported in the literature (Ryan et al., 2022). Prior literature identifies lack of educator training and limited resources as barriers to sustainable integration (Bloompott et al., 2023; Eickhoff, 2021; Klepper et al., 2023; Murray et al., 2024; Priddle et al., 2023). Therefore, a recommendation for practice is for nursing programs to

implement structured faculty development and continuing education expectations for integrating LGBTQIA+ health content, along with providing curricular resources to support implementation.

Institutional Leadership's Impact on the Integration of LGBTQIA+ Health Content into the Curriculum

Most participants reported that leadership and institutional support were provided for integrating LGBTQIA+ health content into the curriculum. Thus, there are implications to be addressed from these findings. Implications from the findings suggest that institutional leadership can influence LGBTQIA+ health content integration by providing or limiting training, guidance, and curricular resources. Prior literature identifies a lack of educator training and limited institutional support as common barriers to the sustainable integration of LGBTQIA+ curriculum (Bloompott et al., 2023; Eickhoff, 2021; Klepper et al., 2023). Although prior research frequently identifies limited institutional support as a barrier, the current findings suggest that when institutional leadership provides training and resources, integration may be more feasible. Therefore, a practice recommendation is for nursing programs to implement structured faculty development and continuing education opportunities related to LGBTQIA+ health integration, along with institutional guidelines and resources to support consistent implementation across the curriculum.

Peer Educator Attitudes Impact the Integration of LGBTQIA+ Health Content into the Curriculum

Most participants described colleagues as having negative perceptions of LGBTQIA+ content and felt discouraged from integrating LGBTQIA+ health topics into the curriculum. Only one participant described having support from a small group of peers. Thus, there are implications to be addressed from these findings. Implications from the findings are that peer

educators' attitudes can discourage or dismiss LGBTQIA+ curriculum integration, which may limit students' exposure to inclusive and evidence-based content. This coincides with healthcare in general, as Day et al. (2023), Gedzyk-Nieman and Hand (2023), and Sherman et al. (2023) discussed that the LGBTQIA+ population faces stigmatization and discrimination when seeking healthcare. Therefore, a recommendation for practice is that institutions include LGBTQIA+ sensitivity training and workshops on integrating curriculum to promote inclusive education and reduce barriers to implementation. Nurse educators are instrumental in curriculum changes in nursing programs that impact patient care and outcomes (Hassmiller & Wakefield, 2022). Supporting this concern, Roy and Clark (2024) found that 54% of pre-licensure nursing students witnessed negative attitudes towards LGBTQIA+ patients from clinical instructors, nurses on the floor, or nursing assistants.

Geographic Region of the United States Impact the Lived Experiences of Nurse Educators in Implementing LGBTQI+ Health Content into the Curriculum

A majority of participants described experiencing community support for LGBTQIA+ content integration, with two participants reporting feeling stigmatized and two participants not discussing the issue directly. Of the 10 participants, three had taught in multiple states; of those, two reported noticing differences in the integration of LGBTQIA+ curriculum across geographic locations. One participant who had taught only in one state also reported experiencing bias in their region. Thus, there are implications to be addressed from these findings. Implications from the findings are that LGBTQIA+ curriculum integration may be influenced by geographic region and the sociopolitical climate of the area. Nursing institutions in U.S. regions characterized by conservative political views and intense religiosity have reported higher rates of homophobia and transphobia (Sherman et al., 2023). Therefore, a recommendation for practice is to ensure that

LGBTQIA+ curriculum integration is standardized across the U.S. for pre-licensure nursing programs. To improve population-level outcomes, a shared strategic framework is needed to address social determinants of health (RWJI, n.d.; NASEM, 2021). This highlights the need for nursing curriculum reform nationwide.

Recommendations for Future Research

Based on the framework, findings, and implications, recommendations for future research can be made. The first recommendation is to conduct a study with a larger sample size to improve the transferability of the findings. A study with 10 participants does not diminish the credibility of participants' lived experiences; however, a larger sample may yield additional perspectives and strengthen understanding of the barriers and supports identified. The second recommendation is to recruit a more diverse group of nurse educators for the study. Increasing diversity allows multiple perspectives to be discussed and evaluated. The third recommendation is to conduct a mixed-methods study to collect quantitative data on the integration of LGBTQIA+ curriculum. Quantitative data on knowledge and training may provide additional insight into the gaps described by participants. The next step in this line of research is to examine LGBTQIA+ curriculum integration across a broader range of nursing programs using a mixed-methods design.

Conclusions

The problem addressed in this study is that LGBTQIA+ patients are at risk for inadequate nursing care because nursing instructors are not required to include LGBTQIA+ curriculum in pre-licensure nursing programs (Sherman et al., 2023). The purpose of this qualitative phenomenological study was to document the lived experiences of nursing educators in implementing LGBTQIA+ education in the pre-licensure curriculum. Multiple studies have

discussed challenges nurse educators face when implementing LGBTQIA+ health content, including limited time, uncertainty regarding where to integrate content, insufficient knowledge and training, and institutional resistance (Eickhoff, 2021).

Findings related to RQ1a indicate that interpersonal barriers and self-reflection led to the intentional use of teaching strategies that improved awareness and acceptance, and that multiple support systems were identified. These findings indicate that faculty resistance may decrease as self-awareness increases. Implications include that curriculum implementation may improve through intentionally developed teaching strategies informed by self-reflection. Including structured self-assessment in professional development initiatives may improve self-awareness and support effective integration of LGBTQIA+ curriculum. Future efforts should ensure that nurse educators engage in self-reflection prior to implementing LGBTQIA+ curriculum changes.

Analysis of RQ1b demonstrated that institutional guidance, training, and direct supervisor support influenced the integration of LGBTQIA+ curriculum. Collectively, this demonstrates that institutions and supervisors play a critical role in a nurse educator's ability to implement curriculum changes. Implications include the need for clear guidance structures to support the integration of LGBTQIA+ health content. Future efforts should ensure that nurse educators receive consistent support from supervisors and institutional leadership when implementing curriculum changes.

Results from RQ1c suggest that colleagues' resistance and discouragement influenced the integration of LGBTQIA+ curriculum. Suggesting that peer attitudes within the academic environment impact a nurse educator's ability to implement curriculum changes. Implications include the need for institutional training and intentional education initiatives to reduce negative

attitudes and foster inclusive professional environments. Future efforts should focus on structured training to improve collegial environments and promote supportive academic cultures.

In examining RQ1d, it became evident that community support for integrating LGBTQIA+ curriculum was evident, with regional differences noted. This highlights the importance of the nurse educator's ability to implement LGBTQIA+ curriculum changes is influenced by geographical location. Implications include that geographic context may affect opportunities for curricular integration. Future efforts should focus on ensuring that nurse educators across all geographic regions have equitable opportunities to enact curriculum integration.

