THE RELATIONSHIP BETWEEN MARGINALITY AND UNDERGRADUATE NURSING STUDENTS

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DEDICATION

To my wonderful husband, Justin, and our beautiful children: Maxwell, Samuel, and Alexandra. Thank you for your constant support, encouragement, and patience throughout this journey. I am truly blessed. To my angel in Heaven, Drew, I miss you every day.

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ABSTRACT

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The fact that the nation's healthcare professionals are not culturally concordant with the population is believed to be a more significant cause of health disparities than the lack of health insurance for millions of Americans (Agency for Healthcare Research and Quality [AHRQ], 2012). The homogeneity of the nursing profession is largely a result of the significantly higher attrition rates that minority nursing students experience when compared to non-minority students (Levesque, 2015; McDermott-Levy, 2011; Pitt, Powis, Levett-Jones, & Hunter, 2012; Shelton, 2012). Although feeling marginalized has been found to be a barrier in a number of qualitative studies, the concept has not been investigated as an independent phenomenon in nursing students.

The purpose of this study was to investigate the relationship between marginality and minority status in undergraduate nursing students enrolled at one of the four University of Wisconsin system schools that offer a baccalaureate nursing program. A non-experimental correlational descriptive design was utilized and the Koci Marginality Index-70 (KMI-70) was used to measure levels or marginalization. A total of 331 participants comprised the research sample. A series of independent-samples *t*-tests were conducted to evaluate differences in mean scores on the KMI-70 in relation to the

demographic variables of interest. Results indicate that there was a significant difference in mean scores for minority (*M*= 177.5, *SD*= 29.3) versus non-minority students (*M*= 166.4, *SD*= 18.1); *t*(329)= 4.3, *p* < =.001.

Analysis of the data did not reveal any statistically significant differences between sexual minority (*M*= 178.4, *SD*= 33.7) and non-minority participants (*M*= 170.3, *SD*= 23.0); *t*(328)= -1.5, *p* =.112 with regard to KMI-70 scores. There was no statistically significant difference in mean scores for male participants (*M*=166.1, *SD*= 25.6) versus female participants (*M*=171.6, *SD*= 23.5); *t*(329)= -1.4, p= .428. Similarly, the difference in mean scores for non-traditional participants (*M*= 166.7, *SD*= 19.8) and traditional-aged participants (*M*=171.8, *SD*= 24.6) did not reach statistical significance, *t*(329)= 1.5, *p*= .111.

The results of this study suggest that more research must be done in order to glean a better understanding of the marginalization faced by minority students. Specifically, more research should be conducted in a number of areas including: 1) sampling of minority nursing students across the U.S., and from diverse educational environments such as associate degree, baccalaureate, and graduate schools; 2) the investigation of marginality in international, LGBTQ, and non-traditional students; 3) the development of a short marginality tool more specific to the realm of nursing education; and 4) further explore the individual subconcepts of marginalization that underlie the KMI-70 as they relate to the population of nursing students.

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INTRODUCTION

Focus of Inquiry

By many measures, the healthcare system in the United States (U.S.) is exceptional with its tremendous advancements in medicine and improved health outcomes. Yet with all of its complexity, glaring disparities in the quality of care persist, especially for racial, ethnic, and sexual minorities (Institute of Medicine [IOM], 2002, 2011a). Registered nurses (RNs) are essential to the many dimensions of health care and provide most of the direct care to patients (National Advisory Council on Nurse Education and Practice [NACNEP], 2013). Similarly, nurses practice in a variety of settings and capacities including hospitals, clinics, schools, and other community agencies. Given the integral and expansive role that RNs play within the realm of healthcare, it is posited that increasing the diversity of the nursing profession would improve the overall health of the nation (AHRQ, 2012; IOM, 2002, 2011a; Sullivan Commission, 2004).

Research conducted over the last several decades suggests that the nursing workforce remains largely Caucasian and female; as such, there is a strong probability that nurses will not be concordant with the diverse U.S. population they serve (AHRQ, 2012; American Association of Colleges of Nursing [AACN], 2012, 2015a; IOM, 2002, 2011a; Sullivan Commission, 2004). The fact that the nation's healthcare professionals

are not culturally concordant with the populations they serve has been shown to be a more significant cause of health disparities than the lack of health insurance for millions of Americans (AHRQ, 2012; Levesque, 2015; Sullivan Commission, 2004).

The homogeneity of the nursing profession is largely a direct result of the significantly higher attrition rates that minority nursing students experience when compared to non-minority students (Bond et al., 2008; Loftin, Newman, Dumas, Gilden, & Bond, 2012; McDermott-Levy, 2011; Mulholland, Anionwu, Atkins, Tappern, & Franks, 2008; Pitt et al., 2012; Shelton, 2012). According to Tinto (1987), students enter higher education with a well-established set of background characteristics and expectations; a student's decision to remain in or prematurely leave a program of study may be influenced by how well the student was able to integrate socially and academically into the academic institution. Those students who are not able to integrate socially may feel marginalized from their peers and the nursing program (Dapremont, 2011; Loftin et al., 2012; Love, 2012). Research suggests that feelings of loneliness, alienation, and "differentness" can contribute to a student's decision to leave a nursing program prematurely (Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Mulholland et al., 2008; Rivera-Goba & Nieto, 2007; West, Usher, Foster, & Stewart, 2014).

Problem of Study

Nursing Profession: Racial and Ethnic Minorities

Over the last several decades, the U.S. population has become increasingly diverse with regard to race and ethnicity. Recent data indicate that the racial/ethnic minority population is comprised of a myriad of groups including Hispanic/Latinos, African Americans, Asians, American Indians, and multiracial Americans (U.S. Census Bureau, 2015). According to the U.S. Census Bureau (2015), individuals who identify as Hispanic or Latino comprise 16.3% of the nation's population, an increase of 43% from 2000. Similarly, the African American population increased its numbers to 12.2%, a rise of 12.4% from a decade earlier. Asians comprise 4.7% of the U.S. population, an increase of 43% since 2000. Collectively, Native Americans and Alaska Natives make up less than 1% of the population, which is an increase of 18.8% since 2000 (U.S. Census Bureau, 2015).

According to a 2010 national survey conducted by the Health Resources and Services Administration (HRSA), only 16.8% of the nearly 3 million RNs in the United States identify themselves as being a racial or ethnic minority. Results of the study indicate that the distribution of RNs by race/ethnicity was 83.2% White (non-Hispanic), 5.8% Asian or Pacific islander, 5.4% African American, 3.6% Hispanic or Latino, 1.7% multi-racial, and .3% Native American or Alaskan Eskimo (HRSA, 2010).

Undergraduate nursing students: racial and ethnic minorities. As a result of both the continued demographic shift in the U.S. and persistent homogeneity of the

nursing profession, a great deal of attention has been focused on diversifying the nursing workforce so that they better represent the population they serve. Research conducted over the last few decades indicates that strong emphasis has been placed on enhancing the racial and ethnic diversity of the nursing population (IOM, 2002, 2011a; Loftin et al., 2012; NACNEP, 2013; Sullivan Commission, 2004). Such efforts have resulted in an increase in the admission rates of minority students to nursing programs across the nation (Loftin et al., 2012). According to the AACN (2015a), the percentage of racial and ethnic minority students enrolled in undergraduate nursing programs during the 2015 school year peaked to its highest rate ever at 30%. Data obtained from the National League for Nursing [NLN] (2011) indicate, however, that only 25% of students who graduated from a baccalaureate nursing program in the U.S. during the 2009-2010 academic school year identified as being a racial/ethnic minority. Of these graduates, 10.6% were African American, 5.4% identified as Asian, 5.1% were Hispanic, and .4% belonged to the American Indian population. The remaining .5% identified as the racial category of 'other' (NLN, 2011).

The lack of diversity in the nursing profession has been attributed in large part to the fact that high attrition rates continue to plague minority nursing students (Bond et al., 2008; Campbell & Mislevy, 2010; Loftin et al., 2012; McDermott-Levy, 2011; Mulholland et al., 2008; Nelson & Belcher, 2006; Newton & Moore, 2009; Nnedu, 2009; Pitt et al., 2012; Ramos, 2011; Shelton, 2012). It has been estimated that between 5% and 23% of non-minority students in the U.S. drop out of a baccalaureate nursing

program (Loftin et al., 2012); whereas the attrition rates of racial/ethnic minority nursing students have been reported to be as high as 85% (Mulholland et al., 2008; Newton & Moore, 2009).

Nursing Profession: LGBTQ Minorities

The lesbian, gay, bisexual, transgender, and queer (LGBTQ) community has also seen growth in recent years. According to a national survey conducted by the U.S. Department of Health and Human Services [DHHS] (2014), 4% of the nation's population reported their sexual orientation as being something other than heterosexual or "straight." It is argued that the LGBTQ community remains the largest minority group within the nursing profession (NLN, 2016; Randall & Eliason, 2012). Unfortunately, limited data are available to accurately determine how many RNs in the U.S. identify as LGBTQ. Demographic data for LGBTQ RNs is not collected at the national or local levels; therefore valid and reliable data for this population is sparse and tends to be limited to individual studies (Levesque, 2015; NLN, 2016). For example, a study conducted by Carabez et al. (2015) was designed to identify current LGBTQ knowledge of practicing RNs in the San Francisco Bay Area. Of the 267 participants in this study, 9.6% (n=28) of the 268 participants identified as belonging to the LGBTQ community.

Randall and Eliason (2012) argue that despite the fact that the LGBTQ population is increasingly more visible in our society, the nursing profession continues to fail in their recognition or support of LGBTQ nurses. The nursing profession as a whole is not in a position to shed light on the LGBTQ nursing community as, currently, there are no

LGBTQ professional nursing organizations in the U.S., nor are there any LGBTQ committees, divisions, or task forces within any major professional nursing organizations (Eliason, Dejoseph, Dibble, & Chinn, 2011).

Undergraduate nursing students: LGBTQ minorities. With regard to LGBTQ nursing students, it has been theorized that LGBTQ nurses and nursing students form one of the largest minorities within the profession, yet limited data are available to determine just how many students identify as LGBTQ (Eliason et al., 2011). Currently, colleges and universities in the U.S. do not collect data on students' sexual orientation, which makes it impossible to determine with any accuracy the number of LGBTQ nursing students currently enrolled in undergraduate nursing programs (Eliason et al., 2011).

Given the dearth of demographic data regarding LGBTQ nursing students, determining an accurate attrition rate of LGBTQ nursing students is not feasible (Eliason et al., 2011; Eliason, Dibble, & Dejoseph, 2010). Therefore, researchers are left with relying on individual studies and extrapolating the results to the larger LGBTQ student population. A 2010 study conducted by the State of Higher Education for LGBT People found that 33% of lesbian students and 38% of transgender students have strongly considered leaving their institution due to issues they experienced on campus that resulted from their sexual identity (Rankin, Weber, Blumenfield, & Frazer, 2010).

Nursing Profession: Gender Minority

The homogeneity of the nursing profession extends to gender as well, as the field remains largely a female-dominated nursing workforce (U.S Census Bureau, 2013). Data

obtained by the U.S. Census Bureau (2014) indicates that the nation is essentially equally divided with regard to gender, with 50.8% of its population being female. Over the last several decades, women have made significant inroads into historically male-dominated professions such as medicine (Kellett, Gregory, & Evans, 2014). According to the Bureau of Labor Statistics (2011), women comprise 32% of physicians and 47% of first-year medical students in the United States. Recent studies show, however, that men comprise only 9.1% of RNs licensed in the U.S, and 12% of students enrolled in a baccalaureate nursing program (AACN, 2012). With only a 1.4% increase over the last 5 years of RNs who are male, there remains a tremendous underrepresentation of men in nursing (HRSA, 2010, 2013; NLN, 2016; U.S. Census Bureau, 2013).

Undergraduate nursing students: Gender minority. The exclusion of males in nursing programs began with the advent of Florence Nightingale's first nurse training program in 1860, a program from which men were explicitly excluded (Nelson & Belcher, 2006). Similarly, the U.S. military banned male nurses from 1901 until 1955, a decision that further minimized the number of male students seeking a degree in nursing (Nelson & Belcher, 2006). In recent decades, a number of highly publicized campaigns have been created to combat the image of nursing as a female profession. According to the AACN (2012), the number of male students enrolled in baccalaureate nursing programs across the nation increased by nearly 3% (from 9.1% to 12%) over the last decade. Although this trend is encouraging, the nursing profession remains a field strongly dominated by females.

Nursing Profession: Age

Demographic data collected in recent years suggest that the nursing population is an aging one (American Nurses Association [ANA], 2014; HRSA, 2013). According to HRSA (2013), more than one-third of the nursing workforce is older than 50 years of age; the expansion of the cohort of RNs aged 41-50 years has increased the average age of the U.S. nursing workforce from 46 to 48 years (HRSA, 2013). According to the ANA (2014), only 14.8% of RNs practicing in the U.S. are under the age of 30.

One factor that has contributed to the increasing mean age of practicing RNs is the high number of young nurses who elect to leave the nursing profession. Research has consistently shown that the youngest generation of RNs (i.e. RNs who are 30 years of age or younger) are significantly more likely to leave the nursing profession within the first 5 years of practice when compared to older nurses (Flinkman, Isopahkala-Bouret, & Salantera, 2013; Hayes et al., 2012; Kovner & Djukic, 2009). Registered nurses who leave the profession permanently negatively impact the current nursing shortage and place significant financial constraints on healthcare institutions across the United States. Perhaps by increasing the number of older (i.e. non-traditional) students graduating from undergraduate nursing programs, the nursing profession will not sustain such high attrition rates of new nurses.

Undergraduate nursing student: Age. The face of America's undergraduate student population is changing dramatically; non-traditional students (i.e. students 25 years of age or greater) have been returning to institutions of higher learning at a rapidly

growing rate (Kenny, Kidd, Nankervis, & Connell, 2011). Recent data suggest that more than 40% of college students are 25 years of age or older, and it is projected that this number will continue to increase over the next several decades (Kenny et al., 2011).

With regard to the nursing student population, results of a survey conducted by the NLN (2011) indicate that 18% of students enrolled in a baccalaureate nursing program identified as being 30 years of age or older. Despite the increased enrollment of non-traditional students in undergraduate nursing programs, this population continues to experience higher attrition rates when compared to "traditional-aged" students (Campbell, 2007). Research suggests that part of the issue stems from the continued marginalization non-traditional students experience on college campuses (Advisory Committee on Student Financial Assistance, 2012; Kasworm, 2008, 2010).

Marginalization

A great deal of research has been conducted that looked at the barriers minority students face when navigating through undergraduate and graduate nursing programs. These barriers can result in feelings of isolation and pressure to conform, as well as feeling disconnected from both peers and the academic institution (Bednarz, Schim, & Doorenbos, 2010; Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; Stott, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010). Many of the barriers identified in the research that are related to the high attrition rates of minority nursing students from undergraduate nursing programs are strongly correlated with the process of marginalization (Hall,

Stevens, & Meleis, 1994; 1999; McDermott-Levy, 2011). In an academic environment that is overwhelmingly female, heterosexual, Caucasian, and homogenous with regard to age (i.e. between the ages of 18 and 24), individuals who do not fit this mold tend to be pushed to the periphery of the institution and are by definition, marginalized individuals (Dong & Temple, 2011; Hall et al., 1994; 1999; Sims & Barnett, 2015).

Rationale for the Study

In its seminal report, *The Future of Nursing: Leading Change, Advancing Health*, the IOM (2011a) called for nurse leaders and educators to diversify the profession so that it better represents the population it serves. According to the report, academic nurse leaders should partner with private and public funders, employers, and education accrediting bodies to:

> Recruit, retain, and foster the success of diverse individuals. One way to accomplish this is to increase the diversity of the nursing student body...The combination of age, gender, race/ethnicity, and life experiences provides individuals with unique perspectives that can contribute to advancing the nursing profession and providing better care to patients (p. 131).

In addition, both the NLN and the ANA have repeatedly emphasized the need to increase the cultural diversity of the nursing workforce (IOM, 2011a). It is posited that in order to achieve a culturally diverse nursing workforce, the profession must first increase the diversity within the nursing student population (IOM, 2011a). As a means of achieving this goal, the national accrediting agency for nursing, the Commission on

Collegiate Nursing Education (CCNE), tasked nurse educators with increasing the number of minorities in the nursing profession (IOM, 201a).

Despite the increased attention and emphasis on diversifying the nursing profession, the existing body of literature regarding factors that contribute to the attrition of minority nursing students remains lacking. For example, the vast majority of research conducted on minority attrition rates and barriers to the successful completion of nursing programs has been generated using qualitative methodology (Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Mulholland et al., 2008; Rivera-Goba & Nieto, 2007; West et al., 2014). Investigating this topic using quantitative methods may serve to expand the body of existing knowledge in this area and perhaps yield new insights about this longstanding issue. Similarly, although feelings of marginalization have been found to be a barrier in a number of qualitative studies (Bednarz et al., 2010; Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; Stott, 2007; Veal, Bull, & Miller, 2012; West et al., 2014; Yeun-Sim Jong et al., 2010), the concept has not been investigated as an independent phenomenon in undergraduate nursing students. The relevance of this study to the existing body of knowledge will be further elucidated.

Homogeneity of Nursing Workforce

A homogenous nursing workforce is believed to be a more significant cause for health disparities than a lack of health insurance (Sullivan Commission, 2004; IOM, 2002, 2011a). The most compelling argument in favor of diversifying the nursing

profession is that it will lead to improvements in public health (HRSA, 2006). The continued lack of heterogeneity within the nursing workforce has necessitated a demographic imperative in which members of the dominant American culture familiarize themselves with other cultures. The term "cultural competence" describes how healthcare providers understand and consider how cultural and social factors influence a person's health and attitudes towards illness and disability (Matteliano & Street, 2012).

According to HRSA (2006) and the Professional Advocacy hypothesis, health professionals from minority populations are more likely than their non-minority counterparts to provide leadership and advocacy for vulnerable populations. Minority nurses are key contributors and leaders in the development and implementation of care models aimed at addressing the unique needs of racial/ethnic and sexual minority populations (AACN, 2015b; Phillips & Malone, 2014; Villarruel, Bigelow, & Alvarez, 2014). Such programs would serve to increase the access to and quality of health care received by this population (HRSA, 2006).

Unfortunately, however, there remains a concerning underrepresentation of racial/ethnic, gender, and sexual minority nurses in influential leadership roles. According to the AACN (2015b), less than 13% of full-time nursing faculty and 6.8% of nursing administrators in nursing education programs in the U.S. identify as being a racial or ethnic minority. With regard to LGBTQ nurses, a national survey of nurse educators in the U.S found that 78% of nearly 1100 participants identified as heterosexual (Lim, Johnson, & Eliason, 2015). Of the remaining participants, 5% self-identified as

lesbian, 4% gay, 2% bisexual, and 10% declined to answer the question (Lim, Johnson, & Eliason, 2015).

In terms of gender, men comprise for only 5% of full-time faculty teaching at baccalaureate and higher-degree schools of nursing and account for an even smaller number of individuals in college leadership roles. According to data obtained by the Robert Wood Johnson Foundation (2012), only 4.5% of the nation's 838 nursing school deans (29 deans) are male. Minority nurse leaders are more likely to be in a position to facilitate the allocation of resources and influence state and national policies aimed at eliminating health disparities (Phillips & Malone, 2014). Nurses who identify as minority status should not bear sole responsibility for addressing the multitude of disparities that plague the healthcare system.