The primary takeaway from this study is that LGBTQIA+ curriculum integration is influenced not only by educator intention but also by the level of professional and institutional support available. Implications of the findings suggest that nurse educators implementing LGBTQIA+ health content may benefit from structured training and support systems to promote consistent integration. Recommendations for future research include conducting the study with a larger sample, recruiting a more diverse group of nurse educators, and using a mixed methods design to collect quantitative data on educators' knowledge and training.

This study is significant because it contributes to understanding the factors that influence the integration of LGBTQIA+ health content in U.S. nursing education. In the United States, the LGBTQIA+ population continues to face stigmatization and discrimination when seeking health care (Day et al., 2023; Gedzyk-Nieman & Hand, 2023; Sherman et al., 2023). Stigmatization begins in nursing school and follows the graduate nurse into practice, suggesting that these behaviors are observed and carried into clinical practice (Roy & Clark, 2024). Upon graduation, many nursing students report not feeling prepared to care for LGBTQIA+ patients and report

being inadequately prepared through their pre-licensure nursing programs (Priddle et al., 2023). Due to the lack of knowledge and comfort regarding LGBTQIA+ curriculum expressed by many nurse educators, graduate nurses are often not adequately prepared to deliver patient-centered, affirming care to the LGBTQIA+ community (Hughes et al., 2022).

In conclusion, this study found that nurse educators continue to face barriers when integrating LGBTQIA+ health content into pre-licensure nursing curricula. Challenges described by participants ranged from colleagues' and students' resistance to institutional policies and educator knowledge gaps. The findings may be of interest to nursing programs, nursing program directors, nurse educators, curriculum designers, and hospital-based educators who are responsible for preparing nurses to provide inclusive, competent patient care.

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Appendices

Appendix A. Interview Guide

Opening

Thank you for agreeing to participate in this interview. This is part of a dissertation study on LGBTQIA+ curriculum integration in pre-licensure nursing programs across the U.S. Your participation is completely voluntary, and you may stop the interview at any time. With your permission, this conversation will be audio recorded to ensure accuracy in transcription. All responses will remain confidential and will be used solely for dissertation research purposes. You are not required to answer any questions that make you feel uncomfortable simply say “next”, and we’ll move on. Do you have any questions before we begin?

Section 1: Demographic Questions

Before I begin the interview questions, I have a few demographic questions. Please respond to the following questions:

1. Age:
2. Gender:
3. Sexual Orientation:
4. Race/Ethnicity:
5. Years of teaching experience (including non-nursing teaching):
6. What state do you currently teach in.

Section 2: Interview Questions

1. Did you experience any internal conflicts or self-reflection when attempting or implementing LGBTQIA+ content into your teaching, and if so, how did that reflect your materials selection and or instructional approach? Please explain.
2. What were your experiences with barriers or support when attempting or implementing LGBTQIA+ health content into the curriculum? First, we’ll address barriers and then address support.
 - 2a. Please describe specific example(s) of any barrier (s) you encountered, and how did those experiences influence your ability to implement LGBTQIA+ health content into the curriculum.
 - 2b. Please describe specific example(s) of any support you encountered, and how did those experiences influence your ability to implement LGBTQIA+ health content into the curriculum.
3. What strategies, if any, did you use to attempt or implement LGBTQIA+ health content into the curriculum?
 - 3a. What was the outcome of applying the strategy(s)? Please explain.
4. What institutional leadership challenges, if any, did you encounter when attempting or implementing LGBTQIA+ content into the curriculum? Please explain.
 - 4a. Did institutional policies or priorities support or hinder your efforts in attempting or implementing LGBTQIA+ content into the curriculum? Please explain.
 - 4b. If you taught in a private or religious institution, how did that setting influence your ability attempting or implementing LGBTQIA+ content into the curriculum? Please explain.

- 4c. Have you ever received guidance or training from institutional leadership regarding LGBTQIA+ curriculum? Please explain.
5. Did colleagues' attitudes toward LGBTQIA+ influence your own attempts or implementation efforts, and if so in what ways?
- 5a. Did you feel supported or discouraged by colleagues' attitudes toward LGBTQIA+ when attempting or implementing LGBTQIA+ content into the curriculum? Please explain and give specific examples as relevant.
6. Do you feel where you currently live and teach support or resist LGBTQIA+ health content integration, and why?
- 6a. If you have taught in other U.S. regions, how do they compare in terms of openness with where you live and teach now? Please explain.
- 6b. In your geographical experiences, how do differences in support of LGBTQIA+ impact your decisions as an educator?

Section 3: Closing Question

Is there anything else you'd like to share about your experience with LGBTQIA+ curriculum integration?

Closing

Thank you for participating in this interview. Your insights are incredibly valuable to this research. A transcript of your responses will be sent to you within the next week for your review. Please feel free to reach out with any questions or clarifications.

Appendix B. Alignment Table

SubRQs to qualitative questions alignment table

RQs	Interview Questions
<p><i>Subquestions</i> RQ1a How do nurse educators describe their lived experiences attempting or implementing LGBTQIA+ health topics in their courses?</p>	<p>1. Did you experience any internal conflicts or self-reflection when attempting or implementing LGBTQIA+ content into your teaching, and if so, how did that reflect your materials selection and or instructional approach? Please explain.</p> <p>P1: described internal conflict because he was unsure whether students would accept LGBTQIA+ content.</p> <p>P2: describes internal conflict because of her religious beliefs, which oppose LGBTQIA+ identities, but she focuses on the fact that she believes that all patients deserve equal treatment.</p> <p>P3: discussed the concern about how students might react to LGBTQIA+ health content but felt a strong professional obligation to represent diverse patient populations.</p> <p>P4: discusses several internal conflicts and engages in self-reflection regarding the integration of LGBTQIA+ curriculum. He was worried about using respectful language to avoid offending anyone. He was also concerned about managing his own emotional labor in relation to this topic integration. He was uncertain due to his limited knowledge and did not feel adequately prepared. Some of his beliefs caused hesitation in integrating LGBTQIA+ health content. He was also concerned about overloading the students with content</p> <p>P5: was worried about others reactions and comfort around implementing LGBTQIA+ content and was not clear about the process. The participant stated, “Some people are going to find out,” indicating fear of being exposed.</p> <p>P6: he describes conflict with people around him while trying to educate them, and he anticipated the resistance because he is accustomed to it.</p> <p>P7: reports no internal conflict or self-reflection, instead identified a gap in LGBTQIA+ health content in the curriculum.</p> <p>P8: reports conflicts during implementation, described as primarily arising from superiors rather than personal self-doubt.</p> <p>P9: She described pausing to examine her own assumptions and knowledge gaps, resulting in reflection about how to use inclusive language, helping her grow personally and professionally.</p> <p>P10: He states directly that he did not experience internal conflict when introducing LGBTQIA+ content into his curriculum.</p> <p>2. What were your experiences with barriers or support when attempting or implementing LGBTQIA+ health content into the curriculum? First, we’ll address barriers and then address support.</p>

2a. Please describe specific example(s) of any barrier (s) you encountered, and how did those experiences influence your ability to implement LGBTQIA+ health content into the curriculum.