Theoretical Framework

Hall and colleagues (1994) introduced a conceptual framework for the study of marginality within the field of nursing. The conceptual definition of marginalization refers to a process that results in groups being peripheralized on the basis of such variables as a person's identity, experiences, associations, and environments (Hall et al., 1994). Margins can be defined as "the peripheral, boundary-determining aspects of persons, social networks, communities, and environments" (Hall et al., 1994, p.24). This multidimensional concept creates a situation in which certain individuals are given limited access to social power; such disparity results in the individual being excluded from tangible and intangible resources, as well as being subject to differential treatment

(Hall et al., 1994). Hall and colleagues (1994) ascribed seven key properties or subconcepts to marginality: 1) intermediacy; 2) differentiation; 3) power; 4) secrecy; 5) voice; 6) reflectiveness; and 7) liminality. *Intermediacy* is the tendency of human-created boundaries to act as both barriers and connections. Living along the margins carries with it a constant risk of personal or territorial invasion by those in power (Hall et al., 1994). *Differentiation* refers to the maintenance of these boundaries so as to preserve the distinct identities of individuals or groups; the more physical or social distance from the center, the more diversity of identities.

The third subconcept, *power,* speaks to the influence exerted by those in power over those individuals that have been peripheralized. *Power* is bidirectional but also hierarchical in that it dissipates as it extends towards the margins of society. This lack of power causes those on the periphery (i.e. the marginalized) to use *secrecy* to conceal any differences and avoid betrayal. *Secrecy* both creates and maintains environments and social groups that are marginalized. Similarly, those in power create an environment where concepts and ideas are expressed in the language of the majority; such an environment results in the devaluation of the *voices* of the marginalized. Silencing a person's *voice* alters one's view of the world and facilitates *Liminality*. *Liminality* speaks to an individual's altered and intensified perceptions of time, worldview and self-image that result from being repeatedly subjected to being marginalized. As a result of the previous subconcepts, *reflectiveness* describes the psychological effects an individual experiences that results from being marginalized. According to Hall and colleagues

(1994*), reflectiveness*, or intense introspection occurs while one constantly relives and analyzes social experiences.

Assumptions

1. Marginalization contributes to social outcomes.
2. Individuals are marginalized based on such variables as a person's identity, experiences, associations, and environments.
3. Social structures, including centers of power, exist in institutions of higher education.
4. Many factors, both external and internal, affect the retention of minority nursing students.

Statement of Purpose

The purpose of this study is to investigate the relationship between marginality and minority status in undergraduate nursing students. Quantitative methodology measuring marginalization with the Koci Marginality index-70 (KMI-70) will be conducted in the four University of Wisconsin system schools that have undergraduate nursing programs.

The study will address the following research questions:

1) Does the level/degree of marginality differ among undergraduate nursing students based on race/ethnicity?
2) Does the level/degree of marginality differ among undergraduate nursing students based on sexual orientation?

3) Does the level/degree of marginality differ among nursing students based on gender?
4) Does the level/degree of marginality differ among undergraduate nursing students based on age (i.e. traditional versus non-traditional status)?

Hypotheses

1) Hypothesis #1: Racial/ethnic minority undergraduate nursing students will have significantly higher marginality scores when comparted to non-minority undergraduate nursing students.
2) Hypothesis #2: LGBTQ minority undergraduate nursing students will have significantly higher marginality scores when comparted to non-minority undergraduate nursing students.
3) Hypothesis #3: Male undergraduate nursing students (minority) will have significantly higher marginality scores when comparted to female (non-minority) undergraduate nursing students.
4) Hypothesis #4: Non-traditional-aged (minority) undergraduate nursing students will have significantly higher marginality scores when compared to traditional-aged (non-minority) undergraduate nursing students.

Definition of Terms

The terms used in the study were:

Baccalaureate Nursing Program

Conceptual definition: The 2 to 2.5 year upper level, or four year degree of

bachelor conferred to universities and colleges (Merriam-Webster Online Dictionary, 2017a).

Operational Definition: All four universities in Wisconsin that offer a baccalaureate nursing program (the Universities of Wisconsin Eau Claire, Oshkosh, Madison, and Milwaukee) were included in the study.

Bisexual

Conceptual definition: A person who is characterized by sexual or romantic attraction to members of both sexes (Merriam-Webster Online Dictionary, 2017b).

Operational definition: Those participants who identify as bisexual on the study's demographic questionnaire.

Gay

Conceptual definition: A man who is sexually attracted to other men (English Oxford Dictionary, 2017).

Operational definition: Those participants who identify as gay on the study's demographic questionnaire.

Lesbian

Conceptual definition: A woman who is sexually attracted to other women (English Oxford Dictionary, 2017).

Operational definition: Those participants who identify as lesbian on the study's demographic questionnaire.

Marginality

Conceptual definition: A process that results in groups being peripheralized on the basis of such variables as a person's identity, experiences, associations, and environments (Hall et al., 1994).

Operational definition: The KMI-70 will be used to measure marginality in study participants.

Minority

Conceptual definition: According to the American Heritage Online Dictionary (2011), a minority is defined as "a racial, religious, political, national, or other group thought to be different from the larger group of which it is part" (para 1). In addition to racial/ethnic minorities, the LGBTQ population is considered a sexual minority within the nursing profession (Eliason et al., 2011). In regard to gender, males are viewed as a gender minority within the field of nursing (AACN, 2012).

Operational Definition: Participants who report belonging to any of the following groups on the demographic questionnaire: racial/ethnic minority (i.e. non-Caucasian), sexual minority (i.e. LGBTQ), male gender, or 25-years of age or older.

Non-Traditional Student (Age)

Conceptual definition: A student enrolled in a college or university who is 25 years of age or older (National Center for Education Statistics, 2016).

Operational definition: Those participants who identify as being 25-years of age or older on the study's demographic questionnaire.

Nursing Student

Conceptual definition: A student in a program leading to RN certification in a form of Nursing (MediLexicon, 2017)

Operational definition: Inclusion criteria of being enrolled at one of the four universities in Wisconsin that offers a baccalaureate nursing program: the Universities of Wisconsin Eau Claire, Oshkosh, Madison, and Milwaukee.

Race/Ethnicity

Conceptual definition: Race is defined as "a group of persons related by common descent or heredity" (Merriam-Webster, 2017c, para 4). Ethnicity is defined as "a social group that shares a common and distinctive culture, religion, language" (Dictionary.com, 2017, para 3).

Operational definition: The race/ethnicity reported by participants on the study's demographic questionnaire.

Transgender

Conceptual definition: According to Merriam-Webster Online dictionary (2017d), a transgender person "identifies with or expresses a gender identity that differs from the one which corresponds to a person's sex at birth" (para 1).

Operational definition: Those participants who identify as transgender on the study's demographic questionnaire.

Queer

Conceptual definition: According to the Parents and Friends of Lesbians and Gays national organization (2015), "queer" is an umbrella term that includes anyone who feels outside of the societal norms in regards to gender or sexuality.

Operational definition: Those participants who identify as queer on the study's demographic questionnaire.

Limitations

1. Participants will be selected from four universities within the state of Wisconsin; therefore the results of this study may not be generalizable to baccalaureate nursing programs in other states or countries.
2. The use of survey research poses a limitation as it requires participants to choose among a set of prescriptive responses and does not allow for the expression of opinion (Simon, 2011)
3. Another limitation of survey research that is conducted electronically is that, once the survey is disseminated to participants, it is difficult for respondents to seek clarification on questions that may be unclear (Simon, 2011)
4. A non-experimental, descriptive correlational design does not provide evidence of causality between the independent and dependent variables.
5. Self-report survey data are limited to what the participants are willing to share with the researcher.

6. The use of a convenience sampling plan has the potential for bias to be introduced into the study (Polit & Beck, 2012).

Summary

Despite the rapidly changing demographics of the U.S, there remains a lack of minority representation within the nursing profession. A lack of diversity in the healthcare professions has been found to be a factor that significantly and negatively impacts minority health care (IOM, 2002, 2011a; Sullivan Commission, 2004). As RNs are integral in providing the most direct care to patients, it is critical that the nursing workforce continues to increase its racial concordance in order to meet the healthcare needs of the population they serve. To ensure a diverse nursing workforce, it is imperative that factors that contribute to attrition of minority undergraduate nursing students, such as marginalization be explored.

CHAPTER II

REVIEW OF LITERATURE

This chapter provides further inquiry into the marginalization experienced by minority nursing students. This review of literature includes studies that address minority students' perceptions of their experiences in college, as well as other facets of marginalization including institutional climate, financial constraints, lack of mentorship, and exclusionary nursing curricula. In order to identify relevant articles, a keyword search was undertaken using multiple electronic literature databases including Academic Search Complete, Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus with Full Text, Education Resources Information Center (ERIC), Medline with Full Text, ProQuest Research Library, PsychARTICLES, PsychINFO, Pubmed, and Science Direct.

A variety of search terms or combination of search terms were used and include: *ethnicity, race, nursing student, minorities, minority perceptions, education, marginalization, minority success, higher education, barriers, retention, LGBTQ, gender, sexual minority, attrition, barriers, male nursing student, and gender minority.* The search was restricted to articles published after 2002, although one article was included from 1996 as it was a seminal study that is relevant to this review of literature. The restriction of articles to those published after 2002 was done because it is the year that the IOM published their report, *Unequal Treatment: What Healthcare Providers Need to*

Know about Racial and Ethnic Disparities in Healthcare (2002). This report served as a catalyst for researchers, educators, and nurse leaders to focus their attention on diversifying the nursing profession. The literature searches were confined to peer-reviewed research studies and literature reviews that were written in the English-language.

Marginalization

The educational system has been identified as being the single most important agent in the process of socialization into the nursing profession; however it is posited that the education system in the U.S. supports and perpetuates the oppression that exists in a socially stratified society (Dapremont, 2011; Love, 2010). Empirical evidence suggests that current educational pedagogies also continue to favor a traditional nursing approach to learning that leaves little room for multicultural dialogue (Dapremont, 2011; Hassouneh, 2008; Lynn, 2006). Research indicates that nursing programs across the U.S. continue to be steeped heavily in a Eurocentric tradition (Dapremont, 2011; Hassouneh, 2008; Loftus & Duty, 2010; Love, 2010; Mulholland et al., 2008; Wong, Seago, Keane, & Gumbach, 2008). According to Hall (1999), Eurocentrism, speaks to the pervasive ideology that holds European and North American values and technologies to be far superior to all others (i.e. those belonging to "the exterior"). Eurocentric views tend to not be expressed overtly by those in power; rather non-minority students and nursing faculty fail to entertain the idea that there is another way to view the world (Dapremont, 2011; Hassouneh, 2008; Love, 2010).

The literature on nursing education suggests that the university system in the U.S. maintains a structure that promotes assimilation to the dominant (i.e. White, heterosexual, female, and traditional-aged) cultural norms (Dapremont, 2011; Evans, 2008; Gilchrist & Rector, 2007; Loftin et al., 2012; Love, 2010; Lynn, 2006). Socialization into the nursing profession is heavily skewed towards the non-minority culture (Dapremont, 2011; Fulbright & Brooks, 2011; Gilchrist & Rechtor, 2007; Gonzales, 2013; Love, 2010; Lynn 2006); as such, minority students are required to not only learn the skills and knowledge of the profession, but to also familiarize themselves with the dominant cultural skills promulgated by the university. Empirical evidence suggests, however that these cultural norms tend to not be congruent with the personal cultural skill sets of racial and ethnic minority students in particular (Anonson, Desjarlais, Nixon, Whiteman, & Bird, 2008; Love, 2010; Lynn, 2006). Nursing schools across the nation teach the language of the profession, to "think as a nurse would", and to adopt the "correct" behaviors based on dominant cultural norms (Haigh & Johnson, 2007; Love, 2010). Oftentimes the notion of what constitutes "professionalism" serves as a type of justification for maintaining majority ideologies about such matters as language, behaviors, and dress code (Haigh & Johnson, 2007; Love, 2010). As a result of these attitudes, minority students may feel disconnected, ignored, and without power (Bednarz et al., 2010; Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; Stott, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010)

Social adjustment has been identified as a central theme in the attrition rates of minority nursing students (Loftin et al., 2012; Love, 2010; Mulholland et al., 2008; Stott, 2007). The "differentness" experienced by minority students manifests itself in several ways. For example, racial and ethnic minority students have consistently reported experiencing intense feelings of disconnect, isolation and loneliness (Bednarz et al., 2010; Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; Sanner & Wilson, 2008; Stott, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010). Struggling with feelings of loneliness and isolation has been shown to significantly hinder a student's ability to effectively navigate the nursing curriculum (Love, 2010; McDermott-Levy, 2011; Rivera-Goba & Nieto, 2007). In order to improve their academic performance, minority students often seek to decrease the degree of stress and dissonance felt in the academic setting by conforming themselves to the majority (Love, 2010). In other words, students viewed fitting in as necessary to their survival in the nursing program, and believed that they could return to their "true selves" once nursing school was over (Love, 2010).

Research suggests that stereotypes and discrimination continue to plague the U.S. education system (Bednarz et al., 2010; Bond et al., 2008; Cooper, Walker, Askew, Robinson, & McNair, 2011; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; Stott, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010). According to Zubernis and Snyder (2007), stereotypes and destructive attitudes perpetuated by society can be internalized by those

individuals who fall victim to such stereotypes. This typecasting and negativity may lead students to feel like outsiders, which, in turn, may hinder minority students' ability to successfully complete their education (Hassouneh, 2008; Levesque, 2015; Love, 2010; Zubernis & Snyder, 2007).

Research suggests that educational environments that are persistently hostile and stressful significantly impede students' ability to be successful academically (Cooper et al., 2011). Social marginalization and discrimination have been shown to lead to overt and covert racial segregation of minority students (Paterson, Osborne, & Gregory, 2004). In order to examine the ways racism is understood and experienced within one medical school in Canada, Beagan (2003) conducted interviews with 25 third-year medical students. The majority of participants felt marginalized through racial segregation at school, and reported being the recipient of racist jokes or comments from peers, faculty, and patients (Beagan, 2003). Results also indicate that the social subgroups that reportedly exist in medical school are divided almost entirely by racial categories. According to Beagan (2003), what was described in his study could reflect racist segregation by the dominant group, or it may represent the minority students' protection against or response to marginalization (Beagan, 2003).

As a result of feeling marginalized and/or not invested in the program (i.e. lacking in authentic, supportive relationships with peers and nursing faculty) minority students have expressed being unhappy or disappointed with the nursing program in general (Rivera-Goba & Nieto, 2007). These negative perceptions have also extended to the

nursing profession as a whole. A number of studies have found that minority nursing students feel hatred, ambivalence, or apathy towards the field of nursing as a direct result of their experiences in the nursing program (Bond et al., 2008; Marchiondo, Marchiondo, & Lasiter, 2010; Rivera-Goba & Nieto, 2007). Furthermore, minority students who have negative experiences in the classroom and/or clinical setting may decide that they do not want to be part of a profession that does not value them as a person (Bartholomew, 2011). These negative experiences may be a deciding factor in students' electing to withdraw from nursing programs.

Marginalization and Race/Ethnicity

Research suggests that racial and ethnic minority nursing students feel that their peers and nursing faculty lack understanding and knowledge of minority cultures (Dapremont, 2011; Gardner, 2005; Hassouneh-Phillips & Beckett, 2003; Paterson et al., 2004; Stewart, 2005). In her seminal article, Yoder (1997) used the principles of naturalistic research and grounded theory to identify the processes by which nurse educators teach ethnically diverse nursing students. Yoder (1997) also sought to formulate a substantive theory that would explain the processes of faculty responding and the potential consequences of educators' actions for students. Data were obtained using in-depth interviews from two groups: 26 nurse educators employed full-time at one of the target universities in California and 17 ethnic minority nurses who recently graduated from one of the target universities. Yoder (1997) found that nursing faculty who demonstrated high levels of cultural awareness and sensitivity more effectively attended

to the needs of minority students in comparison to nursing faculty who demonstrated low levels of cultural awareness and sensitivity (Yoder, 1997).

Failure of educators to act in a culturally competent manner can have significant and detrimental effects on a minority student's ability to obtain a college degree (Paterson et al., 2004). In a qualitative study conducted by Paterson and colleagues (2004), a Vietnamese student reported that her clinical instructor had incorrectly assumed that she would appreciate direct feedback on a clinical-related issue. The instructor had confronted the student in a public setting, causing her a great deal of shame. The student indicated that her culture dictated that the clinical instructor provide her feedback in a written note instead. As a result of the clinical instructor's actions, the student did not complete her clinical rotation because she was overcome with shame; the result of the confrontation was that the student ended up dropping out of the program (Paterson et al., 2004). This perceived cultural insensitivity may cause students to feel misunderstood, devalued, and ignored (Amaro, Abriam-Yago & Yoder, 2006; Beagan, 2003; Bond et al., 2008; Dapremont, 2011; Evans, 2008; Gardner, 2005; Hassouneh-Phillips & Beckett, 2003; Loftin et al., 2012; Love, 2010; Paterson et al., 2004; Stewart, 2005; Stott, 2007; Wong et al., 2008).

Cultural competence and diversity gets little attention in the classroom and clinical settings (Bosse, Nesteby, & Randall, 2015; Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012; Carabez et al., 2015; Gardner, 2005; Lim et al.,, 2015; Paterson et al., 2004; Röndahl, 2009). Cultural competence refers to the ability to deliver services while

taking into consideration the cultural beliefs, behaviors, and needs of the individual (Centers for Disease Control and Prevention [CDC], National Prevention Information Network, 2008).

Fulbright and Brooks (2011) conducted focus groups at the University of Pennsylvania to evaluate the perceptions of both undergraduate and doctoral (PhD) students with regard to the integration of cultural competence in the nursing curriculum. A total of 507 BSN and 56 PhD students participated in the study. Participants in both groups voiced concerns about the curriculum in terms of time spent on cultural competence and felt that they would have difficulties integrating cultural competence into research (PhD group) and clinical practice (BSN group). Furthermore, both groups believed that there were a number of missed opportunities in the classroom and clinical settings to teach cultural competence (Fulbright & Brooks, 2011). A limitation of the study is that both samples were overwhelmingly female (94% for the BSN group and 95% for the PhD group); the homogenous nature of the sample with regard to gender limits the transferability of these findings to male nursing students.

Kardong-Edgren and Campinha-Bacote (2008) conducted a quantitative study that evaluated the effectiveness of four different nursing program curricula in developing culturally competent nursing graduates. Aggregate competency scores were obtained from 218 seniors who were graduating from one of the four target universities in the U.S. using Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). Results indicate that participants

scored only in the culturally aware range (the lowest level of cultural competence) regardless of what program model they attended (Kardong-Edgren & Campinha-Bacote, 2008).