P1: describes barriers related to the perceived controversy of LGBTQIA+ health content, noting that the topic was “still under debate” and raised concerns about community response and potential discrimination. This led him to be cautious with implementation.

P2: described barriers related to a colleague minimizing the importance of LGBTQIA+ health content, contributing to feelings of isolation. She also reported that initially, students' discomfort and reluctance to engage resulted in implementation challenges.

P3: She encountered resistance from some students and found that curriculum changes were slow due to the program's rigid structure.

P4: reported that resistance from some students and staff created a major barrier to implementation, because students were hesitant to accept LGBTQIA+ content and some staff opposed because of their cultural values and beliefs resulting in a slower integration process.

P5: The barriers described by the participant came from the departmental chair, because of the review process, the administration wanted to ensure it was safe for everyone, resulting in multiple meetings to evaluate the implementation.

P6: described barriers related to lack of peer support, noting that some colleagues did not share the same beliefs and viewed him as “some kind of weird person.”

P7: barriers included initial student discomfort and resistance, as well as challenges navigating institutional structures, noting faculty resistance related to cultural and political factors.

P8: described barriers related to a lack of interest from some superiors in introducing LGBTQIA+ health content, which he associated with ongoing discrimination and stigmatization surrounding LGBTQIA+ issues.

P9: identified barriers related to accreditation guidelines that did not include LGBTQIA+ competencies, which made it more difficult to justify the addition of new content.

P10: described barriers related to a taxing curriculum revision process and structural challenges, noting that leadership did not prioritize the inclusion of LGBTQIA+ health content.

2b. Please describe specific example(s) of any support you encountered, and how did those experiences influence your ability to implement LGBTQIA+ health content into the curriculum.

P1: Support came from his supervisor, superiors, and the LGBTQIA+ community, who encouraged him to continue

P2: The institution provided minimal support by providing standardized materials, but she had to rely on her own motivation

P3: Support came from the program director and curriculum committee, which encouraged her.

P4: His integration process was slow and began with face-to-face discussions focused on active listening and allowing students to express themselves

P5: Students wrote letters in support of implementing LGBTQIA+ health content, speeding up the process. Leadership provided guidance and training, while institutional policies facilitated implementation.

P6: reported some support, stating that his institution promoted diversity and inclusion, which helped facilitate implementation of LGBTQIA+ health content, but he emphasized that acceptance ultimately depended on the individual's beliefs.

P7: reported support from some peers who requested LGBTQIA+ health resources to share with their own students.

P8: reported support from some students and key administrators, as well as access to financial support that facilitated the implementation of LGBTQIA+ health content.

P9: reported institutional support for integration through organized workshops and education sessions.

P10: Identified support from his direct supervisor, which helped facilitate the implementation of LGBTQIA+ health content.

3. What strategies, if any, did you use to attempt or implement LGBTQIA+ health content into the curriculum?

P1: His strategies included gradual introduction, orientation, and clarification of course benefits..

P2: Her classroom focus was on encouraging interactive discussions to reduce discomfort, which resulted in students' improved engagement and increased awareness of LGBTQIA+ health needs.

P3: Her primary strategy was to embed the concepts into existing courses and use case studies instead of standalone courses.

P4: resulted in him spending time “training and retraining” himself to make more careful word choices

P5: he described ensuring inclusivity by ensuring everyone was “adequately represented” and that he followed the student union’s guidelines.

P6: reported embedding LGBTQIA+ health content across multiple levels of nursing education and discussing biases and clinical experiences to support student learning.

P7: described using case studies and professional framing to introduce LGBTQIA+ health content and emphasized inclusive care.

P8: described strategies that included targeting specific courses, clearly outlining the purpose, objectives, and goals of LGBTQIA+ health content, designing an easy-to-follow structure to support understanding, using demonstrations as assessments, and educating stakeholders to justify the inclusion of the curriculum.

P9: describes using case studies and patient scenarios involving the LGBTQIA+ population to help students connect theory to real-life practice and encourage empathy.

P10: reported implementing LGBTQIA+ health content by advocating for its inclusion and revising existing curriculum to address identified gaps.

3a. What was the outcome of applying the strategy(s)? Please explain.

P1: reported that following a slow, incremental introduction, students gradually accepted the course content.

P2: reports that the strategies resulted in an increased awareness of LGBTQIA+ health needs among students and the community.

P3: This led to improved student understanding and helped the LGBTQIA+ students feel represented.

P4: helping increase the students' confidence and understanding

P5: The outcome described is that the LGBTQIA+ community felt represented.

P6: did not explicitly describe outcomes of his applied strategies but focused on the ongoing integration and maintaining respectful dialogue.

P7: No specific outcomes are explicitly described, beyond continued implementation.

P8: There is no explicit outcome described.

P9: There is no explicit outcome described.

P10: No explicit outcome reported.

<p>RQ1b How did <u>institutional leadership</u> impact the integration of LGBTQIA+ health content into the curriculum?</p>	<p>1. What institutional leadership challenges, if any, did you encounter when attempting or implementing LGBTQIA+ content into the curriculum? Please explain</p> <p>4a. Did institutional policies or priorities support or hinder your efforts in attempting or implementing LGBTQIA+ content into the curriculum? Please explain.</p> <p>P1: mentioned that there was mixed support from leadership, with some not in favor of integrating LGBTQIA+ content. But his direct supervisor was encouraging, which helped motivate him to continue the integration despite resistance.</p> <p>P2 stated that there were no institutional barriers to integrating LGBTQIA+ health content. The institution did not hinder the process and, in fact, provided standardized textbooks and materials to support the implementation of the curriculum.</p> <p>P3: described the institutional leadership's caution about integrating LGBTQIA+ health content as being due to the prevailing political climate. Although the leadership viewed the content as important, it was not treated as urgent because the institution was focused on other priorities, like accreditation and pharmacology curriculum revisions. Leadership adopted a “test the waters” approach out of concern for potential complaints, which contributed to a slower integration process.</p> <p>P4: institution was generally supportive of integrating LGBTQIA+ health content; however, administrative processing and approval delays created challenges. Leadership was cautious about the implementation due to fear of backlash; however, there was no obstruction to the process. He also felt that the students’ advocacy contributed to the administration's motivation.</p> <p>P5: there was strong supportive policies to protect LGBTQIA+ students and faculty, no policy hindered implementation, the proposed curriculum did go through approval processes there were no policies that hindered implementation.</p> <p>P6: The policies promoted equity, inclusion, and diversity and were generally supportive of LGBTQIA+ content integration. The implementation was uneven in practice because individual educators' personal beliefs sometimes overrode institutional priorities.</p> <p>P7: no institutional policies or priorities restricted the integration of LGBTQIA+ content. But a lack of adequate training and faculty discomfort contributed to avoidance of the topic by some colleagues.</p> <p>P8: Institutional policies did not restrict LGBTQIA+ curriculum integration. Resistance was due to scheduling and curricular impact concerns related to adding content that would affect the academic calendar.</p> <p>P9: No barriers from leadership, workshops, and training sessions were provided to faculty and students that emphasized patient-centered nursing. There is a lack of accreditation guidelines related to LGBTQIA+ competencies, and the already dense curriculum poses challenges when attempting to integrate these competencies.</p>
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P10: Institutional policies did not restrict LGBTQIA+ integration, but leadership attitudes and a lack of prioritization created the barrier. The curriculum approval process is extensive and time-consuming, which further delays implementation.

4b. If you taught in a private or religious institution, how did that setting influence your ability attempting or implementing LGBTQIA+ content into the curriculum? Please explain.

P1: Because he teaches in a religious institution, he found that the environment influenced the integration of LGBTQIA+ health content.

P2: By teaching in the private sector and adding this content, it help increase awareness to students who were previously not familiar with LGBTQIA+ health issues.

P3: teaching in a public setting.

P4: He believed that teaching in a private institution promoted inclusion because the campus was more gender diverse, accepting, and open to curriculum changes related to LGBTQIA+ health content

P5: Public setting, no barrier related to the setting described.

P6: Public setting was generally supportive of diversity and inclusion and did not have religious restrictions on LGBTQIA+ curriculum integration. But individual cultural beliefs among some colleagues contributed to resistance.

P7: public institution and no reports of religious restrictions affecting LGBTQIA+ curriculum integration.

P8: Public setting did not have any religious restrictions.

P9: Public institution, reported no religious restrictions

P10: Private school and reported that the setting contributed to a longer approval process and increased resistance to integrating LGBTQIA+ health content.

4c. Have you ever received guidance or training from institutional leadership regarding LGBTQIA+ curriculum? Please explain.

P1: received LGBTQIA+ training in multiple forms from institutional leadership.

P2: There was no extensive training from leadership, and the materials provided supported her confidence in teaching the LGBTQIA+ content.

P3: The institution provided a general diversity and inclusion orientation but no formal LGBTQIA+ specific training for faculty.

P4: The leadership provided virtual training and ensured the environment aligned with diversity, equity, and inclusion.

P5: reported receiving leadership-supported guidance and training focused on diversity and inclusion. The training emphasized gender inclusivity and LGBTQIA+ representation, supporting his confidence in implementing LGBTQIA+ health content.

P6: reported that leadership provided diversity and inclusion training as part of professional development. But participants were not required, resulting in variable engagement among faculty, with some seeking additional training independently and others opting not to attend.

P7: training provided to support LGBTQIA+ curriculum integration, increasing confidence in teaching the content. However, many colleagues lacked adequate training, which resulted in their discomfort and avoidance of the topic.

P8: Online and in-person training was provided, which helped improve the faculty's ability to teach LGBTQIA+ content in areas such as assessment, communication, and instructional delivery.

P9: Hybrid and online workshops were provided that focused on LGBTQIA+ health and patient-centered care, reinforcing communication skills and supporting knowledge development.

P10: The leadership mandated LGBTQIA+ terminology workshops as part of faculty development efforts to support curriculum implementation and improve understanding among faculty.

<p>RQ1c How did <u>peer educator attitudes</u> impact the integration of LGBTQIA+ health content into the curriculum?</p>	<p>5. Did colleagues' attitudes toward LGBTQIA+ influence your own attempts or implementation efforts, and if so, in what ways?</p> <p>P1: He felt discouraged by his colleagues when he attempted to implement LGBTQIA+ content. Because he lacked support from his colleagues, he was on the verge of abandoning the efforts until he gained support from his supervisor.</p> <p>P2: She felt isolated. At times, her colleagues' attitudes made her feel discouraged, and she had to rely on her own motivations. She said that colleagues discouraged the integration of LGBTQIA+ health content, expressing the belief that it was less important than other clinical topics.</p> <p>P3: stated that colleagues' attitudes towards LGBTQIA+ content varied widely. Some were cautious or reluctant. She noted that a significant barrier was colleagues' discomfort and unfamiliarity with the content, making some hesitant to engage with or teach it. The variability of openness influenced the pace and ease of integration.</p> <p>P4: Colleagues were mostly neutral but not actively supportive. Some colleagues held personal or religious beliefs that made them question the need for LGBTQIA+ integration. Many were uncomfortable or unsure how to approach the topic due to limited knowledge. A few colleagues were hesitant to be visibly involved, despite being supportive.</p> <p>P5: Colleagues showed mild reactions/skepticism but did not hinder or stop implementation.</p> <p>P6: Reported that most of his colleagues were not supportive, "I didn't feel supported by most people". He expressed feeling stigmatized by colleagues. The peer resistance was emotional and value-based. He felt alienated from his colleagues.</p> <p>P7: Reported general stigmatization about the LGBTQIA+ population among colleagues and worried about saying something wrong, resulting in avoidance of the topic.</p> <p>P8: His colleagues' attitudes and stigmatization resulted in discouragement of integrating LGBTQIA+ health topics.</p> <p>P9: She felt emotional strain early in the integration process because one of her colleagues was strongly opposed and "tormented" the integration process.</p> <p>P10: Colleagues' cultural beliefs resulted in biases and "moral judgment" impacting the implementation process.</p> <p>5a. Did you feel supported or discouraged by colleagues' attitudes toward LGBTQIA+ when attempting or implementing LGBTQIA+ content into the curriculum? Please explain and give specific examples as relevant.</p> <p>P1: He felt pressure and scrutiny because of the widespread discussions among faculty questioning the integration of LGBTQIA+ content. On multiple occasions, he mentioned his colleagues "emotionally blackmailed" him and told him not to proceed with the introduction of the course or discuss LGBTQIA+ issues.</p> <p>P2: Felt as though she was the only one pushing for the inclusion of LGBTQIA+ health content, leaving her to feel isolated.</p>
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	<p>P3: Some faculty were enthusiastic and supportive of integrating the material.</p> <p>P4: Colleagues were not actively supportive. A few colleagues expressed support, even if they were hesitant at first.</p> <p>P5: He did not feel discouraged or obstructed by colleagues.</p> <p>P6: He felt a strong sense of discouragement from colleagues. He felt as though they perceived him as “weird” and was isolated from most of his colleagues, except for a small, supportive group.</p> <p>P7: He felt discouraged due to his colleagues' discomfort and stigmatism.</p> <p>P8: He felt tension and strong discouragement from his colleagues.</p> <p>P9: She felt discouraged and harassed by colleagues.</p> <p>P10: There was emotional strain as a result of colleague resistance.</p>
<p>RQ1d How did geographic region of the United States impact the lived experiences of nurse educators in implementing LGBTQI+ health content into the curriculum?</p>	<p>12. Do you feel the region where you currently live and teach supports or resists LGBTQIA+ health content integration, and why?</p> <p>P1: The community he lives in supported his efforts to integrate LGBTQIA+ health content.</p> <p>P2: She did not report any regional, institutional, or community resistance to the integration of LGBTQIA+ health content.</p> <p>P3: She reported that Maryland was receptive and supportive. Michigan showed mixed reactions, with rural areas being more hesitant due to limited exposure.</p>

P4: New York community initially resisted LGBTQIA+ curriculum changes, but attitudes have gradually shifted towards greater acceptance, through some resistance remains.