Nurse educators have the potential to influence students' understanding and level of cultural competence (Starr, Shattell, & Gonzales, 2011). Studies have revealed, however, that nurse educators lack confidence in teaching concepts about another culture (Bosse et al., 2015; Dyck, Oliffe, Phinney, & Garrett, 2007; Sargent, Sedlack, & Martsolf, 2005; Sealey, Burnett, & Johnson, 2006; Starr et al., 2011; Sumpter & Carthon, 2011). Sealey and colleagues (2006) conducted a quantitative study to examine cultural competence among faculty of baccalaureate nursing programs in the state of Louisiana. The Cultural Diversity Questionnaire for Nurse Educators was used to evaluate the levels of cultural competence of 313nurse educators who participated in the study. The majority of participants (96.3%; *n*=157) were female and 74.8% (*n*= 122) identified as Caucasian (Sealey et al., 2006). Results show that very few nurse educators felt prepared to teach transcultural nursing curricula and only 3% of respondents reported transcultural nursing as a specialty area (Sealey et al., 2006). A limitation of this study is that the researchers relied solely on self-report of the respondents and can only be generalized to nursing faculty of baccalaureate programs in Louisiana (Sealey et al., 2006).

Another common theme identified in the literature describes racial and ethnic minority nursing students feeling that they did not fit into the social and educational system promoted by universities (Bond et al., 2008; Gardner, 2005; Dapremont, 2011;

Hassouneh-Phillips & Becket, 2003; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010). Empirical evidence suggests that the cultural norms promulgated by universities across the U.S. tend to lack congruency with the personal cultural skill sets of racial and ethnic minority students in particular (Anonson et al., 2008; Loftus & Duty, 2010; Love, 2010; Lynn, 2006).

Research suggests that nursing students in the U.S. are encouraged to view every person as the same, as equal to all others, regardless of cultural differences (Paterson et al., 2004). This message is conveyed in the mission statements, course syllabi, and classroom instruction across the nation (Paterson et al., 2004). Evidence suggests, however, that this message requires minority students to abandon some degree of their cultural identity (Paterson et al., 2004). It also leaves minority nursing students wondering why their cultural groups are not being represented in the institution or nursing curriculum (Gardner, 2005; Love, 2010; Hassouneh, 2008; Paterson et al., 2004; Wong et al., 2008). Furthermore, White students tend to be on the positive end of the race differential, therefore their experiences with process of socialization into the nursing profession tends to be a much easier transition (Love, 2010). As a result of this dissonance, racial and ethnic minority students sometimes feel compelled or are expected to "act White" in order to fully assimilate into the nursing culture (Amaro et al., 2005; Anonson et al., 2008; Childs, Jones, Nugent, & Cook, 2004; Loftus & Duty, 2010). This finding is supported by a study conducted by Anonson and colleagues (2008) which

found that racial and ethnic minority students felt that they were expected to abandon their minority identity in order to fully assimilate into the nursing culture. Furthermore, racial and ethnic minority students have reported feeling that if they were not successful academically, their failure would somehow add to the ideology that depicts minority students as inferior to non-minority students (Childs et al., 2004; Love, 2010).

In one study, Sanner and Wilson (2008) conducted in-depth interviews to explore the lived experiences of English as Non-Native Language (ENNL) students in a baccalaureate nursing program in the Southwest United States. Three students (one Filipino female, one African female, and one Filipino male) agreed to participate in the study. Participants reported a willingness to do anything it took to continue in the nursing program including taking "the path of least resistance" to keep instructors happy (Sanner & Wilson, 2008). Despite the fact that participants were struggling with a number of issues that were hindering their academic success, the felt that displeasing the nursing instructors would yield negative and undesired ramifications for the student (Sanner & Wilson, 2008). A limitation of this study is the very small sample size (n=3), which significantly limits the transferability of the results to the rest of the population.

Conforming to the cultural homogeneity within the university is not without consequences, however; studies have shown that such conformity can cause tension and discord with students' families and minority friends (Dapremont, 2011; Love, 2010; Paterson et al., 2004). Love (2010) used descriptive phenomenology to explore the phenomenon of socialization among eight African American Nursing students enrolled in

predominantly White universities in the United States. Data were collected using semi-structured interviews; one of the themes that emerged from the lived experiences of participants was the belief that they must fit it and "talk White" in order to be successful academically. A few students discussed this issue negatively, stating that students who were Black but "acted White" were considered "…Oreos…Black on the outside and White on the inside" (Love, 2010, p. 347). These students further explained that "Oreos" are viewed as having an easier time fitting in and were doing better in school (Love, 2010). This study is limited to the lived experiences of African American students and cannot be generalized to other racial/ethnic student populations.

The findings reported by Love (2010) were supported by Dapremont (2011) who conducted a descriptive qualitative study to examine the lived experience of 18 Black nurses who had graduated from a predominantly White associate or baccalaureate degree-granting university in the southeastern United States. Data were collected from 16 female and two male participants, ages 18 to 50 using semi-structured interviews. One of the themes identified in the study is that participants verbalized concerns over the reactions of their minority peers if they studied or interacted with their White peers. Participants reported that forming relationships with White students was important to their academic success because participants believed that White nursing students had access to more curricular information than black students. It was believed that, in order to be successful academically, African American students must develop relationships with White peers so as to obtain this information (Dapremont, 2011). A limitation of this

study pertains to the validity of data analysis as only one person conducted data coding and theme analysis. The rigor of the study would have been enhanced through the involvement of multiple independent investigators.

Amaro and colleagues (2006) utilized grounded theory to identify and explore nurses' perceptions of barriers present in nursing education. The researchers conducted semi-structured interviews with 17 RNs (14 females, 3 males) who had recently graduated from one of four accredited nursing programs located in the central costal valley of California. Eight of the 17 participants identified as Asian, 4 as Latino, 2 Portuguese, 2 African American, and 1 African. With regards to education, 11 had graduated from an associate degree program, and 6 held a baccalaureate degree in nursing. Most of the participants included in the study reported a high level of needs or barriers. In terms of academic needs, the most common issues were the need for tutoring and study groups, and a significant concern for the study workload. Common cultural needs identified include a lack of ethnic role models, poor communication with educators and peers, as well as a general lack of assertiveness regarding the issues stemming from their minority status (Amaro et al., 2006). One limitation of the study is the study sample; only three males were included in the study as well as a small number of African (n=1) and African American (n=2) participants. Such small numbers call into question the transferability of the study's results to the larger population.

Rivera-Goba and Nieto (2007) used a qualitative phenomenological approach to explore the meaning and significance of mentoring for Latinas/os in nursing. Seventeen

nurses who recently graduated from a number of universities in the eastern U.S. were interviewed; all participants reported experiencing marginalization throughout their schooling (Rivera-Goba & Nieto, 2007). Participants indicated that being marginalized made them feel isolated and they were treated as though they lacked the ability and/or intelligence to be effective nurses (Rivera-Goba & Nieto, 2007). A limitation of this study is that the researchers collected data from students who had successfully completed the nursing program. Excluding current nursing students may potentially limit a researcher's ability to identify those barriers that are judged insurmountable by minority students.

Evidence suggests that positive faculty interactions can be empowering and promote a sense of confidence in their abilities as a nursing student (Dapremont, 2011; Gonzales, 2013; McEnroe-Pettite, 2010). Empirical evidence suggests that minority nursing students possess a strong desire to interact more consistently with mentors and role models that are culturally concordant with their background (Crisp, 2010; Gardner, 2005; Rivera-Goba & Nieto, 2007; Sayles & Shelton, 2003; Scott, 2007; Taxis, 2006). Empirical data have consistently shown, however, that there remains a lack of minority role models or mentors both at the university level and within the college of nursing (Amaro et al., 2006; Gardner, 2005; Nnedu, 2009; Rivera-Goba & Nieto, 2007; Taxis, 2006). In Rivera-Goba and Nieto's qualitative study, only three of the 17 Hispanic participants had a Hispanic advisor or mentor in the nursing program. All three of the

participants spoke of the significant role that the advisor played in supporting their academic and professional success (Rivera-Goba & Nieto, 2007).

Mills-Wisneski (2005) used descriptive phenomenology to explore minority students' perceptions regarding the presence of minority faculty in undergraduate nursing programs. Data were collected using semi-structured interviews from 71 African American students enrolled in their junior year at one of nine target universities located in the North Atlantic and Southern regions of the United States. The sample consisted of 66 females and five males who ranged in age from 19 to 44 years (Mills-Wisneski, 2005). Participants reported that faculty who were of the same race/ethnicity or gender were easier to approach and that they felt hesitant seeking assistance from non-minority faculty members. Faculty mentors were perceived as serving a critical role in providing minority students with informational, academic, and emotional support in both the education and clinical practice settings, as well as socializing students to the role of the professional nurse (Mills-Wisneski, 2005). The transferability of this study is limited by the homogeneity of the sample in terms of race (all participants were African American) and gender (93% were female)

Evans (2008) conducted semi-structured interviews to investigate barriers to success from 12 Hispanic/Latino and two American Indian baccalaureate nursing students. Undergraduate nursing students from two private and two public universities in Spokane Washington agreed to participate in the study. Participants reported that they strongly desired to have a faculty mentor to help guide them through the program and be

a source of support; however there were no faculty of color in the nursing program and very few minority students on campus (Evans, 2008). Without a mentor, students reported feeling alone in the program and believed they were constantly confronted with a lack of awareness on the part of White faculty and student peers with regard to being a minority nursing student (Evans, 2008). The study is limited by the fact that the sample was largely of Hispanic ethnicity; the homogeneity of the sample with regard to ethnicity limits its transferability to other populations.

Gardner (2005) utilized phenomenology to investigate the lived experiences of 15 racial and ethnic minority students while enrolled in a predominantly White nursing program in the United States. Three of the participants identified as being East Indian, two Hispanic, two Hmong, two African American, two Nigerian, one Filipino, one Nepalese, one Vietnamese, and one Chinese. Participants ranged in age from 22 to 47 years. Thirteen of the participants were female, two were male. Nine students identified as being foreign-born; the remaining six were born in the United States. All of the participants; however had been residing in the U.S. for at least four years. A number of themes emerged from the analysis of data including feelings of loneliness, isolation, and differentness from faculty and peers, as well as feeling an absence of acknowledgement of individuality from nursing faculty with regard to their race/ethnicity (Gardner, 2005). A limitation of the study is that some of the racial/ethnic groups included in the study were very small, which may hinder the transferability of the study to the larger population.

The results of Gardner's (2005) study were supported by Dapremont's (2011) study of the lived experiences of African American nurses who persisted in a largely Caucasian undergraduate nursing program. Dapremont (2011) reported that 78% of participants (*n*= 14) viewed faculty support as significantly affecting student success. Many of the participants spoke negatively about this theme and shared feelings of anger and discouragement about not being supported by nursing faculty. A limitation of this study pertains to the validity of data analysis since only one person conducted data coding and theme analysis. The rigor of the study would have been enhanced through the involvement of multiple independent investigators.

According to Levett-Jones, Lathleen, Higgins, and McMillan (2009), a student's confidence, resilience, and motivation are strongly influenced by the extent to which students feel a sense of belonging to both the nursing program and their peers. Social isolation may lead to depression, anxiety, and sense of a lacking in support from peers and nursing faculty (Beagan, 2003; Cooper et al., 2011; France et al., 2004; Gardner, 2005; Griswold, 2014; Sanner & Wilson, 2008; Sayles & Shelton, 2003; Shelton, 2008; Stott, 2007; Taxis, 2006; Twale & DeLuca, 2008).

France and colleagues (2004) used a phenomenological approach to explore the lived experienced of Black nursing students (*n*=4) in a largely White university in the southeastern United States. One of the themes that the researchers identified was participants feeling that they were essentially shoved to the corner within the nursing program. Participants shared that a lack of relationships, collegiality, and support from

peers was a significant barrier to their academic success (France et al., 2004). One participant discussed the difficulty of being one of the only Black students in the nursing program because there was no one else further along in the program to turn to for guidance or advice. According to the student "most other nursing students…have upperclassmen that they can relate to or get help when it comes to studying, how to study, and what to study" (France et al., p. 30). A lack of support by nursing faculty and peers, coupled with smaller numbers of minority nursing students on campus create an environment where students feel they do not have an adequate outlet for sharing their feelings or concerns (Childs et al., 2004; France et al., 2004; Hassouneh-Phillips & Beckett, 2003; Stott, 2007). Harboring negative feelings and experiences without having access to an adequate outlet to openly discuss these issues is strongly associated with attrition from nursing programs (Childs et al., 2004; Stott, 2007).

Research suggests that racial/ethnic and gender minority students feel that their minority status automatically sets them up to be recognized by nursing faculty, peers, and healthcare professionals (Dyck et al., 2007; LaRocco, 2007; MacWilliams, Schmidt, & Bleich, 2013). For example, the study conducted by Dyck and colleagues (2007) reported that male nursing students felt that they were more likely to be recognized by nursing faculty because of their minority status, and therefore encouraged to participate or lead classroom and clinical discussions. These perceptions also led students to believe that they were constantly "under a microscope" and had to continuously prove themselves worthy of their place in the nursing program (Dyck et al., 2007).

In a study conducted by Doutrich, Wros, Valdez, and Ruiz (2005), the researchers utilized Heideggerian phenomenology to explore the lived experiences of Hispanic nurses working in the northwestern U.S. A total of 27 practicing nurses were interviewed about their lived experiences in nursing education specifically. One theme that Doutrich and colleagues (2005) identified was participants feeling the burden of being "the voice" for the Hispanic culture (Doudrich et al., 2005). Participants described being repeatedly called upon by their nursing instructors and peers to provide an "expert opinion" on the views, opinions, and cultural norms of the Hispanic population in both the classroom and clinical setting (Doudrich et al., 2005). A limitation of the study is that researchers used Heideggarian phenomenology to understand the lived experience of Hispanic nurses working in the Pacific Northwest; such methodology precludes generalizability as the purpose of the study was to offer an understanding of the experience of the participants only.

Language continues to be a significant barrier in both general and nursing education for students who identify ENNL (Amaro et al., 2006; Childs et al., 2004; Malecha, Tart, & Junious, 2012; Olson, 2012; Suliman & Tadros, 2011). Much of the literature on students who identified as ENNL stresses the vital role that communication plays in the process of socialization (Edgecombe, Jennings, & Bowden, 2013). All forms of communication (written, verbal, and nonverbal) are steeped in cultural nuances that can be confusing to those individuals who are new to particular social, academic, or clinical context (Amaro et al., 2006; Edgecombe et al., 2013). Issues with

communication have also been shown to create barriers to minority students' forming and maintaining authentic relationships with peers, nursing faculty, patients, and clinical staff (Amaro et al., 2006; Edgecombe et al., 2013; Woodward-Kron, Hamilton, & Rischin, 2007). Communication barriers between racial/ethnic minority and non-minority nursing students have led to feelings of distrust, suspicion, and competition (Edgecombe et al., 2013; Mattila, Oitkajarvi, & Eriksson, 2010; Sanner & Wilson, 2008).

Students who speak with heavy accents and use of culture-specific terminology or slang reported facing multiple barriers including impatience and outright discrimination (Amaro et al., 2006; Hassouneh-Phillips & Beckett, 2003; Love, 2010). Furthermore, ENNL students have reported that communication difficulties have caused nursing faculty to ignore them or preclude them from learning activities (Amaro et al., 2006; Edgecomb et al., 2013; Mattila et al., 2010; Sanner & Wilson, 2008).

A multitude of studies have shown that racial-motivated prejudice and discrimination are still quite prevalent within universities across the nation (Beagan, 2003; Bond et al., 2008; Gardner, 2005; Hassouneh-Phillips & Beckett, 2003; Hassouneh, 2008; Love, 2010; Smith, McAlister, Tedford-Gold, & Sullivan-Bentz, 2011; Sue, Lin, Torino, Capodilupo, & Rivera, 2009). Experiences with discrimination come from a variety of sources including peers, nursing faculty, nurses, patients, and other ancillary healthcare professionals. Microaggressions, a form of discrimination can be characterized as brief, daily assaults on minority individuals that can take the form of

social, environmental, verbal, nonverbal, intentional, or unintentional insults (Sue et al., 2009).

Sue and colleagues (2009) used focus groups to explore minority students' experiences of difficult dialogues on race in the classroom. The sample consisted of 14 participants (8 Blacks, 3 Asians, 2 Latinos, and 1 biracial) who were students at Teachers College, Columbia University and reported having experienced a difficult dialogue about race in the classroom. Interviews with the participants about microaggressions in the classroom revealed that minority students continue to face negative assumptions about intelligence and criminality. Furthermore, participants reported being made to feel that they were foreigners and not welcome in the classroom (Sue et al., 2009). A limitation of this study is that the findings can only be generalized to minority students enrolled at Columbia University.

Hassouneh-Phillips and Beckett (2003) used a critical hermeneutics approach to investigate the experiences of nine racial and ethnic minority women in three nursing doctoral programs in the western United States. Demographic data indicates that the majority of participants (n=8) identified as African American with one participant reported being of Asian descent (Hassouneh-Phillips & Beckett, 2003). Results indicate that the influence of racism is pervasive and is deeply embedded within the fabric of the educational institution (Hassouneh-Phillips & Beckett, 2003). One participant reported that nursing faculty and peers "put so much effort into showcasing their acceptance of her sexual orientation that they were completely oblivious of her ethnicity, and, this made

little or no effort to camouflage their racism" (Hassouneh-Phillips & Beckett, 2003, p. 261). One limitation of the study is that the sample was largely of one race/ethnicity (e.g. African American), which limits the transferability of the findings to the larger population of racial and ethnic minority students.

Del Prato (2013) used an interpretive phenomenological design to study the lived experiences of 13 nursing students enrolled in associate degree programs in the northeastern United States. Participants ranged in age from 19 to 42 years and included nine women and four men. Two participants identified as a racial/ethnic minority and one male participant identified as gay. Results indicate that they were the subject of condescending remarks, constant criticism, and repeated verbal threats of failure (Del Prato, 2013). Participants also reported feeling that they were subject to harsher criticism and negativity from their professors (Del Prato, 2013). One student reported "It was always the male students, the older students… who had a bit more challenging times… They were the ones that had the problems… Where…the pony-tailed blonde haired girls- the pretty faces- just kind of smoothed by." (Del Prato, 2013, p. 288). Such interactions with nurse faculty are strongly correlated with attrition as students who perceive faculty as uncaring or having no regard for their overall psychological and emotional wellbeing are significantly more likely to leave a program of study prematurely (Campbell & Mislevy, 2010; Twale & De Luca, 2008; Wilcoxson, Cotter, & Joy, 2011).

Minority students have also reported hearing or being the subject of racist or insensitive jokes told by peers, patients, or faculty (Beagan, 2003). According to Essed

(1991), racist jokes are predicated upon a prescribed set of characteristics or stereotypes that are means to perpetuate the imbalance of power between the minority and non-minority populations. Other studies have reported more subtle forms of discrimination at the hands of those in the 'majority' (Beagan, 2003). According to Essed (1991) one such form, deemed "everyday racism" refers to the micro processes through which inequities of power are perpetuated in society. These societies are characterized by the majority of its citizens espousing the commitment to the principles of tolerance, justice, and equality, yet inequitable practices are deeply entrenched in everyday life and are seen as "normal" (Essed, 1991). Challenges to "everyday racism" are difficult because each incident, taken independently are minor; the trivial nature of "everyday racism" leaves students struggling with whether or not it is worth the risk to say anything to those in power (Beagan, 2003).