P5: He felt supported by the community and institution due to the openness and inclusivity of California.

P6: He reports that the region where he currently teaches is supportive, and the environment is positive towards LGBTQIA+ health content.

P7: Reported community support overall, but teaching in Texas meant encountering conservative or religious beliefs among some students, which made the context more cautious and sometimes challenging.

P8: Felt that the community in Florida generally approved of the integration of LGBTQIA+ topics.

P9: She reported that the region where she teaches is supportive of LGBTQIA+ content.

P10: He perceived his region as supportive of LGBTQIA+ curriculum integration.

13. If you have taught in other U.S. regions, how do they compare in terms of openness with where you live and teach now? Please explain.

P1: No comparison has only taught in Florida.

P2: teaches in Texas, not in any other U.S. region

P3: She reported that Maryland was more diverse and receptive, while Michigan's response varied widely, particularly in rural areas.

P4: He has taught only in New York and cannot compare.

P5: He had previously taught in Washington State and did not notice the difference between California and Washington.

P6: He has only taught in one region, California, and therefore cannot provide a comparison.

P7: Only taught in one region.

P8: Only taught in one region.

P9: Only taught in Texas.

P10: He compared California and New York, noting that California had an easier and more direct process, whereas New York involved more procedural requirements and multiple layers of approval.

14. In your geographical experiences, how do differences in support of LGBTQIA+ impact your decisions as an educator?

	<p>P1: The challenges came from colleagues and some supervisors, not from the region.</p> <p>P2: The challenges identified by participant 2 stem from personal religious beliefs and colleagues' attitudes, rather than the geographic region.</p> <p>P3: She reported that the implementation of LGBTQIA+ topics was smoother in Maryland. In contrast, Michigan, especially in rural areas, required more caution, adaptation, and sensitivity.</p> <p>P4: He reported that regional attitudes significantly influenced the process, as early resistance created challenges; however, with ongoing dialogue, the implementation was gradual, and community acceptance increased.</p> <p>P5: He did not view his geographic location as a barrier across the two states in which he taught.</p> <p>P6: He attributes the supportive climate of his location to having influenced his experience.</p> <p>P7: The regional cultural climate influenced implementation by requiring sensitivity and caution, as conservative or religious student beliefs could create challenges when introducing LGBTQIA+ topics.</p> <p>P8: Although the region was generally supportive, there are still regional stigmas present that created challenges in implementing LGBTQIA+ content.</p> <p>P9: She felt fully supported by her region, which facilitated implementation and did not create barriers.</p> <p>P10: In California, inclusivity and institutional support facilitated a direct pathway to integration, while in New York, greater administrative requirements and multiple leadership layers created additional steps and challenges for implementation.</p>
<p><i>Conclusion of interview questions</i></p>	<p>1. Is there anything else you'd like to share about your experience with LGBTQIA+ curriculum integration?</p> <p>Participant 1 reiterated that early integration efforts sparked significant discussion and resistance but noted that public orientation sessions and supervisor support enabled him to continue despite discouragement.</p> <p>Participant 2 reported no additional insight and stated she had nothing further to add.</p> <p>Participant 3 emphasized that seeing LGBTQIA+ students feel represented in the curriculum validated her efforts and reinforced her commitment to ongoing integration.</p> <p>Participant 4 noted that although institutional support existed, additional resources and effective evaluation strategies were still needed to strengthen the integration of LGBTQIA+ curriculum.</p>

	<p>Participant 5 emphasized minority rights, equity, and recognition, noting that LGBTQIA+ individuals experience discrimination and neglect due to their minority status.</p> <p>Participant 6 emphasized the importance of meeting students “where they are,” noting that comfort and validation are major challenges. He stressed that integration must be manageable and not burdensome.</p> <p>Participant 7 emphasized that the institutional approval process and training were the primary gaps in integration, and that cultural and personal biases among students and colleagues necessitated a sensitive implementation approach.</p> <p>Participant 8 discussed the emotional weight of implementing LGBTQIA+ content and the perceived risks to professional identity and career.</p> <p>Participant 9 shared that the integration process encouraged both professional and personal growth.</p> <p>Participant 10 emphasized that curriculum structures and leadership processes were the primary barriers during implementation.</p>
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Appendix C. Codebook

RQ1a

1 Internal Conflict/Self-Reflection

P	Participant Excerpts	Initial Code(s)
1	"I considered whether it would be acceptable by the students."	Concern about student acceptance
2	"Because my faith, my religion is actually against LGBTQ."	Religious values influencing instructional hesitation
3a	"I worried about how students might react."	Anticipation of student response
3b	"I worried... whether I had the right language or the right depth of knowledge to present the material appropriately."	Self-reflective awareness of knowledge gaps
4a	"Some of the students were not in total agreement."	Perceived student resistance
4b	"Personal or religious beliefs... self-reflection."	Religious beliefs
5	"I felt like some people were going to find out."	Fear of LGBTQIA+ status being exposed
6	"Conflict with people around me."	Resistance
7	When asked about internal conflict responded "no."	No internal conflict
8	"I did not experience internal conflicts."	No internal conflict
9a	"Teaching LGBTQIA+ health content made me pause and examine my own assumptions and knowledge gaps."	Self-reflective awareness of knowledge gaps
9b	"I wanted to be sure that all my students felt represented and respected."	Supportive of students
10	"I personally do not.... Any internal conflict."	No internal conflict

Internal Conflict/Self-Reflection Preliminary Pattern Grouping (Analytic Memo)

- Student resistance (4)
- Religious beliefs (2)
- Fear of being exposed (1)
- No internal conflict (3)
- Knowledge gap (2)
- Colleague resistance (1)

Theme 1: Variety of self-reflection/internal conflict revealed.

2a Barriers to Implementation

P	Participants Excerpts	Initial Code(s)
1	"Discrimination within the student community."	Discrimination (student resistance)
2	"Some of my colleagues made me feel like the curriculum wasn't as important as others."	Colleague resistance
3a	"I worried about how students might react."	Student resistance
3b	"Adding new content means negotiating with the curriculum committee, and it was very slow and resistance to change."	Anticipate resistance from the curriculum committee
4	"The major conflict that we actually had came from some of the students, and some actually came from staff."	Student resistance Colleague resistance
5	"I experienced some barriers, coming from my departmental chair."	The departmental chair is resistant to change
6	"I had a little bit of conflict with people around me.. superiors... and some of the people I was trying to educate."	Student resistance Leadership resistance
7a	When discussing students, "Others are resistant at first." "It wasn't flowing... because at first, they weren't comfortable."	Student resistance
7b	"My biggest challenge is navigating institutional structures."	Institutional structure
7c	"Sometimes faculty discomfort or fear of saying the wrong thing leads to avoidance of the topic."	Colleague resistance

8	“My superiors were not interested in the idea of introducing this content.”	Leadership
9	“I think one of the major challenges was that the nursing curriculum and accreditation guidelines did not specifically include LGBTQIA+ health competencies.”	Accreditation guidelines
10a	“How the curriculum was structured, and the process of trying to include it.”	Institutional structure
10b	“Leadership...do not prioritize the inclusion of the LGBTQIA+ content.”	Leadership

Barriers to Implementation Preliminary Pattern Grouping (Analytic Memo)

- Colleague resistance (3)
- Student resistance (5)
- Leadership (3)
- Institutional Structure (4)
- Accreditation guidelines (1)

Theme 2: Multi-level institutional and interpersonal barriers to implementation.

2b Support & Enablers

P	Participants Excerpts	Initial Code(s)
1a	“Encouragement from the LGBTQIA+ community.”	Community support
1b	“I also received comments and support from my supervisors.:	Leadership support
2	When answering about institutional and leadership training, “they actually provided some standardized test books and materials for me to use.”	Leadership support
3a	“My biggest support was, it was small, but it came from like, a passionate group of faculty colleagues.”	Colleague support
3b	“I also had the support of my program director.”	Leadership support
4	“The institutional body was actually well in support, and the faculty.”	Institutional support Colleague support
5a	“The student union, they had my back, they really loved what I wanted to do.”	Student support
5b	“There were actually policies that supported the implementation.”	Institutional support
6	“The institution promotes diversity.”	Institutional support
7a	“Some students are immediately engaged and appreciate the inclusivity.”	Student support
7b	“The support system I also received was in dollars, LGBTQ centers.”	Community support
8a	“I received support from... administrators.”	Leadership support
8b	“We also went as far as receiving some financial boosts... LGBTQI centers ...came out in support, some students were also supportive.”	Community support Student support
9	My supervisor supported me...I also received support from the institution.”	Leadership support Institutional support
10	“The support came from my supervisor, the one directly above me.”	Leadership support

Support & Enablers Preliminary Pattern Grouping (Analytic Memo)

- Leadership (6)
- Community (3)
- Student (3)

- Institutional (4)
- Colleague (2)

Theme 3: Support for LGBTQIA+ curriculum integration emerged from multiple sources

3 Strategies used

P	Participants Excerpts	Initial Code(s)
1	“Introducing the course, bringing everyone together for an orientation...for integration in the first and second year.”	Orientation
2	There wasn’t really any strategy... I made sure the class would ask questions and interact.”	Class discussion
3a	“Instead of creating a separate lecture, I looked for a natural entry point in courses I already taught.”	Integration into the existing curriculum
3b	“I developed standardized patient simulations where patients identified as transgender or part of a same-sex couple, so students had to practice communication, assessment, and care.”	Simulation
4a	“I started with face-to-face talks... I gave the students an opportunity to express how they feel.”	Orientation Class discussion
4b	“Giving them a room to actually mix with one another... it was not a single-person journey, it’s a group of people, so they come together to form peer groups.”	Group discussion Peer support
5	“I made it very inclusive and felt comfortable.”	Student support/safety
6	“I try to share stories from clinical rotations and see how we can get to discuss.”	Classroom discussion Real-world examples
7a	“With guided discussion and role-playing.”	Classroom discussion Role play
7b	“I often have to frame it in terms of professional standards and patient safety.”	Real-world application
7c	“Some of the strategies I included were weaving content throughout different classes.”	Integration into existing curriculum
8a	When describing strategies for implementation, “The aim is to avoid stigmatization... and outline the purpose of what the course intends to offer.”	Orientation Classroom discussion
8b	“We also gave some demo assessments... so students would understand.”	Demonstration
9	“The main strategy I used was incorporating case studies and patient scenarios involving LGBTQIA individuals.”	Case studies Patient Scenarios
10a	“I implemented introducing the course content.”	Orientation
10b	“Advocate for inclusion.”	Patient care

Strategies used: Preliminary Pattern Grouping (Analytic Memo)

- Orientation (4)
- Class discussion (5)
- Integration (2)
- Group/peer (1)
- Real-world applications (case studies, simulation, scenarios, role-play, examples) (4)
- Patient safety/inclusion (2)

Theme 4: LGBTQIA+ curriculum integration was achieved through multiple, intentional teaching strategies.

3a Outcomes of Strategies

P	Participants Excerpts	Initial Code(s)
1	“Student, accepting the course.”	Student acceptance
2	“It actually increased the awareness of the unique health of the LGBTQIA.”	Student awareness
3	“I’ve had students approach me privately after class to thank me, some identified as LGBTQIA+ themselves, who said it was like the first time they felt represented in nursing education.”	Psychological student safety
4	“I felt like their comfort tends to increase, and their knowledge actually went up, their confidence was actually boosted...giving me the feeling that the gender affirming was actually well implemented.”	Increased awareness Confidence Student acceptance
5	The participant stated he made sure everyone was comfortable, and when asked how the strategies worked, replied, “It worked perfectly fine.”	Psychological safety
6	Focused on ongoing integration	Ongoing integration
7	“When asked about outcomes stated, “taking a responsive, sexual, and reproductive health history...and minority stress, stigma, suicide prevention.”	Student awareness
8		Ongoing integration
9		Ongoing integration
10		Ongoing integration

Outcomes of Strategies Preliminary Pattern Grouping (Analytic Memo)

- Acceptance (2)
- Awareness (3)
- Psychological classroom safety (2)
- Confidence (1)

Theme 5: The integration of LGBTQIA+ curriculum fostered acceptance, awareness, and classroom safety.

RQ1b: How did institutional leadership impact the integration of LGBTQIA+ health content into the curriculum?