Empirical evidence suggests that non-minority students tend to not view "race" and "racism" as issues in college and often fail to recognize how their "Whiteness" impacts their lives or school experiences (Beagan, 2003; Love, 2010; Sue et al., 2009). White students argue that because both the university and surrounding city are multicultural, and that minority students have the same educational opportunities as Whites, racism is not an issue (Beagan, 2003; Love, 2010). Interpersonal exchanges between students that involved acts of "everyday racism" tend to not be perceived by the aggressor as discriminatory, as they believe their actions were innocent or harmless. Regardless of the intent (overt versus subtle), discrimination can be very emotionally

taxing to students as each incident stirs up both new and old emotions (Love, 2010; Smith, Allen, & Danley, 2007).

A number of studies have shown that White nursing faculty tends to be unable to identify any oppressive teaching techniques or university policies, and that faculty view minority nursing students as negatively "sticking together" (Hassouneh-Phillips & Beckett, 2003; Gardner, 2005; Levett-Jones et al., 2009; Rivera-Goba & Nieto, 2007). Failure of nursing faculty to identify or understand the plight of minority students has led these students to believe that displeasing or disappointing nursing faculty in any way would cause them additional stress in an already tenuous environment (Gardner, 2005; Love, 2010; Sanner & Wilson, 2008). In order to avoid conflict, minority students are made to feel that ignoring the negative behaviors or remaining unobtrusive were the only strategies that would ensure the successful completion of the nursing program (Gardner, 2005; Love, 2010).

Marginalization and LGBTQ

Research that investigates the experiences of sexual minority students in nursing programs is essentially nonexistent. Similarly, there is limited empirical literature on the lived experiences of LGBTQ nurses within nursing or other medical professions (Carabez et al., 2015). The dearth of empirical data about this "silent minority" largely stems from the fact that many LGBTQ students and nurses elect to not divulge their sexual orientation to peers and university faculty for fear of discrimination and negative

repercussions from peers, patients, and administrations (Bowers et al., 2006; Röndahl, 2011).

In a broader context, the hostile environment that LGBTQ students often experience during their academic careers has been documented in numerous studies over the last 30 years (Rankin, 2003; Rankin et al., 2010). Many LGBTQ students feel compelled to hide their sexual orientation out of fear of discrimination or harassment, thereby isolating themselves socially and emotionally (Brown, Clarke, Gortmaker, & Robinson-Keilig, 2004; Rankin, 2003). In 2003, the Policy Institute of the National Gay and Lesbian Task Force conducted a LGBTQ campus climate assessment of fourteen campuses across the nation (Rankin, 2003). The sample consisted of 572 individuals who identified as gay, 458 lesbian, 334 were bisexual, and 68 transgender. Results of the survey indicate that 41% of respondents believed that their university was not adequately addressing issues related to sexual minorities. Furthermore, 43% of respondents identified their campus as being homophobic and all respondents indicated that LGBTQ individuals were likely to be harassed on campus (Rankin, 2003).

Recent studies of undergraduate nursing students and faculty suggest that attitudes regarding the LGBTQ population are slowly changing and becoming less overtly tied to negative stereotypes (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007; Eliason et al., 2011). It is posited, however, that such results may reflect neutrality or heterosexist attitudes rather than true acceptance of the LGBTQ community (Dinkel et al., 2007). Both society in general and nursing education in particular have remained largely

heteronormative in that there is a general assumption that heterosexuality is the norm or the only sexuality of individuals and society (Röndahl, 2011). A consequence of heteronormativity is that all individuals (including members of the LGBTQ population) are assumed to be heterosexuals. The assumption of heteronormativity may lead members of the LGBTQ community to hide their sexual orientation and remain invisible so as to avoid any negative consequences or additional stressors while navigating their college careers (Röndahl, 2011).

Discrimination based on a person's sexual orientation remains a socially sanctioned form of prejudice and includes a number of behaviors such as the promulgation of heterosexism, devaluation of the LGBTQ equality movement, and aversion to the LGBTQ community (Massey, 2009; Tomlinson & Fassinger, 2003). Recent literature suggests that many LGBTQ students are developing and exploring their sexual identity for the first time during their college years (Schmidt, Miles, & Welsh, 2011; Schmidt & Nilsson, 2006). Homophobia and discrimination can significantly and negatively impact a person's health and well-being (CDC, 2008; Herek, 2003; Schmidt et al., 2011). Furthermore, being immersed in an intolerant environment may pressure LGBTQ individuals to hide their sexuality out of fear of recriminations (Gortmaker& Brown, 2006; Herek, 2003). Gortmaker and Brown (2006) used quantitative methodology to compare the campus experiences, perceptions, and needs of "out" versus closeted LGBTQ students enrolled as undergraduate or graduate students at a Midwestern state university. The researchers created a survey that was derived from a number of

published surveys and used a listserv to send the survey to approximately 22,000 students. A total of 80 LGBTQ students returned a completed survey and were included in the study.

Results of the study indicate that 80% of closeted students and 44% of "out" students reported that the perceived high probability of harassment and/or unequal treatment from peers led them to hide their sexual identity. Similarly, 71% of closeted and 39% of "out" participants reported feeling the need to hide their identity from faculty out of fear of recriminations (Gortmaker & Brown, 2006). A limitation of this study is that it utilized a sample from one university, which limits the generalizability of the results to other populations.

The continued psychological stress associated with discrimination has also been shown to significantly influence career development and career self-efficacy (Murphy, 2007; Schmidt et al., 2011). Discrimination and homophobia are very real issues that persist in society and within academic institutions. Murphy (2007) used quantitative methodology to study the relationship between college students, homosexuality, and suicide in University of Washington undergraduate students. A total of 528 participants were included in the study; of the 528 participants, 404 self-identified as heterosexual and 117 participants reported belonging to the LGBTQ community. The seven remaining students indicated that they were currently unsure of their sexual identity (Murphy, 2007). Data were collected using the Youth Risk Behavior Survey.

Results suggest that the majority of LGBTQ participants in the study reported being the target of homophobic statements and microaggressions by student peers and faculty (Murphy, 2007). Furthermore, LGBTQ students were found to be two times more likely than heterosexual students to have planned and attempted suicide within the previous 12 months (Murphy, 2007). This study is limited by the fact that the researcher used a non-random convenience sample, which limits the transferability of the results to the larger population. The researcher also relied exclusively on self-report, which call into question the validity and reliability of the results Murphy, 2007). The results of Murphy's study support Rankin's (2003) qualitative study on campus climate and the LGBTQ community, which found that 30% of participants experienced harassment and microaggressions in the classroom setting and that in-class was the third most common place to experience bias and discrimination (Rankin, 2003).

Balsam, Molina, Beadnell, Simoni, and Walters (2011) assessed microaggression scores on LGBTQ individuals across the nation. Participants were recruited via advertisements sent to email listservs, LGBTQ national organizations, and print media. A total of 297 individuals participated in the study and completed the 18-item LGBT People of Color Microaggressions Scale to assess the unique microaggressions associated with racism and heterosexism. Results indicate that all participants scored very high on the microaggression scale with males scoring higher than females on the scale (Balsam et al., 2011). Being subjected to microaggressions on a consistent basis can have significant and long-term negative effects on a person's self-efficacy and psychological well-being

(Balsam et al., 2011). One limitation of this study is that it used nonrandom sampling in that it relied on volunteers to participate in the study; as with other nonrandom samples, one cannot determine the extent to which the volunteers differed systematically from those who chose not to participate (Balsam et al., 2011).

Research suggests that universities across the nation are failing to provide LGBTQ students with an environment that is conducive to learning and scholarship; less than 8% of accredited universities offer protective policies that include sexual identity and expression (Levesque, 2015; Rankin et al., 2010). Perceptions of campus climate can have significant implications on a student's emotional, academic, and professional development (Levesque, 2015; Rankin et al., 2010). In their study, Tomlinson and Fassinger (2003) used to examine the relationships among lesbian identity development, perceptions of campus climate, and vocational development in 192 undergraduate lesbian women. Participants were recruited through LGBTQ email listservs on a number of campuses throughout the United States. The Lesbian Identity Development questionnaire was used to assess the dimensions of sexual identity development (Tomlinson & Fassinger, 2003). The Iowa Vocational Purpose Scale was used to measure vocational development and perceptions of campus climate were measured using the General Campus Climate Survey. The researchers found that campus climate was the strongest predictor for both psychological vocational development (career-related self-efficacy and career indecision) and vocational purpose (i.e. career-related commitment, competence, and organization). This study is limited by the fact that it was cross-sectional in nature;

therefore any development conclusions about lesbian identity development may only be implied. Another limitation is that the sample self-selected to participate in the study, which calls into question the generalizability of the results to the greater population (Tomlinson & Fassinger, 2003).

Gonyea and Moore (2007) conducted a secondary analysis of data collected in the 2006 National Survey of Student Engagement. A total of 14, 629 students participated in the study and included first-year freshman (51%) and fourth-year senior (49%) students from 31 four-year universities across the United States. Approximately 6% of all respondents (*n*=839) identified as LGBTQ and were equally divided between first-year and senior-year students. Results indicate that students who were "out" or forthcoming with their sexual identity were highly likely to engage in enriching educational experiences such as studying abroad, intramural activities, and collaborating with faculty on research and other endeavors (Gonyea & Moore, 2007). Furthermore, LGBTQ participants rated their campus environment significantly less positively and believed their campus to be less supportive of LGBTQ students when compared to their heterosexual peers (Gonyea & Moore, 2006). The study is limited by the fact that researchers utilized secondary data in their analysis rather than data collected by the research team.

The belief that campus environments are less supportive of LGBTQ students was supported by research conducted by the Campus Pride Organization (Rankin et al., 2010). In spring 2009, the researchers created a campus climate survey that was disbursed to

universities in each of the 50 states and all Carnegie Basic Classifications of Higher Education. A total of 5,149 surveys were returned by undergraduate students (46%; *n*=2384), graduate students (17%; *n*=863), administrators (7%; *n*=333), faculty (10%; *n*=498), and staff members (21%; *n*=1071) employed at the universities. Results indicate that student respondents were significantly less likely than heterosexual peers to feel comfortable in the campus climate in general and the classroom climate specifically (Rankin et al., 2010). Furthermore, LGBTQ student participants seriously considered leaving their institution more often and feared for their physical safety far more than their heterosexual peers. LGBTQ student respondents also indicated that they avoided LGBTQ areas on campus and elected to not disclose their sexual identity to university personnel and peers for fear of the negative consequences (Rankin et al., 2010).

The nursing curriculum has also been found to be lacking with regard to sexual minorities and LGBTQ health (Bosse et al., 2015; Brennan et al., 2012; Carabez et al., 2015; IOM, 2011b; Obedin-Maliver et al., 2011; Röndahl, 2009, 2011). Until recently, medical and nursing textbooks that discussed sexuality often framed sexual orientations other than heterosexuality as a problem or deviation from what is considered "normal" (Röndahl, 2009). Röndahl (2009) used a qualitative descriptive design to investigate nursing students' and medical students' experiences of LGBTQ knowledge within their respective education. The sample was comprised of five nursing students and three medical students (five women and three men) at a university in Sweden. Participants reported feeling that LGBTQ individuals were an invisible group in current nursing

curricula. Participants also stated that while the notion of treating everyone equal is like a 'red thread' through education, "there is also another (discursive) red thread that for which the starting point is heteronormativity" (Röndahl, 2009, p. 347). A limitation to the study is that it was conducted outside of the United States, and it consisted of a very small sample, which limits it's transferability to other populations.

Lim and colleagues (2015) used a cross-sectional non-probability survey of nursing leaders to assess the knowledge of faculty in baccalaureate nursing programs in the U.S. and their readiness to teach about LGBTQ health. The researchers found that the mean reported time that nurse educators devoted to LGBTQ health topics was a little over two hours (essentially one class period). Furthermore, when rating their readiness to include and teach LGBTQ content in nursing courses, nearly 25% reported that they were uncomfortable or minimally comfortable with teaching LGBTQ topics (Lim et al., 2015). In response to the survey question regarding faculty awareness of LGBTQ health issues, 43% of the 1,119 respondents indicated that they possessed limited knowledge of LGBTQ health needs and disparities (Lim et al., 2015). When participants were asked, in the last two years, how often they read LGBTQ health-related articles in professional journals, 70% of respondents reported that they never or seldom read about these issues (Lim et al., 2015). Part of this issue stems from the fact that there remains a dearth of available literature on LGBTQ health. Eliason and colleagues (2010) conducted a literature review of ten nursing journals with the highest impact factors between 2005 and

2009. The researchers found that only eight articles were written that focused specifically on LGBTQ health (Eliason et al., 2010).

The Lesbian, Gay, Bisexual, and Transgender Medical Evaluation Research Group contacted the Deans of medical education at 176 universities in the U.S. and Canada and asked them to complete a 13-item questionnaire created by the researchers. A total of 132 Deans participated in the study and reported a great deal of variability in the content and quality of LGBTQ-specific instruction that medical students received (Obedin-Maliver et al., 2011). Furthermore, 70% of the Deans of these universities rated their school's curriculum in the area of LGBTQ education as "fair" or worse (Obedin-Maliver et al., 2011). Although a limitation of the study is that it surveyed medical schools rather than nursing programs, these findings support the results of a study conducted by Carabez and colleagues (2015) which found that nearly 80% of the participants (RNs currently practicing in the San Francisco Bay Area) reported having no education or training about LGBTQ health care.

Marginalization and Gender

One of the most significant barriers that the nursing profession faces with regard to increasing the representation of males in nursing is the pervasive belief that nursing is largely a profession for women. A principle reason why nursing has been portrayed as a female occupation is because the modern profession has been formed around the Florence Nightingale model (Anthony, 2004; Brady & Sherrod, 2003; Cude & Winfrey, 2007; Keogh & O'Lynn, 2007; Kouta & Kaite, 2011; McMillian, Morgan, & Ament, 2006;

Muldoon & Reilley, 2003; O'Connor, 2015; O'Lynn, 2007). Nightingale often espoused her beliefs that nursing was not suited for males as the skills and personality necessary to be an effective nurse are more feminine, ladylike qualities (Bartfay, Bartfay, Clow, & Wu, 2010; Evans, 2004; O'Connor, 2015; O'Lynn, 2007). These views continue to be deeply entrenched within the U.S. population as research suggests that society largely perceives the nursing profession as being dominated by women and gay men (Harding, 2007; Liminana-Gras, Sanchez-Lopez, Saavedra-San Roman, & Corbalan-Berna, 2013; Lloyd, 2013; MacWilliams et al., 2013; O'Lynn, 2007).

Nightingale's views are also reinforced by widely-held patriarchal perspectives of male behavior in that men should strive to enhance their masculinity through the pursuit of power and status (Abrahamsen, 2004; Evans, 2004; Kellett et al., 2013; Kouta & Kaite, 2013; MacWilliams et al., 2013; Muldoon & Reilley, 2003). Research shows that men in the nursing profession commonly report being asked by colleagues, patients, family members, and friends why they elected not to pursue a degree in medicine (i.e. a more masculine profession); such queries ultimately call into question why a man would elect to pursue a more "feminine" profession, rather than one which has been assigned greater importance with regard to patriarchal power and influence (Abrahamsen, 2004; Evans, 2004; Kellett et al., 2014; Loughrey, 2008; Meadus & Twomey, 2014).

A joint survey was conducted by the National Student Nurses Association, the American Assembly for Men in Nursing, and the Bernard Hodes Group to explore the reasons why men remain significantly underrepresented within the nursing workforce

(Hart, 2005). Researchers developed a 34-question survey that was disseminated online and completed by 498 male nurses working across the U.S. Results indicate that 40% of respondents reported feeling awkward or defensive when telling others that they were nurses, largely because of the negative stereotyping associated with men in the nursing profession (Hart, 2005). Furthermore, 38% of participants reported that society's view of nursing as a female profession is believed to be the main reason why more men aren't attracted to the field of nursing (Hart, 2005). The study is limited by the use of a new survey for which validity and reliability has not been thoroughly investigated.

Similarly, the feminine connotations and imagery associated with the term "nurse" can create significant role strain in male nurses and nursing students (Cude & Winfrey, 2007; Harding, 2007; Kada, 2010; O'Connor, 2015). In a study conducted by Dyck and colleagues (2009), the researchers used interpretive ethnography to explore the experiences of six third- and fourth-year undergraduate male nursing students enrolled at one of two Canadian nursing schools. Data were collected using semi-structured interviews and observations conducted at classroom teaching sessions (Dyck et al., 2009). Researchers found that role strain was evident in male nursing students and stemmed from the emasculated, gay stereotype that society places onto male nursing students. According to Dyck and colleagues (2009), the stereotype "does a disservice both to students who are gay (assuming them to be both feminine and emasculated) and those who are not (ascribing to them a sexual orientation that they do not self-identify with)" (Dyck et al., p.651). One limitation of the study is the use of semi-structured interviews.

Despite the fact that researchers attempted to safeguard against research bias, the structure of the interview has the potential to influence both the scope and depth of participant responses (Polit & Beck, 2012). Transferability is also limited as the study took place at two universities outside of the United States.

O'Connor (2015) used a qualitative interpretive approach to investigate the gendered aspects of career choice for males who chose nursing as a profession. Participants were RNs working at a hospital in Ireland. Interviews with the 18 participants yielded a number of themes including significant frustrations with the pervasive perception of male nurses being gay (O'Connor, 2015). Participants also spoke about how they were not encouraged in high school to pursue a career in nursing, oftentimes feeling that their aspirations of becoming nurses were dismissed by teachers and guidance counselors. A number of participants in the study reported fears of ridicule and physical violence by peers had the participants shared their career aspirations with fellow students (O'Connor, 2015). Generalizability to nurses who are male in the U.S. is a limitation of the study as it was conducted in a hospital in Canada.

The patriarchal forces that have positioned nursing and caregiving within the feminine domain can significantly hinder men's success in nursing school and beyond (Kellett et al., 2014). Research indicates that male nurses who are concerned about being perceived as gay, or less of a man for pursuing a "female" profession may de-emphasize caring, nurturance, and altruism as motivations for entering the nursing profession because these qualities tend to be viewed as feminine traits (Ierardi, Fitzgerald &

Holland, 2010; LaRocco, 2007; O'Connor, 2015). Furthermore, it is postulated that the perpetuation of the feminine stereotype by the nursing profession, as well as the pervasive use of feminine language and value systems in nursing education, creates a situation of oppression for those who do not fit the stereotype (MacIntosh, 2002).

The marginalization of male nurses' masculinity due to the feminine nature of the nursing profession and peer suspicions of homosexuality may cause feelings of anger and stress over discrimination (Kellett et al., 2014; Meadus & Twomey, 2011; Stokowski, 2012). Similarly, being immersed in a new feminine social context often leaves male nurses students feeling bewildered, confused, and alienated (Kellett et al., 2014; Meadus & Twomey). Feelings of anger, stress, and alienation may also stem from the fact that men take on the status of "gender minority" within the nursing profession, a position that may be foreign to many of them (Connell & Messerschmidt, 2005; Harding, 2005; Kellett et al., 2014; Rajacich, Kane, Williston, & Cameron, 2013; Stokowski, 2012).

One source of marginalization may be the perpetuation of gender stereotypes with regard to the notion of caring attitudes and behaviors within the nursing profession (Grady, Stewardson, & Hall, 2006). In Dyck and colleagues (2009) qualitative study, male nursing students reported feeling that the nursing curricula placed significant emphasis on feelings, self-reflection, and emotional expression. Many study participants indicated that they struggled meeting the "emotional requirements" of the nursing program and that failure to meet these expectations could lead to ostracism or failure (Dyck et al., 2009; Grady, Stewardson, & Hall, 2008; MacWilliams et al., 2013). Failure

of nursing faculty to recognize the different ways in which male and female nursing students express emotions (such as caring, compassion, and altruism) may lead male nursing students to feel marginalized and de-valued (Grady et al., 2008).

Grady and colleagues (2008) conducted an interpretive phenomenological study to explore the ways faculty perceive and respond to caring in male nursing students at a university in the southwestern United States. Semi-structured interviews were conducted and each of the six participants (five female, one male) were interviewed twice. Participants reported that there were a number of barriers to male nursing student acquisition of caring behaviors and attitudes; yet none of the participants was able to identify ways that they had overtly or inadvertently hindered caring in the male nursing student population (Grady et al., 2008). A limitation to this study is the small sample size (n=6) and lack of diversity with regard to gender (83.3% female).

The literature suggests that male nursing students experience their nursing education much more differently than their female counterparts as they face a number of barriers associated with their minority status (Brady & Sherrod, 2003; Spahr, 2012). The advent of both civil rights legislation and affirmative action initiatives brought forth a lessening of discriminatory practices within educational institutions in the United States (O'Lynn, 2004). While these legislative endeavors caused the expansion of opportunities for women in such fields as engineering, pharmacy, and medicine, schools of nursing did not actively increase the enrollment of men. This is largely due to the fact that men were not considered a protected class under affirmative action mandates (O'Lynn, 2004). With

men being almost nonexistent in the nursing profession and nursing education, nursing curricula developed in a manner that was clearly preferential to women (O'Lynn, 2004).

Research suggests that the nursing curriculum tends to minimize or ignore the history and contributions of men in the field of nursing and lack gender neutrality in nursing textbooks (Bell-Scriber, 2008; Brady & Sherrod, 2003; Cude & Winfrey, 2007; MacWilliams et al., 2013; Muldoon & Reilly, 2003). Bell-Scriber (2008) found that male nursing students included in her study viewed the nursing textbooks, especially the pediatric and mental health textbooks, to be skewed heavily towards women. Specifically, the stories and pictures depicted in nursing textbooks use female examples almost exclusively (Bell-Scriber, 2008).

Many nurses erroneously assume that nursing began with Nightingale, and that the shift of men into nursing is a recent event. Records and biblical accounts from the Byzantine period through the middle ages suggest, however, that the earliest nurses were men (Williams, 2006). Similarly, the very first nursing school began in India around 250 BC and only men were allowed to attend because they were the only individuals considered "pure" enough to take on the role of caregiver (Williams, 2006). These events, however, are often overlooked in nursing textbooks and curricula; failing to acknowledge the contributions of men to the history of nursing reinforces the pervasive belief that nursing began with Nightingale and that its history is exclusively female (McLaughlin, Muldoon, & Moutray, 2010).

Bell-Scriber (2008) used a qualitative approach with a case study to identify important differences between male and female learners' perceptions of the nursing education climate. The researcher used a number of data collection methods including classroom observations, semi-structured interviews, and a review of the textbooks used in the observed courses (Bell-Scriber, 2008). The cohort selected for observation (n=53) was comprised of 36 females and eight males; in addition, the seven nurse educators (four doctorally-prepared and three prepared at the master's level) who taught courses for the cohort were also observed. In depth interviews were then conducted with four males and four females from the cohort, as well as with the seven nurse educators (Bell-Scriber, 2008).

Results of the in-depth interviews with the four male students revealed that the most important unsupportive factor was the nurse educators' behaviors and characteristics. One student stated "[There is] a terseness. Sometimes in voice tone. Sometimes in body language…You just don't know what you're talking about and your feelings on a specific subject don't matter" (Bell-Scriber, 2008, p. 146). These views were supported by their female peers as they reported feeling that the male students in the class were often singled out and "picked on" more in comparison to the females. Furthermore, one of the nurse educators reported feeling that male nursing students in her class are condescending and disruptive. The educator further stated that the male students probably went into nursing because their other plans didn't work out, which most likely caused them to have a chip on their shoulder (Bell-Scriber, 2008, p. 147).

One limitation of this study is the small sample size of male nursing students (*n*=4), which limits the Transferability of the study's findings.

In his study, O'Lynn (2004) developed a survey to to investigate the prevalence and perceived importance of barriers to men who graduated from a nursing education program in the United States. A sample was obtained by mailing the Inventory of Male Friendliness in Nursing Programs survey to two populations: current members of the American Academy of Men in Nursing (AAMN) and RNs who currently held a license in the state of Montana. With regard to the AAMN subsample, the 111 participants attended 64 different nursing schools in 22 states. Thirty-three percent of the AAMN subsample graduated within the previous 10 years and the majority (83%) of AAMN participants identified as Caucasian (O'Lynn, 2004). From the Montana subsample, 64 participants attended 26 different nursing schools in 19 states. Forty-five percent of the Montana subsample graduate within the previous 10 years and 96% identified as Caucasian (O'Lynn, 2004).

Participants in both groups reported several barriers to their nursing education including not feeling welcome as a male student in the clinical setting, being nervous that female patients would accuse them of sexual inappropriateness when providing intimate care, and not being invited to all of the program's activities (O'Lynn, 2004). This study is limited by the fact that data collection was reliant on respondent memory and that the majority of participants (61.3%) graduated from nursing school more than 10 years ago.

Meadus and Twomey (2011) utilized a phenomenological approach to explore the experience of being a male nursing student in a predominantly female-concentrated baccalaureate nursing program. Students were recruited from three nursing programs within a province of Canada. Data were collected from participants through five focus groups; a total of 27 students participated in the study and ranged in age from 20 to 38 years. One of the themes identified by the researchers, *Visible/Invisible* spoke to participants' perception of being recognized specifically because of their gender in the classroom. Participants commented on nursing faculty "picking out" male students in class much more often and being put on the spot in front of peers. In clinical, however, participants reported feeling invisible because their "standing out" as a male student hindered their recognition as a nursing student by patients and other healthcare professionals (Meadus & Twomey, 2011). The generalizability of this study is limited by the fact that a phenomenological study provides insight into the educational experiences of the participants. Similarly, the study took place in Canada, which further limits its relevance to male nursing students in the United States.

Male nursing students also face a number of unique challenges with regard to communication in the classroom and clinical settings. Given the fact that the overwhelming majority of nurses and nurse educators are female, male nursing students are consistently exposed to communication patterns that are uniquely feminine (Yoshimura & Hayden, 2007). According to Yoshimura and Hayden (2007), the speech patterns of females "emphasize more of the relational nature of communication, using

verbal and nonverbal messages together to communicate information about equality, support, and relational status, while male communication patterns tend to focus on instrumental goals…and accomplish tasks" (p.111). The area of nonverbal communication is also a source of miscommunication between males and females. Women tend to be more skilled and generally have more experience navigating a nonverbal environment than males; as such females tend to be better able to convey their care and concern for clients and patients through nonverbal communication (Yoshimura & Hayden, 2007, p. 113).

A study conducted by Ellis, Meeker, and Hyde (2006) supported the communication issues that male nursing students face when communicating with female peers and nursing faculty. Ellis and colleagues (2006) used phenomenology to explore the perceptions of male nursing students with regard to their positive and negative experiences in a baccalaureate nursing program. A sample of 13 male students was obtained from three baccalaureate nursing programs at three universities in Southern Louisiana. One of major themes identified by researchers was communication differences stemming from participants' gender (Ellis et al., 2006). Male participants viewed their female peers as "caring, organized, and helpful, but also moody and overly dramatic" (p.534). Participants also reported feelings of frustration that the curriculum strongly emphasized the psychosocial aspects of nursing and felt that classroom discussions, test questions, and the curriculum in general were "set up for women by women." (Ellis et al., 2006, p.524). A limitation of this study is that all but one

participant identified as Caucasian, which restricts the transferability of the results to other racial and ethnic populations. Another limitation is that the interviewer was female, which may have impacted participant responses (Ellis et al., 2006).

Male nursing students have been found to be limited in the clinical setting because bias exists with regard to what procedures they can and cannot do (Keogh & O'Lynn, 2007). Similarly, it is common practice for nursing programs to place restrictions on clinical experiences for male students by not allowing them to participate in clinical on obstetric hospital units (Keogh & O'Lynn, 2007). Cude (2004) conducted a qualitative study of three male students enrolled in a maternal-newborn clinical at a university in Oklahoma. Participants reported that although they had received the same training as their female colleagues, they were told to stand in the corner or stay out of the way, whereas female students were encouraged to assist in the birthing process. Participants also reported feeling that the nursing staff on the maternity unit looked at them with annoyance and disdain (Cude, 2004).

Stott (2007) used a descriptive qualitative design to investigate factors that influence both the academic and clinical practice performance of male undergraduate nursing students at an Australian university. Participants in the study (n=8) reported feeling isolated or excluded from the clinical and academic settings because of a lack of male nursing faculty or male nurses to act as role models for students. Participants indicated that it would have been extremely beneficial to have a male perspective of what it's like to be a male in a profession that is largely female dominated (Stott, 2007). The

application of the study's findings is limited to only male students in nursing programs in Australia.

Marginalization and Age

Over the last few decades, colleges and universities across the nation have seen tremendous growth in enrollment of non-traditional students (Jeffreys, 2007; Sims & Barnett, 2015). According to the U.S. Department of Education, National Center for Education Statistics (2012), there is a projected rise of 20% in enrollment of students 25 years of age and older in undergraduate programs in the country over the next decade. Despite this growth, it is suggested that non-traditional students remain a marginalized population through institutional policies and practices (Hagdorn, 2005; Kasworm, 2010). Research suggests that non-traditional students often struggle as they navigate through a system of higher education that has been created to accommodate traditional-aged students (Hagedorn, 2005; Kasworm, 2008, 2010). According to poet Adrienne Rich (1986)

> When those who have power to name and to socially construct reality choose not to see you or hear you… when someone with the authority of a teacher, say, describes the world and you are not in it, there is a moment of psychic disequilibrium, as if you looked in a mirror and saw nothing. It takes some strength of soul… to resist the void, this non-being, onto which you are thrust, and to stand up, demanding to be seen and heard (p. 199).

It is argued that this statement could be used to describe what non-traditional students in higher education experience every day (Sims & Barnett, 2015; Stokes, 2006; Willans & Seary, 2011). Willans and Seary (2011) conducted two semi-structured interviews and two focus group interviews of nine non-traditional students enrolled in a university in Australia. The purpose of the study was to explore non-traditional students' engagement in secondary education. Students reported likening their experiences to being a novice paintball player who is constantly bombarded from all directions and worn down by the "constant hits". For the non-traditional student, these "hits" stem from tensions surrounding social interactions with peers, institutional protocols, and personal challenges associated with other roles and responsibilities (Willans & Seary, 2011). The generalizability of this study is limited to non-traditional students enrolled at the target university in Australia.

Although non-traditional students bring a rich and complex set of life experiences and circumstances to the collegiate environment, they may still be faced with varied support and negative sociocultural contexts of secondary education (Jeffreys, 2007; Kasworm, 2008). Kasworm (2010) conducted an interpretive qualitative research study to explore the experiences of adult learners (i.e. non-traditional students) at two research-extensive universities within the United States. Data were collected from 10 men and 13 women of varying ages (age range 31 to 47 years) and races (17 Caucasian, 4 African American, and 2 Hispanic). The interviews focused on participant's experiences and interactions within the university, as well as their learning engagements in the classroom

setting (Kasworm, 2010). Respondents described themselves as being a clear minority within the university culture and often felt a sense of "otherness" on campus. Participants reported feeling as if they had to prove their value and worth as a student in each new classroom environment with one student commenting "this university still doesn't recognize our presence as a plus" (Kasworm, 2010, p. 153). Many discussed feelings of isolation as they felt that the non-traditional population was dispersed all across a youth-oriented campus without being offered any avenues for connecting with other non-traditional students (Kasworm, 2010).

Non-traditional students, unlike traditional-aged students do not tend to view themselves as going away to college and beginning a life separated from family and community; rather the role of "college student" is integrated into an already complex life of varying responsibilities (Kasworm, 2008; Stokes, 2006). Non-traditional students often enter college through a crossroads or life crisis such as a divorce, financial uncertainty, or work-related issues (Kasworm, 2008). As a result, these individuals can experience emotional upheaval stemming from simultaneously trying to develop a student identity, overcome life circumstances, and navigate through the college experience (Kasworm, 2008).

Kenny and colleagues (2011) conducted an action research study to consider issues of non-traditional nursing students in Australia. The researchers conducted an extensive review of the extant literature, and also developed a questionnaire that was sent to 29 nursing programs across the country. Results of the nurse educator survey data

indicated that the attrition rate of non-traditional undergraduate nursing students in the programs surveyed was approximately 6% (Kenny et al., 2011). Participants identified a number of barriers associated with non-traditional students completing their undergraduate degree including competing commitments to family and work and a lack of confidence in their abilities as a student (Kenny et al., 2011). Participants also reported the lack of family and peer support, deficits in academic skills (e.g. technology, literacy, and mathematics), and timing conflicts between clinical times and shift work for their jobs as additional barriers (Kenny et al., 2011). This study was conducted in Australia, which limits the application of the study's findings to non-traditional students in the United States.

Research suggests that many non-traditional students experience a significant amount of stress and anxiety regarding balancing academics with their other responsibilities (Kasworm, 2008; Ramos, 2011). Ramos (2011) used a quantitative causal-comparative design to explore the differences in perceived stress and coping styles among non-traditional graduate students in both on-campus and distance-learning programs. A total of 36 non-traditional students enrolled in distance-learning classes and 36 non-traditional students enrolled in on-campus courses at one of two Midwestern universities participated in the study. Ramos (2011) used the Perceived Stress Scale to measure participants' perception of stress and the Moos Coping Response Inventory to assess students' coping responses. Results suggest that both groups of non-traditional students experience high levels of stress from a number of areas including balancing full-

time employment while attending school, children and childcare demands, and caring for a parent (Ramos, 2011). Ramos (2011) also found that participants who worked part-time had significantly less stress when compared to participants who worked full-time (Ramos, 2011). This study is limited by the fact that the population of study was non-traditional graduate students, which limits its transferability to undergraduate nursing students.

Despite the landscape of higher education shifting to become more diverse, scholars have paid little attention to the presence of non-traditional students and their impact of institutions of higher education (Sims & Barnett, 2015). Donaldson and Townsend (2007) conducted a review of literature and content analysis of articles published between the years 1990 and 2007 in seven refereed journals. The researchers found that of the 3,219 articles published in the seven targeted journals, only 41 (1.27%) focused in non-traditional undergraduate students (Donaldson & Townsend, 2007). Given the fact that scholarly journals such as those used in Donaldson and Townsend's (2007) study are used to shape the policies, practices, and conversations on college campuses, the lack of representation of non-traditional students in the core body of literature serves to only further marginalize this population (Sims & Barnett, 2015).

Stone (2008) examined the impact of navigating university life on a group of 15 female and 5 male non-traditional undergraduate students enrolled at the University of Newcastle in Australia. Using an interpretive phenomenological approach, the researcher conducted interviews with the participants who age ranged from 32 to 52. Participants

reported a number of barriers or challenges associated with navigating through their respective academic programs. Participants likened their life to a juggling act in that finding enough money and time to spend with family was a constant challenge (Stone, 2008). Financial struggles, difficulties integrating socially with peers, and problems organizing and prioritizing competing needs were common themes identified in the study, as was the added stress of dealing with changes in relationships with partners and children (Stone, 2008). The findings of this study are limited to non-traditional students in Australia, specifically those students enrolled at the University of Newcastle.

Summary

The literature reviewed illuminates the need to further examine the marginalization of minority undergraduate nursing students. Despite the fact that a great deal of attention has been placed on diversifying the nursing profession, the field remains very homogenous with regards to race, gender, and sexual orientation. Similarly, a number of qualitative studies have been conducted to identify barriers that minority students face when navigating through nursing programs, yet attrition remains a significant issue both in the United States and abroad. As population demographics continue to shift rapidly, it is imperative that the field of nursing better represent the individuals for which they are caring. Marginalization has not been investigated as an independent phenomenon in undergraduate nursing students, nor has any study explored marginalization using a definition that encompasses racial/ethnic, gender, age, and sexual minorities. Exploring this topic using quantitative methods may serve to expand the body

of existing knowledge in these areas and perhaps yield new insights about this longstanding issue.

CHAPTER III

METHODOLOGY

The researcher used a non-experimental, descriptive correlational design to investigate the relationship between minority status and marginalization in undergraduate nursing students in Wisconsin. A correlational design was necessary because the demographic variables of interest (e.g. race/ethnicity, sexual orientation, gender, and age) cannot be manipulated so as to perform random assignment of participants (Polit & Beck, 2012). According to Polit and Beck (2012), most nursing studies utilize a non-experimental research design because most human characteristics cannot be altered or manipulated ethically. The goal of descriptive studies in nursing education is to describe and analyze phenomena that occur within the realm of education. In this study, the existence of marginalization in baccalaureate nursing programs was described and analyzed. Once the level of marginalization is clearly described, the results of this study can be used to develop hypotheses or theories for later research (Polit & Beck, 2012). Furthermore, future studies could determine whether marginalization of students affect attrition rates of minority nursing students.

Setting

A nursing workforce that is diverse, and reflective of the population it serves, contributes to improved patient satisfaction and health outcomes (AHRQ, 2012; IOM, 2011a). A diverse and inclusive nursing workforce is critical to successfully addressing

the needs of a diverse population; however, Wisconsin's nursing workforce lags behind both state and national demographics (Wisconsin Center for Nursing [WCN], 2013). The percentage of White, non-Hispanic nurses practicing in Wisconsin is currently 93.5%, with only 2.0% of nurses identifying as being African American, 1.4% Hispanic, and 3.0% reported belonging to the category of "other" (U.S. Census Bureau, 2015). State demographics indicate an overall non-Hispanic White population of 83.3%, with an additional 6.3% identifying as being Black or African American, 2.9% Hispanic, 2.3% Asian, and 1.0% American Indian (U.S. Census Bureau, 2015). These demographic data indicate that the Wisconsin nursing profession continues to lag behind the nation with regard to the racial and ethnic makeup of the state.