4a. Institutional policies or priorities support or hinder your efforts

P	Participants Excerpts	Initial Code(s)
1	“I also received comments and support from my superiors and my supervisors.” “That was a major backbone for... the introduction.”	Supervisor support
2	“There wasn’t really any hindrance; it was just the opposition from some of my colleagues that the curriculum wasn’t necessary.”	No hindrance No support
3a	“I also had the support of my program director, who encouraged me to pilot the LGBTQIA+ spaces and models within my courses.”	Supervisor support
3b	“Leadership saw that the LGBTQIA content wasn’t important. Okay, they felt it was important, but not urgent.”	Administrator hindrance
4	“Thankfully, the institutional body was actually well in support of the faculty.”	Institutional support
5	“There were actually policies that supported the implementation... the policies meant to protect the interests of LGBTQIA students and faculty members in the institution.”	Policy support
6	“The institution promotes diversity, but we understand that even with this, people still choose to side with whatever they believe.”	Institutional support
7	“My biggest challenge is navigating institutional structures; curriculum changes require approval.”	Institutional hindrance

8	“There was no policy in place prior to the effort of introducing the course, but as I mentioned at first, some administrators did not like the idea of us increasing.”	Administrator hindrance
9	“My supervisor, yeah, supported me. I also received support from the institution as a whole, so it wasn’t really more of a challenge.”	Supervisor support Institutional support
10	“The support came from my supervisor, the one directly above me.”	Supervisor support

Preliminary Pattern Grouping (Analytic Memo)

- Supervisor support (4)
- No perceived institutional impact (1)
- Administrator hindrance (2)
- Institutional support (4)
- Policy support (1)

Theme 6: Supervisor and institutional support emerged as the most influential sources of support for implementing LGBTQIA+ curriculum.

4b. Private or religious institution and influences.

P	Participants Excerpts	Initial Code(s)
1a	“Religious institution... received several forms of training on LGBTQI.”	Religious – training provided
1b	“Not everyone was in support of the idea, but...I got major support from my supervisor.”	Religious- supervisor support
2	“I teach at a private institution.” “So far, it has actually increased the awareness of the unique health of the LGBTQIA, because most of them were not aware that the LGBTQIA community health plays a crucial role in the health sector.”	Private -increased awareness
3	“I currently teach in a public setting.”	Public
4	“Private, I feel like most private schools actually try their best to make gender accepted.”	Private - accepting
5	Public institution.	Public
6	Public institution.	Public
7	When asked if they work in a private or religious institution, participant 7 answered “No, I don’t.”	Public
8	“Public institution.”	Public
9	“I’m a public institution.”	Public
10	“Private institution.” “They were able to make an approval of the content, and with time, it sorted out. I believe that the bottleneck and the glaze are one of those things that delayed the introduction of the course content. “	Private – slow approval process

Preliminary Pattern Grouping (Analytic Memo)

- Training (1)
- Supervisor support (1)
- Accepting (1)
- Increased awareness/ impact on learners (1)
- Slow approval process (1)

Theme 7: Institutional setting shapes LGBTQIA+ curriculum integration.

4c. Guidance or training from the institution.

P	Participants Excerpts	Initial Code(s)
1	“I did receive; there are several forms of training on LGBTQI.”	Training provided

2	“They actually provided some standardized test books and materials for me to, you know, use to follow up the syllabus, so that was just the only thing that was provided.”	Materials provided
3a	“No, my institution didn’t provide formal training for me.”	No formal training
3b	“What we had was more of a general diversity and inclusion orientation that touched on cultural competency lightly, but it wasn’t specific enough for nursing faculty who needed to teach clinical care to the LGBTQIA population.”	Diversity and Inclusion (general)
4	“They provided support and offered training services. Most of which were actually virtual.”	Training provided
5	“They provided us with the guidance and the training. Those guidelines and training were meant to ensure gender inclusiveness.” “The training included gender and diversity that is for inclusion; the rights and interests of LGBTQIA people were represented.”	Training provided Guidance provided
6	“I think there’s still a need for structured training around the topic, and personnel had to seek out professional development independently, some people do.”	No training Independent training
7	When asked about additional training, participant 7 responded, “Yeah, definitely there is training.”	Training provided
8	When asked about LGBTQIA+ training, participant 8 responded, “They provided materials and training, and particularly, I was the head of the training of this content.” “It was kind of online training and in-person training.”	Training provided Materials provided
9	“They organize workshops and sessions, both hybrid and online sessions for LGBTQI students and all, so yeah, I received so much support from the institution.	Training provided Support from the institution
10	“They also went as far as trying to train, fellow teachers and lectures on this...so we added faculty training.”	Training provided

Preliminary Pattern Grouping (Analytic Memo)

- Training LGBTQIA+ (1,4,5,7,8,9,10) - 7
- Guidance (5) -1
- Materials (2,8) -2
- Support (9) -1
- No formal training (LGBTQIA+) (3,6) -2
- Diversity and Inclusion/ not specific (3)-1

Theme 8: Institutional training and guidance supported LGBTQIA+ curriculum integration.

RQ1C: How did peer educator attitudes impact the integration of LGBTQIA+ health content into the curriculum

5. colleagues’ attitudes

P	Participants Excerpts	Initial Code(s)
1a	“Most of my colleagues emotionally blackmailed me.”	Emotionally blackmailed
1b	“I almost gave up...I almost thought about dropping the idea.”	Almost gave up
2	“The curriculum wasn’t necessary.”	Perceived as unnecessary
3	“Faculty openness has also varied more widely in Michigan.”	Openness varied

4	“The major conflict that we actually had came from some of the students, and some actually came from the staff...Their beliefs, their culture... They feel like it’s actually against everything that they stand for.”	Against integration
5	“Whenever something new is about to be implemented, you get reactions from your colleagues.”	Negative perception
6a	“You know how our colleague’s gonna look at you like, you’re some weird kind of person, you’re some weird kind of human.”	Negative perception
6b	“Most of the people around me who do not have or share the same belief with me were against me.”	Against integration
7	“Not every faculty member feels comfortable teaching these topics.”	Uncomfortable
8	“I did not receive support from my colleagues; I was blackmailed.”	No support Blackmailed
9	“I think there was this colleague I had that was not in support of what I was always teaching.”	No support
10	When asked about colleagues’ attitudes, participant 10 stated “that there was this moral judgment, bias. We introduce morality, and this already lacks inclusivity. “	Moral judgment Bias

Preliminary Pattern Grouping (Analytic Memo)

- Blackmailed (1, 8) – 2
- Almost gave up (1) -1
- Perceived as unnecessary (2) -1
- Openness varied (3) -1
- Against integration/no support (4, 6, 8) -3
- Negative perception/moral/bias (5,6,10)- 3
- Uncomfortable (7) -1

Theme 10: Colleagues’ attitudes influenced LGBTQIA+ curriculum integration.

5a. Feeling of support or discouragement by colleagues.