In Wisconsin, a substantial gender gap continues to exist within the nursing profession, with no significant gains being made in the employment of more males. In 2010, 6.8% of nurses in Wisconsin were reported to be male, with only a .1% increase in males in the nursing profession (to 6.9%) in 2012 (WCN, 2013). With regard to the diversity of nurse faculty, the gender, race, and ethnicity profile continues to be very different than the profile of the students. The WCN (2013) recently conducted a statewide survey of the deans of the colleges of nursing with the aim of systematically gathering and analyzing nursing workforce data. Results indicate that nursing faculty teaching in baccalaureate nursing programs in Wisconsin remains largely White (93.5%) and female (95%). No data were collected regarding participants' sexual orientation (WCN, 2013).

Population and Sample

In order to investigate the relationship between the aforementioned demographic variables and the dependent variable of marginality in baccalaureate undergraduate nursing students in Wisconsin, the researcher used a convenience sampling plan for the research study. The demographic variables of race/ethnicity, sexual orientation, gender, and age were investigated in relation to marginality; therefore the target population was all undergraduate nursing students currently enrolled full-time in a baccalaureate nursing program at one of the four target universities. With regard to inclusion criteria for the study, participants must have met the following conditions: 1) be currently enrolled full-time or part-time in the undergraduate nursing program at one of the four target universities; 2) be 18 years of age or older; and 3) be able to read, write, and speak English.

Power Analysis

The power of a statistical test for the existence of implicit bias denoted the probability of creating a Type II error (Mertler & Vannatta, 2013; Polit & Beck, 2012); respective to this study, a Type II error would claim that there is no difference in the degree of marginalization among baccalaureate nursing students who differ in race/ethnicity, sexual orientation, gender, or age. In order to determine statistical power, a number of parameters were determined and included the significance level, sample size, directionality, and effect size (Polit & Beck, 2012). It is important for the researcher to

establish statistical power prior to beginning the study so as to ensure that the study has enough participants to adequately establish effect.

According to Polit and Beck (2012), investigators can estimate sample size based on whether the anticipated effect is small (*d*=.20), medium (*d*= .50), or large (*d*=.80). Most nursing studies can expect an effect size to fall within the range of .20 to .40 (Polit & Beck, 2012). Assuming a moderate effect size of .35 with an alpha level of $\alpha = .05$ and power equal to .80, such parameters correspond to a sample size of 129 participants in each group- minority versus non-minority (Polit & Beck, 2012). Each of the four target universities has a total enrollment in the baccalaureate undergraduate nursing program of approximately 300-400 students.

According to a survey conducted by Dean-Baar, Cook, and Laurent (2010) on nursing programs in Wisconsin, 91.2% of the baccalaureate student population in the state is female. With regard to race, 85.6% of students enrolled in a baccalaureate undergraduate nursing program in Wisconsin identify as White/Caucasian, approximately 4.5% identify as Hispanic/Latino, 3.9% as Asian, and 3.1% as African American (Dean-Baar et al., 2010). Despite the fact that American Indian and Alaskan Natives make up 1% of the population in Wisconsin (U.S. Census Bureau, 2015), this group remains underrepresented across nursing programs in the state. According to Dean-Baar (2010), American Indian and Alaskan natives comprise only .29% of students enrolled in baccalaureate nursing programs in Wisconsin. Including all four baccalaureate

undergraduate nursing programs in the study is necessary in order to achieve the size and diversity of the sample needed.

Protection of Human Subjects

Approval from the Institutional Review Board (IRB) was obtained for the dissertation prior to the initiation of data collection procedures. A thorough explanation of the study was provided to potential participants and informed consent was obtained by the researcher. To minimize the risk of emotional discomforty and/or fatigue, particpants were be assured that they could stop participation in the study at any time. There was a risk that participants may feel that they are being coerced into participating in the study since they are students and may feel that they are "at the mercy" of their instructors/professors. To minimize this risk, the researcher performed the following actions: 1) contacted participants via email rather than approaching participants in person. All email correspondences were sent to the undergraduate program assistant at each campus who have access to the listserv of students currently enrolled in the baccalaureate nursing program; 2) inform participants that participation is completely voluntary and that they may stop participating in the study at any time; 3) informed participants that they could ask questions of the researchers at any time before the commencement of the surveys; and 4) informed participants that choosing to participate or not participate in the study would not affect their grade or their standing in the undergraduate nursing program with which they are affiliated.

By using electronic data collection technology, there may be a risk of loss of confidentiality. To minimize this risk, all data obtained from participants were collected anonymously using PsychData technology. PsychData utilizes Secure Socket Layer 256-bit encryption technology to ensure protection of all data transactions on their website. Data is encrypted at the instant that a user submits it and can only be decoded by the target server. Data was stored on the PIs work computer as no other individual has access to the computer. The computer is password protected and housed in the locked office (single occupancy) of the PI.

Data were analyzed using SPSS Statistical Software Version 20 (the program is downloaded on the PI's computer). Printouts of the data were stored in a locked file cabinet in the office of the PI. Data will be stored on the personal computer and locked file cabinet of the PI for a period of five years. After five years have lapsed, all electronic and hard copies (i.e. printouts) of the data will be destroyed. To further minimize the risk of loss of confidentiality, the following statement was added to the consent form, "There is a potential risk of loss of confidentiality with any email, downloading, and internet transactions."

Instrument

Operational Definition of Marginality

Koci (2004) developed a marginality scale based on specific scales from the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Working with a measurement expert, Koci (2004) explored the subconcepts of marginality put forth by Hall and

colleagues (1994) and identified a scale from the MMPI-2 that reflected each subconcept. For example, *differentiation* is operationalized using the Ego Strength Supplementary Scale; this scale looks at adaptability, resilience, and personal resourcefulness (Koci, 2004). The subconcept of *secrecy* is measured using the Cynicism Content Scale; the purpose of this scale is to measure the level of trust/distrust in others and how one guards his or her reactions to others. The Dominance Supplementary Scale, used to measure the subconcept of *voice*, speaks to one's level of self-confidence and comfort in social situations (Koci, 2004). *Reflectiveness* is operationalized using the Obsessiveness Content Scale; this subscale evaluates a person's ability to make decisions and his or her tendency to frequently worry or ruminate about issues (Koci, 2004). The concept of *liminality* is measured using the Poignancy Content Scale; individuals who score high on this scale tend to be high strung, experience feelings more intensely, and are more sensitive than other people (Koci, 2004). Both *intermediacy* and *power* are measured using two scales as the extra scales are needed to more accurately reflect the subconcepts. With regard to *intermediacy*, the Social Discomfort Content Scale (measuring a person's level of comfort in social situations) and Low Self Esteem Content Scale were used (Koci, 2004). Finally, the subconcept of power was operationalized using the Masculinity/Femininity Scale (which evaluates a person's tendency towards submissiveness, passivity, and insecurity) and the Repression Supplementary Scale; individuals who score high on this scale tend to be conventional, submissive, and avoid unpleasant or disagreeable situations (Koci, 2004).

The KMI-70 uses a Likert scale for measurement and creates a total score that indicates the degree or level of marginalization experienced by an individual. Scores for the KMI-70 range from 70-280; the higher the score, the more marginalized the individual. In terms of reliability and validity of the instrument, the KMI-70 utilizes subscales from the MMPI-2. The MMPI-2 has been used extensively in a large variety of psychological and personality research and has been updated to reflect appropriate ethnic representation (Greene, 2000). Data on both the test-retest reliability and internal consistency measures of the MMPI-2 range from .58 to .91 (Hathaway & McKinley, 1989). The MMPI-2 contains three types of validity measures: 1) those designed to detect inconsistent responding; 2) those aimed at detecting when test-takers are exaggerating or over-reporting psychological symptoms; and 3) those designed to detect when test-takers are downplaying or underreporting psychological symptoms (Koci, 2004). Previous studies that used the KMI-70 have reported strong internal consistent reliability with a Coefficient alpha of .96 (Koci, McFarlane, Gilroy, & Maddoux, 2012).

Data Collection

Pilot Study

According to Hall and colleagues (1994), a number of characteristics including female gender and race/ethnicity predispose a person to experiencing marginalization. Data indicate that the vast majority (90%) of nursing students are female (U.S. Census Bureau, 2013), which puts minority undergraduate nursing students at an increased risk of being marginalized. As part of her dissertation, Koci (2004) developed the KMI-95 as

a means of measuring marginalization in abused women. Through further psychometric testing the KMI-70 was advanced and found reliable (α=.96) and valid. The tool has not been used to evaluate marginalization in the nursing student population; therefore, the purpose of the pilot study was to evaluate the psychometric properties of the KMI-70 using baccalaureate undergraduate nursing students enrolled at Texas Woman's University (TWU).

A total of 191 participants comprised the research sample and were included in the final data analysis. When comparing the sample used in the pilot study to the larger population (i.e. all students enrolled in a baccalaureate undergraduate nursing program in Texas), the statistics indicated that the sample was representative of the population from which it was obtained. According to the Texas Center for Nursing Workforce Studies (2014), the majority of students currently enrolled in baccalaureate undergraduate nursing programs in Texas are female (85%) and White (51%). A further breakdown of the race/ethnicity of the nursing student population indicates that approximately 24% are Hispanic, 14% Asian, and 12% African American (Texas Center for Nursing Workforce Studies, 2014). Furthermore, nearly half of nursing students in Texas (47.2%) fall within the age range of 18 and 25 years (Texas Center for Nursing Workforce Studies, 2014).

Results of the pilot study indicated that the KMI-70 was found to have strong internal consistency reliability (Coefficient alpha= .95), which is consistent with findings from other studies (Koci et al., 2012). An exploratory data analysis was conducted to determine if the KMI-70 distribution was normally distributed. Results of the

Kolmogorov-Smirnov test for normality indicated that the KMI-70 distribution did not deviate significantly from a normal distribution (D = .062, p = .073). Similarly, the summated scores generated a skewness statistic of -.115; according to Morgan, Leech, Gloeckner, and Barrett (2013), if the absolute value of the skewness is less than one, the variable can be considered to be approximately normal. Looking at each individual question within the KMI-70, the only question that was skewed was "I cannot do anything well" (skewness statistic = 1.148). Further analyses indicated that the mean score for the KMI-70 was 154.5, with a median of 157.0, and a mode of 158.0. The range of the KMI-70 scores was 124.0, and the minimum and maximum values obtained were 95.0 and 219.0 respectively. The standard deviation of the KMI-70 was found to be 24.8.

Prior to conducting inferential statistics, a number of subsets of demographic variables were collapsed in order to control for the skewness found in the data set. The variable "Ethnicity" was collapsed to include only minority students (n = 91, 47.6%) and non-minority students (n = 100, 53.3%). Similarly, the variable "Marital Status" was collapsed to represent only single (n = 112, 58.6%) and married (n = 72, 38%) participants. A third demographic variable, "Highest Level of Education Completed" was restricted to those with a high school diploma (n = 84, 44%), Associate's degree (n = 36, 19%) or Bachelor's degree (n = 63, 33%). The category of "Total Annual Household Income" (THI) was collapsed to include only two levels: those students who made $50,000 or less per year (n= 102, 53.4%) and those students who made $50,001 or more

per year (*n* = 89, 46.6%). A final category, "Number of Children" was collapsed to represent participants who did not have any children (*n*= 147, 77%) and those students who reported having one or more children (*n* = 44, 23%).

A series of ANOVAs were conducted to test for differences in marginalization by the demographic variables of interest. Table 2 provides a summary of the means and standard deviations of marginalization. Results indicate that there were significant differences in mean scores for minority versus non-minority students, F (1, 189) = 4.08, p = .033. Students who identified as being a racial minority (*n*= 91, 47.6%) had significantly higher marginality scores when compared to non-minority participants (*n* = 100, 52.4%). Furthermore, those students who reported English as a second language (*n*= 35, 18.3%) also experienced higher mean scores on the KMI-70, F (1, 189) = 5.568, p = .019.

Further evaluation of the findings indicated that there was a significant effect of age on marginalization scores, F (3, 187) = 8.39, p = .000. Students between the ages of 18 and 25 (*n* = 109, 57.1%) had significantly higher marginalization scores when compared to all other age groups. Whether or not the participant had children was found to be a statistically significant factor as well, F (1, 189) = 6.885, p = .009. Participants without children (*n*= 147, 77%) scored notably higher on the KMI-70 than those students with one or more children (*n*= 44, 33%). Similarly, a person's marital status also had significant effects on marginalization scores, F (1, 189) = 20.26, p = .000. Participants who were never married (*n*= 112, 58.6%) reported higher marginality scores than those

who were currently married (*n*= 72, 37.7%). Nursing students seeking a first college degree (*n*= 84, 44%) were also more likely to report higher marginality scores, *F* (1, 189) = 4.27, *p* = .015 when compared to students who had a previous Associate's degree (*n*= 30, 18.8%) or Bachelor's degree (*n*= 63, 33%). Along the same vein, socioeconomic status was found to be inversely correlated with marginality scores *F* (1, 189) = 4.27, *p* = .015. Participants who reported their THI as being $50,000 or less (*n*= 102, 53.4%) had significantly higher scores on the KMI-70, *F* (1, 189) = 16.86, *p*= .000 when compared to those student of higher socioeconomic status (*n*= 89, 46.6%).

Multiple regression was conducted to identify which combination of demographic variables might best predict marginality scores on the KMI-70. The intercorrelations can be found in Table 3. The combination of variables to predict scores on the KMI-70 include age, ethnicity, marital status and THI which were statistically significant, *F* (4, 186) = 10.79, *p* < .000. The beta coefficients are presented in Table 4. Results indicate that ethnicity, marital status, and THI significantly predict marginality scores when all four variables (i.e. age, ethnicity, marital status, and THI) are included. The adjusted R^2 value was .171. This indicates that 17.1% of the variance in marginality scores was explained by the model. According to Polit and Beck (2012), this is a medium effect size.

Current Study

After obtaining permission from the Institutional Review Boards of each of the four baccalaureate undergraduate nursing programs in Wisconsin, the PI contacted the

students indirectly by sending emails to the undergraduate program assistant from each of the four campuses. The program assistants have access to the listserv with email addresses of all undergraduate students currently enrolled full-time or part-time in the baccalaureate undergraduate nursing program on the four campuses. They forwarded the emails from the PI to the students. All baccalaureate nursing students from the target universities then received an initial email from the PI with an informational flyer attached. The flyer provided a synopsis of the study and a link to the consent form and online survey. A follow-up email was sent by the PI to the potential participants at one-week intervals for the duration of the study (one month). The purpose of the follow-up emails was to remind students of the study and to foster participation. Participation was also enhanced by providing an incentive for idividuals who complete the study. The incentive was the chance to win one of four $50 Amazon gift cards; the four winners were chosen at random by the PI.

Potential participants who met the inclusion criteria listed above followed the link given to them in the informational flyer. The link took them to a secure site provided by PsychData where they gained access to the informed consent page. Potential participants demonstrated their consent to participate in the study by checking the box on the consent form that stated “I DO give my consent to participate in the pilot study”. This digital signature was used in lieu of a written signature. If the participants consented to take part in the study, the students then followed a link (provided on the consent page) to the demographic questionnaire and the KMI-70. The questionnaire and surveys took

approximately 20-25 minutes to complete. Participant questionnaires and surveys were submitted anonymously using PsychData research services.

CHAPTER IV

ANALYSIS OF DATA

Chapter IV presents the results of the study, *The Relationship between Marginality and Minority Status in Undergraduate Nursing Students.* Results presented include the demographic data of the sample utilized, as well as the results of a series of *t*-tests that assessed the differences in mean scores obtained from the KMI-70 for each of the demographic variables of interest (e.g. race, sexual orientation, gender, and age). Two ANOVA's tests were conducted to further investigate any differences between groups with regard to both race/ethnicity and age.

Description of the Sample

Of the approximately 1200 baccalaureate nursing students enrolled in the four UW campuses, a total of 357 to participate in the study; however, 21 participants did not complete the survey past the informed consent question and an additional five students completed less than 50% of the KMI-70 survey. As a result, 331 participants comprised the research sample and were included in the final data analysis. This research sample constitutes 27.5% of the total baccalaureate nursing student population on the four UW campuses. Table 1 presents a summary of the demographic data for study participants.

A descriptive analysis of the data found that the majority of participants included in the study were female (87.0%) and between the ages of 18 and 24 (81.3%). With respect to ethnicity, 86.4% identified as White/Caucasian, whereas the remaining

participants identified as Hispanic/Latino (3.3%), Black/African American (3.6%), Asian/Pacific Islander (5.4%) or "Other" (1.2%). Of the participants included in the study, 96.4% reported English as being their primary or native language. In terms of sexual orientation, 93.7% indicated that they were heterosexual; the remaining participants identified as lesbian (1.2%), gay (1.2%), or bisexual (3.3%). One participant identified as belonging to the category of "Other" but did not specify further, and a second participant (.3%) declined to answer the question.

When comparing the sample used in the study to the larger population (i.e. all students enrolled in a baccalaureate undergraduate nursing program in Wisconsin), the statistics indicated that the sample was representative of the population from which it was obtained. According to a survey conducted by the WCN (2013) on nursing programs in Wisconsin, 91.2% of the baccalaureate student population in the state is female and 85.4% report being between the ages of 18 and 24. With regard to race, 85.6% of students enrolled in a baccalaureate undergraduate nursing program in Wisconsin identify as White/Caucasian, with the remaining 14.4% identifying as follows: 4.5% Hispanic, 3.9% Asian, and 3.12% African American (WCN, 2013).

Despite the fact that American Indian and Alaskan Natives make up 1% of the population in Wisconsin (U.S. Census Bureau, 2015), this group remains underrepresented across nursing programs in the state. According to the WCN (2013), American Indian and Alaskan natives comprise only .29% of students enrolled in baccalaureate nursing programs in the state. Currently, colleges and universities in the

U.S. do not collect data on students' sexual orientation (Eliason et al., 2011), which makes it impossible to determine with any accuracy whether the sample used in this study is representative of the larger population with regard to sexual orientation.

Table 1

Demographic Data

	N	*%*	*Cumulative %*
Gender			
Male	43	13.0	13.0
Female	288	87.0	100.0
Age			
18-25	269	81.3	81.3
26-33	40	12.1	93.4
34-41	13	3.9	97.3
42-49	8	2.4	99.7
50-55	1	0.3	100.0
Ethnicity			
White or Caucasian	286	86.4	86.4
Hispanic or Latino	11	3.3	89.7
Black or African American	12	3.6	93.4
Asian/Pacific Islander	18	5.4	98.8
Other (Please specify)	4	1.2	100.0
English is primary/native language			
Yes	319	96.4	96.4
No	12	3.6	100.0
Sexual Orientation			
Heterosexual	310	93.7	93.7
Lesbian	4	1.2	94.9
Gay	4	1.2	96.1
Bisexual	11	3.3	99.4
Other (please specify)	1	0.3	99.7
Declined to answer question	1	0.3	100.0

Findings

The KMI-70 was used to evaluate the degree of marginalization experienced by study participants. With regard to reliability, the KMI-70 was found to have strong internal consistency reliability (Coefficient alpha= .954), which is consistent with findings from both the pilot study (Coefficient alpha= .948) and other studies (Koci et al., 2012).

Further analyses indicated that the mean score for the KMI-70 was 170.9, with a median of 170.0, and a mode of 163.0. The range of the KMI-70 scores was 147.0, with the minimum and maximum values obtained were 99.0 and 246.0 respectively. A higher score on the KMI-70 correlates with a higher degree of marginalization. The standard deviation of the KMI-70 was found to be 23.8.

Prior to conducting the statistical analysis, the assumptions of normality that underlie parametric tests were investigated for the demographic variables of interest so as to ensure the appropriateness of the statistical analyses. Table 2 presents a summary of the statistical measures for normality by demographic variable. With regard to race/ethnicity, Levene's test for equality of variances was not found to be violated for the present analysis, $F(4, 326) = 2.0$, $p = .09$. The distribution is negatively skewed with skewness statistics ranging between -.56 (Caucasian) and -1.3(Black or African American). In terms to peakedness of the distribution, kurtosis statistics ranged from .21 (Asian or Pacific Islander) and 1.61 (White or Caucasian). The racial/ethnic category of "other" generated a kurtosis statistic of -5.60. According to George and Mallery (2010),

values of asymmetry and kurtosis between -2 and +2 are considered acceptable in order to prove normal univariate distribution; therefore, the category of "other" was excluded from the ANOVA. The *t*-test for independent samples is considered robust for violations of normal distributions (George & Mallery, 2010); as such the category of "other" was included in the racial/ethnic minority category for the t-test of independent samples.

The sample obtained for the study did not yield a large representation of LGBTQ participants (n=20). In order to control for the significant skewness and kurtosis found in the data set, the individual subcategories of the LGBTQ sample were collapsed to a single "LGBTQ" category. Subsequently, Levene's test for homogeneity of variance was not found to be violated, $F(1, 328) = 2.55$, $p = .112$. The distribution is positively skewed with a skewness statistic of .40 for heterosexual participants and .10 for LGBTQ participants. Kurtosis statistics were found to be .73 for heterosexual participants and 1.10 for LGBTQ participants.

With regard to the variable of gender, Levene's test for equality of variances was not found to be violated, $F(1, 328) = .67$, $p = .41$. The distribution is positively skewed with a skewness statistic of .04 for male participants and .50 for female participants. Kurtosis statistics were found to be .78 for males and .96 for females.

In terms of the final variable of interest, age, Levene's test for equality of variances was not found to be violated $F(3,326) = 1.58$, $p = .19$. The distribution is positively skewed with skewness statistics ranging from .30 (18-24 years of age) to 1.58

(42-49 years of age). Kurtosis statistics obtained for the variable of age ranged from .81 to 1.82.

Table 2

Statistical Measures for Normality by Demographic Variable

	N	*F*	*P*	*Skewness*	*Kurtosis*
Gender		.67	.41		
Male	43			.04	.78
Female	288			.50	.96
Age		1.58	.193		
18-25	269			.30	.81
26-33	40			.65	1.31
34-41	13			1.27	1.29
42+	9			1.58	1.82
Ethnicity		2.01	.094		
White or Caucasian	286			-.56	1.61
Hispanic or Latino	11			-1.26	1.32
Black or African	12			-1.33	.50
American	18			-.22	-.03
Asian/Pacific Islander	4			-.04	-5.60
Other (Please specify)					
Sexual Orientation		2.55	.112		
Heterosexual	310			.40	.73
LGBTQ	20			.10	1.11

A series of independent-samples *t*-tests were conducted to evaluate differences in mean scores on the KMI-70 in relation to the demographic variables of interest. Table 3 presents a summary of the mean scores and standard deviations obtained from the KMI-70. Results indicate that there was a significant difference in mean scores for minority

(*M*= 177.5, *SD*= 29.3) versus non-minority students (*M*= 166.4, *SD*= 18.1); *t*(329)= 4.3, *p* ≤ .001. For a breakdown in the differences, the following hypotheses were addressed: *Hypothesis #1: Racial/ethnic minority undergraduate nursing students will have significantly higher marginality scores when comparted to non-minority undergraduate nursing students.*

A t-test was conducted to evaluate differences in mean scores for racial/ethnic minority and non-minority nursing students. Results indicate that racial/ethnic minorities scored significantly higher on the KMI-70 (*M*= 199.1, *SD*= 27.4) when compared to non-minority participants (*M*= 166.3, *SD*= 27.4); *t*(329)= -9.9, *p* ≤ .001. Further analysis of race/ethnicity revealed that participants who identified as ENNL reported higher marginality scores (*M*= 186.9, *SD*= 33.6) when compared to scores obtained from participants whose primary or native language is English (*M*= 170.3, SD= 23.2); *t*(329)= -2.4, *p*= .037.

Table 3

Means and Standard Deviations on KMI-70 by Demographic Variable

	N	*M*	*SD*	*t*	*p*
Minority	132	177.5	29.3	4.3	< .001
Non- Minority	199	166.4	18.1		
Gender					
Male	43	166.1	25.6	-1.4	.428
Female	288	171.6	23.5		
Age					
18-24	269	171.8	24.6	1.5	.111
25+	62	166.9	19.8		
Ethnicity					
Non-minority	285	166.3	19.7	-9.9	< .001
Minority	46	199.1	27.4		
English is primary language					
Yes	319	170.3	23.2	-2.4	.037
No	12	186.9	33.6		
Sexual Orientation					
Heterosexual	310	170.3	23.0	-1.5	.112
LGBTQ	20	178.8	33.7		

A one-way ANOVA was then conducted to investigate further the differences in mean scores between the various racial/ethnic groups with regard to KMI-70 scores. Results of the tests for normality with regard to race/ethnicity are presented in Table 4.

While there was a significant difference in mean scores for White/Caucasian (non-minority) participants when compared to Hispanic/Latino, Black/African American, or Asian/Pacific Islander (minority) participants, F (2,326) = 29.05, $p < .001$, results

indicate no significant differences in mean scores between Hispanic/Latino, Black/African American, or Asian/Pacific Islander participants. Results of the ANOVA with a Tukey Post Hoc analysis are presented in Table 4.

Table 4

Tukey Post Hoc Analysis of Means Scores on KMI-70 by Race/Ethnicity

Race (I)	Race (J)	Mean Difference (I-J)	*SE*	*p*
White/ Caucasian				
	Hispanic/Latino	-45.4	6.3	< .001
	Black/African	-37.7	6.1	< .001
	American	-29.7	5.0	< .001
	Asian/Pacific Islander			
Hispanic/Latino				
	White/Caucasian	45.4	6.3	< .001
	Black/African	7.7	8.6	.896
	American	15.7	7.7	.274
	Asian/Pacific Islander			
Black/African American	White/Caucasian	37.7	6.1	< .001
	Hispanic/Latino	-7.7	8.6	.896
	Asian/Pacific Islander	7.9	7.7	.840
Asian/Pacific Islander				
	White/Caucasian	29.8	5.0	< .001
	Hispanic/Latino	-15.7	7.9	.274
	Black/African American	-7.9	7.7	.840

Hypothesis #2: LGBTQ minority undergraduate nursing students will have significantly higher marginality scores when comparted to non-minority undergraduate nursing students.

A *t*-test was also computed to determine if sexual minorities experience higher levels of marginalization than non-minorities. Results did not reveal any statistically significant differences between sexual minority (M= 178.4, SD= 33.7) and non-minority participants (M= 170.3, SD= 23.0); $t(328)= -1.5$, $p = .112$ with regard to KMI-70 scores. The majority of LGBTQ participants included in the study identified as being bisexual (n=11); given the fact that a bisexual person is, by definition an individual who is sexually attracted to both men and women, it was hypothesized that being sexually attracted to individuals of the same sex and the opposite sex may impact marginality scores. Therefore, a second t-test was performed to investigate the differences in mean scores between lesbian (n=4), gay (n=4), or "other" (n=1) participants and those individuals who did not belong to a sexual minority (n=310). Results revealed a significant difference between marginality scores for sexual minority participants when bisexuals were excluded (M=183.6, SD= 51.2) versus those individuals who identified as heterosexual (M= 170.4, SD= 23.1); $t(317)= -1.5$, $p < .001$.

Hypothesis #3: Male undergraduate nursing students (minority) will have significantly higher marginality scores when comparted to female (non-minority) undergraduate nursing students.

A *t*-test was computed to determine if male participants experience higher levels of marginalization than female participants. Results suggest that there was no statistically significant difference in mean scores for male participants (*M*=166.1, *SD*= 25.6) versus female participants (*M*=171.6, *SD*= 23.5); *t*(329)= -1.4, p= .428.

Hypothesis #4: Non-traditional-aged (minority) undergraduate nursing students will have significantly higher marginality scores when compared to traditional-aged (non-minority) undergraduate nursing students.

A t-test was conducted to evaluate differences in mean scores for traditional-aged and non-traditional-aged participants. Results indicate that there was no significant difference in KMI-70 scores for non-traditional participants (*M*= 166.7, *SD*= 19.8) when compared to traditional-aged participants (*M*=171.8, *SD*= 24.6); *t*(329)= 1.5, *p*= .111. A one-way ANOVA was then conducted to investigate further the differences in mean scores between the different age groups with regard to KMI-70 scores. Results indicate that there is no significant difference in marginality scores between participants with respect to age, *F* (4,326) = .629, *p*= .642. Results of the ANOVA are presented in Table 5.

Table 5

Means and Standard Deviations of KMI-70 by Age

	N	*M*	*SD*	*F*	*p*
Age				.63	.640
18-24	269	171.8	24.6		
26-33	40	166.0	20.2		
34-41	13	166.6	14.1		
42-49	8	170.1	28.1		
50-55	1	167.0			

Summary of Findings

In Chapter Four an analysis was presented of the data. When comparing the sample used in the study to the larger population, the statistics indicated that the sample was representative of the population from which it was obtained with regard to the demographic variables of interest. Several *t*-tests were then conducted to evaluate differences in mean scores on the KMI-70 in relation to participants' race/ethnicity, sexual orientation, gender, and age. There was a statistically significant difference in mean scores on the KMI-70 for certain minority versus non-minority participants.

With regard to specific variables of interest, both race/ethnicity and ENNL participants score significantly higher on the KMI-70 than did non-minority participants. There was no significant differences in mean scores obtained from sexual minority participants when compared to non- minority participants; however, when bisexual participants (*n*=11) were excluded from the analysis, KMI-70 scores for lesbian and gay participants were significantly higher than those scores obtained from non-minority

participants. Neither gender nor age minorities were significantly different in their mean scores when compared to non-minority participants.

CHAPTER V

SUMMARY OF THE STUDY

Given the integral role that registered nurses play within the realm of healthcare, it is posited that increasing the diversity of the nursing profession to better represent the population they serve will improve the overall health of the nation (HRSA, 2006). Research suggests, however that the nursing workforce remains largely Caucasian and female (HRSA, 2010). The homogeneity of the nursing profession is largely a due to the significantly higher attrition rates that minority nursing students experience when compared to non-minority students (Bond et al., 2008; Loftin et al., 2012; McDermott-Levy, 2011; Mulholland et al., 2008; Pitt et al., 2012; Shelton, 2012). Those students who are not able to integrate socially may feel marginalized from their peers and the nursing program (Dapremont, 2011; Loftin et al., 2012; Rivera-Goba & Nieto, 2007). Research suggests that feelings associated with marginalization (e.g. loneliness, alienation, and differentness) can contribute to a student's decision to leave a nursing program prematurely (Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Mulholland et al., 2008; Rivera-Goba & Nieto, 2007; West et al., 2014).

Summary

The purpose of this non-experimental, descriptive correlational study was to investigate the relationship between minority status and marginalization in undergraduate

nursing students in Wisconsin. The study addressed the following research question: Does the level/degree of marginality differ among undergraduate nursing students based on race/ethnicity, sexual orientation, gender, or age? After Institutional Review Board approval, a convenience sample of 331 participants enrolled at one of the four target universities in Wisconsin was used in the study. Participants completed a demographic questionnaire (Appendix A) which included information about race/ethnicity, sexual orientation, gender, and age, as well as the KMI-70 (Appendix B) which measured participants' level of marginalization using a Likert scale. Several *t*-tests were conducted to assess the differences in mean scores obtained from the KMI-70 for each of the demographic variables of interest (e.g. race, sexual orientation, gender, and age). Two ANOVAs were then conducted to further investigate any differences between groups with regard to both race/ethnicity and age.

Discussion of the Findings

Race and Ethnicity

Participants who belonged to a racial or ethnic minority group reported significantly higher levels of marginalization than those levels that were reported by non-minority students. These findings are consistent with numerous qualitative studies that explored the lived experiences of racial and ethnic minority students as they traversed through nursing school (Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010). A theme identified in the literature describes racial

and ethnic minority nursing students feeling isolated and that they did not fit into the social and educational system promoted by universities (Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010).

What is perhaps more alarming is how significant the gap is between racial and ethnic minorities in relation to non-minority participants with regard to mean scores on the KMI-70. Results of the study revealed that participants who belong to a racial/ethnic minority generated KMI-70 scores that were, on average 33 points higher than those scores obtained from non-minority participants. When compared to the mean scores obtained from participants in the pilot study, racial/ethnic minority students scored an average of 40.5 points higher (M=199.1) when compared to racial/ethnic minority students in in the pilot study (M= 158.6). The significant discrepancy in numbers may be influenced by the fact that the sample obtained in the pilot study consisted of 91 racial/ethnic minority participants (45.6%), whereas the sample obtained in the current study was approximately half that (n= 45; 13.6%). Perhaps a more robust sample may yield numbers that more closely approximate one another.

A second factor that may have influenced the large difference in mean scores is that fact that Wisconsin is a very racially homogenous state relative to other geographic areas of the United States. According the U.S. Census Bureau (2015), 83.3% of Wisconsin residents identified as Non-Hispanic White, whereas 45.3% of residents of Texas are Non-Hispanic White. The racial/ethnic heterogeneity found in Texas is

mirrored at the national level as well with only 61.6% of U.S. population belonging to the category of Non-Hispanic White (U.S. Census Bureau, 2015).

Much of the research conducted on the personal, social, and institutional barriers that racial/ethnic minority students face while traversing through an undergraduate nursing program have been conducted in geographic areas that are more racially diverse than Wisconsin (Bond et al., 2008; Del Prato, 2013; McWha, 2013; Rivera-Goba & Nieto, 2007; Sanner & Wilson, 2008; Wong et al., 2008). The findings from these studies discuss how racial and ethnically diverse students report feelings of loneliness, alienation, and being "different" from their peers; all of these feelings are strongly associated with the process of marginalization (Hall et al., 1994). Perhaps students who reside in racially homogenous geographical areas and attend nursing programs with an overwhelmingly White student body may feel increased levels of marginalization.

The study did not show any statistically significant differences in mean scores for the major racial and ethnic minority groups (e.g. Hispanic/Latino, Black/African American, and Asian/Pacific Islander) included in the study. Although quantitative data on marginalization of minority students is limited, qualitative evidence seems to support the finding that all racial/ethnic minorities experience marginalization to a more significant extent than do non-minority nursing students (Bond et al., 2008; Del Prato, 2013; Rivera-Goba & Nieto, 2007; Sanner & Wilson, 2008; Wong et al., 2008).

The difference in mean scores for EENL participants versus non-minority individuals reached the level of statistical significance. This finding is consistent with

previous studies that found a perceived lack of peer and faculty support was a significant predictor of attrition of ENNL students from undergraduate nursing programs (Malecha et al., 2012; Olson, 2012; Sanner & Wilson, 2008; Scheele, Pruitt, Johnson, & Xu, 2011; Suliman & Tadros, 2011). Meyers (2007) conducted a qualitative study to examine the lived experiences of ENNL students with regard to the social, educational, and clinical challenges encountered during their tenure in the undergraduate nursing program. Participants reported feelings of loneliness and social isolation as barriers to their education experience. Participants further elucidated that they felt that their non-minority peers were not embracing them and that they were purposefully being excluded from peer groups (Meyers, 2007).

LGBTQ

Results of the study did not reveal any statistically significant differences between sexual minority and non-minority participants with regard to KMI-70 scores. These findings are inconsistent with the extant literature that suggests that LGBTQ individuals feels isolated and marginalized from peers and academic institutions (Balsam et al., 2011; Brown et al., 2004; Carabez et al., 2015; Dinkel et al., 2007; Gortmaker & Brown, 2006; Massey, 2009; Murphy, 2007; Rankin, 2003; Rankin et al., 2010; Tomlinson & Fassinger, 2003). The sample size obtained for the study was small (n=20) as it represents approximately 6% of the participants; however this number is consistent with national measures which estimate that 4% of the U.S. population belongs to the LGBTQ community (DHHS, 2014).

More than half of the participants in the study identified as bisexual (*n*=11); the sexual attraction of bisexual individuals to both same-sex and opposite-sex persons may have contributed to the lack of statistical significance for LGBTQ minorities. Bradford (2008) conducted a qualitative study to investigate how bisexual individuals experience cultural attitudes towards bisexuality and how these experiences have affected their self-concept. Twenty self-identified bisexual individuals (10 male and 10 female particpants) were interviewed using a series of open-ended questions. Respondents reported feeling that they lived a dichotomous life, existing in both the "gay" and "straight" cultures. Similarly, participants stated that they felt their sexuality was somewhat invisible to society unless they made it a point to talk about it with others (Bradford, 2008).

The Pew Research Center (2013) conducted a survey of 1,197 adults who self-identified as belonging to the LGBTQ community. Data were collected using an online survey format and included questions about the lived experiences of being a sexual minority. Results of the study suggest that bisexual individuals differ from gay and lesbian individuals in a number of respects (Pew Research Center, 2013). For example more than 77% of gay males (*n*=398) and 71% of lesbians (*n*= 277) reported that the majority of the most important individuals in their lives were aware of their sexual orientation, compared to only 28% of bisexual participants (*n*= 479). Furthermore, approximately 50% of gay men and lesbians indicated that their sexuality was very or extremely important to their identity, whereas only 24% of bisexual participants reported similar feelings. Finally, the study found that the vast majority of bisexual participants

had partners or were married to individuals of the opposite sex (Pew Research Center, 2013).

The findings obtained from the studies conducted by Bradford (2008) and the Pew Research Center (2013) may help explain why the LGBTQ participants were not significantly different from the non-minority participants as the majority of the sample (*n*=11) identified as bisexual. Living a dichotomous life (i.e. living in both the "gay" and "straight" cultures), feeling that a person's sexual orientation is not a significant part of ones identify, and limiting the number of individuals aware of their sexual identity are all factors that may positively impact perceived marginality. This appears to be supported by the fact that mean scores for sexual minority participants (*n*=9) were significantly different from non-minority individuals when bisexual participants (*n*=11) were excluded from the analysis.

Gender

There was no statistically significant difference in mean scores between gender minority (i.e. male) and non-minority (i.e. female) participants. These findings are not supported in the literature as numerous studies have elucidated upon the marginalization of men in nursing programs (Bartfay et al., 2010; Bell-Scriber, 2008; Dyck et al., 2009; Lloyd, 2013; Meadus & Twomey, 2011; Rajacich et al., 2013; Stott, 2007). Although not statistically significant, the KMI-70 scores for females was, on average, five points higher (*M*=171.6) than those scores obtained from male participants (*M*= 166.1). The higher mean scores for female participants may stem from the fact that gender

inequalities continue to exist in society. Despite many advancements and legislative acts, the U.S. remains largely patriarchal and unequal with regard to women (Klasen & Lamanna, 2009). According to Klasen and Lamanna (2009), gender gaps continue to exist in many areas including health, employment, and pay.