P	Participants Excerpts	Initial Code(s)
1	“Most of my colleagues emotionally blackmailed me, and they were of the opinion that I should not go further in introducing the course.”	Discouragement
2	When asked about colleagues’ attitudes about implementing LGBTQIA+, they stated, “It kind of made me feel discouraged at some point, but I thought about what motivated me to want to bring this curriculum into the system, so I think that was just the only thing that kept me going, my motivation. “	Discouragement
3	“My biggest support was, it was small, but it came from a passionate group of faculty colleagues, who were also committed to inclusivity.”	Support from a small group
4	No explicit discussion of feeling supported or discouraged by colleagues.	No discussion
5	“Reactions from your colleagues, but those reactions are not big enough to stop the movement; they’re not big enough to stop the implementation process.”	Discouragement
6	“It wasn’t so supportive of some colleagues.”	Discouragement
7a	“So, there is also cultural resistance; some students and even colleagues see this as a political issue rather than a care need.”	Discouragement
7b	“Sometimes, on the faculty, discomfort or fear of saying the wrong thing can lead to avoidance of the topic altogether.”	Discouragement

8	"I did not receive support from my colleagues. I was blackmailed."	Discouragement
9	"This colleague I had that was not in support of what I was always teaching, and then kept on tormenting and like reporting, and also, yeah, that was a major challenge."	Discouragement
10	When asked about colleagues' attitudes, participant 10 stated "that there was this moral judgment, bias. We introduce morality, and this already lacks inclusivity."	Discouragement

Preliminary Pattern Grouping (Analytic Memo)

- Colleague discouragement/ resistance (1, 2, 5, 6, 7, 8, 9, 10) - 8
- Support from a small group (3) – 1

Theme 11: Colleague resistance and discouragement during LGBTQIA+ curriculum integration.

RQ1d: How did the geographic region of the United States impact the lived experiences of nurse educators in implementing LGBTQIA+ health content into the curriculum?

12. Regional support

P	Participants Excerpts	Initial Code(s)
1	"The community that I am living and working in, yeah, supports the introduction of health content."	Support
2	Does not discuss community or regional climate.	No discussion
3	No explicit discussion of regional support.	No discussion
4	"I would say the community have not actually accepted the curriculum fully yet."	Non-supportive – not accepting
5	When asked about where they lived and how they believed the community felt, participant 5 answered, "I felt supported."	Support
6	When asked about support or resistance where the participant lives, they responded, "I think it is supportive."	Support
7	"There are times they stigmatize anybody who openly identifies as part of the community."	Non-supportive stigmatization
8	When asked about support within the community, participant 8 responded, "They are open to LGBTQIA members and everything as related to them, their mental health, and everything, so they are open to the content and everything, so they're receptive."	Support
9	"Yeah, the community I live they has a platform where they're supported fully."	Support
10	When asked about community support, participant 10 responded, "Yes, the community actually supported that."	Support

Preliminary Pattern Grouping (Analytic Memo)

- Support/ receptive community climate (1, 5, 6, 8, 9, 10) -6
- Non-supportive/ stigma (4, 7) -2
- No discussion (2,3) -2

Theme 12: Perceived community support for LGBTQIA+ health content curriculum integration.

13. Compare other U.S. regions related to openness.

P	Participants Excerpts	Initial Code(s)
1	Only taught in Florida	One state

2	Only taught in Texas	One state
3	I began my teaching career in Maryland, where I was a clinical instructor for a BSN program while completing my master's degree. So, after that, I relocated to Michigan, where I have been a full-time faculty member."	Maryland Michigan
4	Only taught in New York.	One state
5	When asked if they had been taught in any other state besides California, participant 5 answered, "I thought in Washington."	California Washington
6	Only taught in California.	One state
7	Only taught in Texas.	One state
8	Only taught in Florida.	One state
9	Only taught in Texas.	One state
10a	New York and California	California New York
10b	Where I taught (California), they are open to acceptability, they are open to everyone, and they have this gender inclusiveness and sexual inclusiveness, so nobody is discriminated against."	
10c	"I am here (New York), that there were a lot of alternatives before approval, if they wanted to implement, it should have been a very straight pathway."	

Preliminary Pattern Grouping (Analytic Memo)

- One State (1, 2, 4, 6, 7, 8, and 9) -7
- Two States (3, 5, 10) -3

See below for Theme 13.

14. Differences in geographical location and impact on LGBTQIA+ curriculum decisions.

P	Participants Excerpts	Initial Code(s)
1	No regional issues reported	None
2	No regional issues reported	None
3	"A few administrators worried that introducing this content might spark complaints from students or parents, especially in more conservative communities."	Michigan -Leadership worried about conservative communities
3b	"In Maryland, I found both students and faculty to be generally receptive when I introduced LGBTQIA+ health topics." "Baltimore is a very diverse city, and many of the nursing students had already been exposed to conversations around inclusion, so there was curiosity and engagement."	Maryland – receptive, students had previous exposure
3c	"In Michigan, the response has been more mixed. The University is fairly progressive, students are open and supportive, but when I've worked with students from more rural parts of the state during clinical rotations, I've noticed that a bit more hesitancy and sometimes a lack of prior exposure."	Michigan – mixed response, students' lack of previous exposure
4	No regional issues reported.	None
5	When asked if any regional differences, Participant 5 stated, "not at all."	California and Washington – no difference
6	No regional issues reported	None
7	"Sometimes the old personal biases is against them, leading to discourse during discussion."	Texas only personal biases against the LGBTQIA+ community
8	No regional issues reported.	None
9	No regional issues reported.	None

10a	Where I taught (California), they are open to acceptability, they are open to everyone, and they have this gender inclusiveness and sexual inclusiveness, so nobody is discriminated against.”	California – open and accepting
10b	“I am here (New York), that there were a lot of alternatives before approval, if they wanted to implement, it should have been a very straight pathway.”	New York – difficult approval process

Preliminary Pattern Grouping (Analytic Memo)

- No regional comparisons/ issues (1,2,4, 6, 8, and 9) -6
- Regional context noted within one state (Texas) (7) -1
- Multi-state experience, no regional differences perceived (5) – 1
- Multi-state experience, regional differences perceived (3, 10)- 2

Theme 13: Perceived regional climate shaped openness to LGBTQIA+ curriculum integration.

Conclusion of interview: Any additional information participants wanted to share.

P	Participants Excerpts	Initial Code(s)
1	Reiterate supervisor support and colleagues' resistance.	Supervisor support Colleague resistance
2	No additional insight.	No additional insight
3	Shared that LGBTQIA+ students felt represented.	Student representation
4	Felt more resources were needed.	Need for resources
5	“I feel like it’s very important for LGBTQIA course content to be implemented, and their rights should be respected.” “I know it’s important, they have to be respected because they constitute the gender minority, and once anyone identifies with any minority population, whether it's by race or by gender, they tend to be neglected, they tend to be discriminated against. “	Importance of integration Equality/rights emphasis
6	Ensuring that integration is manageable and not burdensome.	Integration feasibility
7	The institutional approval process and training are the primary gaps in integration.	Approval process barriers Need for training
8	Discussed risk to career and professional identity.	Professional risk
9	Gained professional and personal growth through the integration process.	Professional growth
10	Barriers came from structures and leadership.	Structural barriers Leadership barriers

Additional Insights

This question was included to capture any final reflections; responses were brief and did not demonstrate a consistent pattern warranting theme development.