Over half of the world's population is female (U.S. Census Bureau, 2015), yet it is argued that females experience social injustice and gender discrimination from the day they are born (Klasen & Lamanna, 2009; Williams, 2013). No society in the world is spared from treating women, to some degree, like second-class citizens. According to Williams (2013), gender inequalities remain pervasive in a number of areas including education, political leadership, and in most career fields. Women are even marginalized when it comes to access to powerful, influential, and successful role models (Klasen & Lamanna, 2009).

Given the fact that females are exposed to gender inequalities and marginalization from birth, scoring higher than males on the KMI-70 is not necessarily surprising. Koci (2004) developed a marginality scale based on specific scales from the MMPI-2. The MMPI-2 is a broad-based test designed to assess a number of major patterns of personality, emotional, and behavioral disorders (Hathaway & McKinley, 1989). According to Roberts, Wood, and Caspi (2008), personality traits are defined as "the relatively enduring patterns of thoughts, feelings, and behaviors that distinguish individuals from one another" (p. 375). There is a general consensus that most personality traits can be categorized into five broad domains: extroversion, agreeableness, conscientiousness,

neuroticism, and openness to experience. It is argued that these five domains are present in adolescence and relatively stable over time (Cott & Matthews, 2009; Roberts et al., 2008).

If females are exposed to gender inequalities and marginalization since birth (Klasen & Lamanna, 2009; Williams, 2013) such prolonged exposure may significantly impact a person's personality. Similarly, as males enter the field of nursing, the dissonance that may result from the clash between patriarchal societal norms and the "feminized" arena of nursing may leave male nursing students feeling a bit bewildered, lost, or stressed (Kellet et al., 2014; Rajacich et al., 2013). With that being said, males are not considered a gender minority in the vast majority of social situations; therefore, the short interval of exposure to marginalization in nursing programs may not be enough in severity, duration (or both) to alter their personality appreciably. As a result the KMI-70, which is a measure of personality, may not be the correct tool to quantitatively capture marginalization within this population.

Age

The difference in means scores on the KMI-70 for traditional versus non-traditional students was not statistically significant. The results of this study are in contrast to a multitude of studies that found marginalization to be an issue with non-traditional aged students (Hagdorn, 2005; Jeffreys, 2007; Kasworm, 2008; 2010; Ramos, 2011; Sims & Barnett, 2015; Stokes, 2006; Willans & Seary, 2010). What is noteworthy is the fact that the mean score for traditional-aged students was higher (M=171.8) than what was found for non-traditional students (M= 166.7). This finding is supported in the pilot study, which

also found mean scores on the KMI-70 to be higher for participants 18-24 years of age (*M*= 161.6, *SD*= 23.7) when compared to non-traditional students (*M*= 148.4, *SD*= 24.2). One factor that may have contributed to the lower KMI-70 scores for non-traditional aged students when compared to traditional-aged students is that older students may be more resilient and better equipped to cope with feelings of isolation and "differentness" from peers. Non-traditional-aged students' cumulative life experiences may provide enhanced maturity and wisdom when compared to traditional-aged students.

Montgomery, Tansey, and Roe (2009) collected quantitative data from 239 mature-aged students enrolled in undergraduate nursing programs in the United Kingdom. The purpose of the study was to explore the characteristics of mature-aged students including how they perceive themselves, as well as any barriers that hindered their ability to successfully navigate the nursing curriculum. Participants identified a number of personal characteristics that they believed ensured their academic success including a strong work ethic, focus, and a deep resolve to achieve their goal of graduating from nursing school. Participants also believed that their life experiences better qualified them to cope with the stressors of nursing school (Montgomery et al., 2009).

The findings obtained from Montgomery et al. are supported in subsequent research conducted by Kenny and colleagues (2011). The researchers conducted mixed methods research to explore the lived experiences of mature-aged (i.e. non-traditional) students enrolled in undergraduate nursing programs in Australia. Researchers found that mature-aged students (*n*=70) tended to be more self-confident and more motivated to endure the

stressors associated with nursing programs when compared to their younger counterparts. Participants reported that their decision to return to school was very considered and deliberate, and that family responsibilities solidified their need to be successful in the program (Kenny et al., 2011). Participants also shared that their cumulative life experiences and coping strategies helped them successfully navigate through the rigor of the program (Kenny et al., 2011).

Forbus, Newbold, and Mehta (2011) used survey data to examine the differences between non-traditional and traditional-aged students with regard to stress factors and coping strategies. A total of 374 traditional students and 97 non-traditional students enrolled in a four-year university located in the southwestern U.S. participated in the study. Results of the study suggest that non-traditional students tend to be presented with stressful situations more often than do traditional-aged students. These stressful situations are believed to result from their numerous work, social, financial, and domestic commitments that put significant time constraints on their ability to focus on coursework (Forbus et al., 2011).

Forbus and colleagues (2011) did find differences in coping styles between traditional-aged versus non-traditional students. Traditional-aged students tended to employ more passive and negative coping methods such as skipping classes, failing to turn in assignments on time (or at all), and electing to socialize more with peers rather than focus on academics. Conversely, non-traditional students tended to utilize more active and positive coping methods including task-oriented coping through time management,

utilization of multiple study methods, and seeking guidance from faculty (Forbus et al., 2011). This study suggests that, although non-traditional students tend to be exposed to an increased number of stressful situations, their life experiences and coping styles may better equip them to deal with the stress in a positive manner when compared to traditional-aged students.

The findings from these studies support the hypothesis that non-traditional-aged students' cumulative life experiences may provide enhanced maturity and wisdom when compared to traditional-aged students. Similarly, the decision of non-traditional aged students' to return to academia tends to be a very deliberate and considered decision (Forbus et al., 2011); as such, these students may possess increased levels of resiliency, dedication, and maturity when compared to traditional-aged students. This maturity and resiliency may influence marginality scores that are obtained from a tool that is based upon measurements of personality (Koci, 2004).

Application of Findings to Theoretical Framework

With an increasingly diverse U.S. population, the future of healthcare depends upon the ability of nursing professionals to meet the unique needs of minority communities. Unfortunately, the field of nursing remains largely homogenous with regard to race/ethnicity, sexual orientation, gender, and age (AHRQ, 2012; American Association of Colleges of Nursing [AACN], 2015a; IOM, 2002, 2011a). The findings from this study coupled with the extant literature support the hypothesis that marginalization continues to be a significant issue in nursing academia.

According to Hall and colleagues (1994), there are seven key properties or subconcepts of marginalization as it applies to the domain of nursing. The first, *intermediacy* encompasses the very essence of marginalization and refers to boundaries that act as both barriers and connections in a person's life (Hall et al., 1994). Individuals who have issues with *intermediacy* tend to be uncomfortable in social situations and have low self-esteem (Koci, 2004). This is widely supported in the literature in that minority students have consistently reported experiencing intense feelings of disconnect, isolation, and stress when attempting to socialize into nursing education and practice (Bednarz et al., 2010; Bond et al., 2008; Dapremont, 2011; Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Noone, 2008; Rivera-Goba & Nieto, 2007; Sanner & Wilson, 2008; Stott, 2007; West et al., 2014; Yeun-Sim Jong et al., 2010).

The second subconcept of marginalization, *differentiation*, speaks to the hierarchy that exists in society that places the most powerful and influential individuals in the center. Society's center tends to be more homogenous and predictable, which allows these individuals to exert quite a bit of *power* (another subconcept of marginalization) over the rest of society by pushing those individuals who are "not like them" out into the periphery (Hall et al., 1994). *Differentiation* manifests itself by negatively impacting a person's resiliency, adaptability, and resourcefulness (Koci, 2004). One theme that has been consistently demonstrated in the literature is minority students feeling that they were essentially shoved to the corner within the nursing program (Bond et al., 2008; France et al., 2004; Loftin et al., 2012; Noone, 2008; Rivera-Goba & Nieto, 2007; Sanner &

Wilson, 2008). Similarly, a lack of resiliency may be a contributing factor as to why minority students continue to be plagued with significantly higher attrition rates when compared to non-minority students (Bond et al., 2008; Loftin et al., 2012; McDermott-Levy, 2011; Mulholland et al., 2008; Pitt et al., 2012; Shelton, 2012).

The belief that non-minority students hold the majority of *power* within nursing education was also supported in a number of studies. Minority nursing students have consistently reported that they have formed relationships with White students because they believe that non-minority students have access to more curricular information than minority students. Minority students report that such relationships are critical to their academic success because the educational culture and nursing curricula are heavily skewed towards non-minority students (Dapremont, 2011; Love, 2010; Sanner & Wilson, 2008).

A fourth concept of marginalization, *secrecy* refers to those along the periphery feeling compelled or pressured to keep information to themselves in order to establish and maintain bonds with peers (Hall et al., 1994; Koci, 2004). For example, LGBTQ students have consistently reported hiding their sexual identities out of fear of recriminations from peers and faculty (Balsam et al., 2011; Gortmaker & Brown, 2006; Herek, 2003; Murphy, 2007). Racial and ethnic minority students have similarly sought to decrease the level of stress and dissonance felt in the academic setting by conforming themselves to the majority (Dapremont, 2011; Love, 2010; McDermott-Levy, 2011; Rivera-Goba & Nieto, 2007).

Another subconcept, *voice* portrays marginalized individuals as possessing distinctive forms of communication that sets them apart from the dominant society (Hall et al., 1994; Koci, 2004). Research suggests that all forms of communication (written, verbal, and nonverbal) are heavily steeped in cultural nuances that can be confusing to those individuals who are new to particular social, academic, or clinical context (Amaro et al., 2006; Ellis et al., 2006; Edgecombe et al., 2013; Yoshimura & Hayden, 2007).). Issues with communication have also been shown to create barriers to minority students' forming and maintaining authentic relationships with peers, nursing faculty, patients, and clinical staff (Amaro et al., 2006; Edgecombe et al., 2013; Woodward-Kron et al., 2007). Communication barriers between racial/ethnic minority and non-minority nursing students have led to feelings of distrust, suspicion, and competition (Edgecombe et al., 2013; Mattila et al., 2010; Sanner & Wilson, 2008).

Employing communication patterns that are different from the majority is not an issue that is specific to racial and ethnic minority students. Male nursing students also face a number of unique challenges with regard to communication in the classroom and clinical settings. Given the fact that the overwhelming majority of nurses and nurse educators are female, male nursing students are consistently exposed to communication patterns that are uniquely feminine (Yoshimura & Hayden, 2007). According to Yoshimura and Hayden (2007), women tend to employ both verbal and nonverbal messages to communicate information about equality, support, and relational status,

whereas male communication patterns tend to focus on pragmatism and the accomplishment of tasks.

Liminality, another key property of marginalization refers to the alteration and intense focus on a person's self-image, worldview, and perception of time (Hall et al., 1994; Koci, 2004). *Liminality* manifests itself by influencing individuals to be overly sensitive, intense, and high strung when compared to the non-marginalized population (Koci, 2004). A similar subconcept, *reflectiveness* is a byproduct of the cumulative effects of all of the other key properties of marginalization. According to Hall and colleagues (1994), a consequence of being marginalized is living a life of intense introspection. *Reflectiveness* negatively impacts a person's ability to make decisions and causes the individual to obsess over and be overwhelmed by personal issues and problems (Koci, 2004).

Both *liminality* and *reflectiveness* have been widely demonstrated in the available literature. It is argued that marginalized individuals experience high and prolonged exposure to "social pain" and that such sustained exposure can significantly alter a person's life and wellbeing (Fine, Stoudt, Fox, & Santos, 2010; Love, 2010; Rivera-Goba & Nieto, 2007; Wilkinson & Pickett, 2009). Adverse outcomes associated with marginalization include attrition from school, lack of social trust, and low social participation (Fine et al., 2010; Wilkinson & Pickett, 2009). Marginalized individuals also experience significantly higher rates of stress, depression, and anxiety (Levett Jones et al., 2009; Wilkinson & Pickett, 2009).

Conclusions and Implications

Increasing Diversity in the Classroom: Impact of Attrition

The successful integration of a student into a program of study, from both an academic and social perspective, has been proven to be a critical step in the person's ability to effectively navigate the curriculum (Smith et al., 2011; West et al., 2014). Research has shown that students who feel socially excluded or marginalized can experience such negative effects as diminished self-esteem, depression, stress, and anxiety (Levett-Jones et al., 2009; West et al., 2014). Furthermore, a student's ability and motivation to learn, as well as one's self-concept, and confidence are strongly influenced by the extent to which the student feels connected with peers and the academic institution (Brown, 2009; Edgecombe et al., 2013; Levett-Jones et al., 2009). Research suggests that feelings of loneliness, alienation, and "differentness" can contribute to a student's decision to leave a nursing program prematurely (Loftin et al., 2012; Love, 2010; McDermott-Levy, 2011; Mulholland et al., 2008; Rivera-Goba & Nieto, 2007; West et al., 2014). The broader implications of minority student attrition will be further elucidated.

Psychological impact of attrition. Attrition has been associated with a number of negative psychological effects including a decrease in a person's self-esteem and a lowering of one's self-confidence (Lloyd, 2008; Watson et al., 2008). A study conducted by O'Donnell (2009) found that students who withdrew from nursing school experienced feelings of distress and shame over their decision to leave the program. Similarly,

participants reported viewing their decision to withdraw from nursing school as a substantial personal failure that would significantly impede their ability to realize their career goals (O'Donnell, 2009). Results of O'Donnell's study (2009) support previous findings of participants experiencing feelings of intense anger, frustration, and resentment for not accomplishing their academic and professional goals (Lloyd, 2008; Watson et al., 2008).

Research suggests that minority students may feel a deeper sense of personal failure because they believe that their withdrawal further perpetuates the ideology that minority students are inferior to non-minority students (Dapremont, 2011; Love, 2010). Furthermore, the decision of a minority student to leave the program may cause their minority peers to experience feelings of vulnerability and become discouraged themselves; such feelings may result in their peers leaving the program as well (O'Donnell, 2009)

Financial impact of attrition. The financial ramifications associated with attrition of students from academic institutions are significant with widespread downstream effects. In addition to tuition, nursing students incur the expenses associated with the purchase of student uniforms, nursing equipment, immunizations, and health screenings (Cook, 2010). Oftentimes, students are also responsible for paying healthcare certifications such as cardiopulmonary resuscitation and a Certified Nursing Assistant license (Cook, 2010). In terms of financial losses sustained by the academic institution, universities must purchase and maintain laboratory equipment for their nursing program,

as well as carry insurance for students as they participate in clinical at a variety of clinical agencies (Cook, 2010). Similarly, students who do not complete course work cost private donors, state, and federal governments approximately $4 billion in wasted grants and scholarships (Schneider & Yin, 2011).

When a nursing student leaves a baccalaureate program of study before completion, his or her seat remains empty for the duration of their program. Results of a five-year longitudinal study conducted by Schneider and Yin (2009) from the American Institute of Research found that state and local governments spent more than three billion dollars to help offset the education costs for students who withdrew from community colleges in the United States. If one was to include the federal monies allocated to these students, the costs would be in excess of four billion dollars (Schneider & Yin, 2009). Furthermore, the U.S. has spent nearly $10 billion over the last five years investigating student attrition from universities within their first two years after admission (American Institutes for Research, 2012).

Impact of attrition on the academic environment. Not only is it necessary to increase minority recruitment and retention in higher education to meet the workforce needs of the healthcare profession, diversifying higher education brings its own benefits to the classroom by enhancing the quality of learning (Hurtado, 2010). According to Hurtado (2010) diversifying nurse faculty and students contributes to the richness of the environment for learning, research, and teaching. Diversity at the university level fosters intellectual development by enhancing creativity, innovation, and problem-solving

(Hurtado, 2010). A study conducted by Sommers (2006) looked at the effects of a group's racial composition on the decision-making process. The researcher found that the level of critical analysis of decisions and the alternatives was higher in groups exposed to minority opinions in comparison to those groups who were not. The life experiences and viewpoints of minority group members were found to stimulate the discussion of multiple perspectives and alternatives (Hurtado, 2010).

A growing body of research also suggests that enhancing the diversity of students and faculty facilitates the exploration of diverse perspectives and increases a person's tolerance towards racial, gender, and sexual differences (Hurtado, 2010). According to Hurtado (2010) diverse classroom settings have been found to increase student satisfaction of the college experience, enhance leadership ability, and improve motivation and active engagement for all students. Furthermore, meaningful engagement with diverse peers allows students to learn to respect and appreciate the cultural differences that exist among peers and to become aware of any assumptions or biases that may influence social interactions (Hurtado, 2010).

Increasing Diversity of Nursing Profession: Race and Ethnicity

Creating a nursing workforce that is more representative of the racial and ethnic diversity characteristic of our nation is important because the U.S. remains plagued with disparities in health care (Gilchrist & Rector, 2007; IOM, 2002, 2011a, 2011b). These disparities tend to occur along racial and ethnic lines, as well as to those individuals who are a sexual minority (NACNEP, 2013; Röndahl, 2009, 2011). These disparities can be

attributed to a number of complex factors; however cultural concordance of the client and the health care provider has been found to play a major role (Levesque, 2015; Meghani et al., 2009; Sullivan Commission, 2004). According to Kumar, Schlundt, and Wallston (2009), race concordance occurs when the race of a patient matches with that of the healthcare provider. It is believed that patient-provider concordance will increase the level of comfort and trust felt by the patient, as well improve the quality of communication, partnership, and decision-making between patients and healthcare professionals (HRSA, 2006; Meghani et al., 2009). The concordance hypothesis states that increasing the number of minority health professionals will provide greater opportunity for patients to see a practitioner from the same cultural group (HRSA, 2006). Within the field of healthcare, minority health professionals are considered those individuals who self-identify as belonging to a racial/ethnic or sexual (i.e. LGBTQ) minority group. Specific to the nursing profession, men are also considered a minority as they comprise less than 10% of the nursing workforce in the United States (AACN, 2012).

According to the IOM (2011a), nurses from different cultural groups may be in a better position to work with patients from their own minority groups because personal experiences may transcend any cultural or linguistic barriers. Unfortunately, there is a significant gap in the literature with regard to race concordance and nursing professionals; what few studies have been conducted on the topic investigated race concordance between patients and physicians only (Kumar et al., 2009; Meghani et al.,

2009). With that being said, the race concordance hypothesis is relevant to all members of the healthcare profession and insight can be gained from exploring the results of such studies. For example, research has shown that racially and ethnically diverse populations tend to seek health care from providers who are from similar groups (IOM, 2011a). Furthermore, when racially and ethnically diverse healthcare providers are available, minority patients are much more likely to utilize healthcare services more appropriately and efficiently, thus reducing the overall costs of health care (AHRQ, 2012; IOM, 2011a). A national study conducted by Bach, Pham, Schrag, Tate, and Hargraves (2004) found that 22% of African American patients' medical visits were to African American physicians, yet this group of doctors comprises less than 5% of the nation's physicians. The disproportionate pairing suggests that African American patients actively sought out providers of the same race/ethnicity (Bach et al., 2004).

With regard to service patterns, achieving greater diversity among health professionals, and nurses in particular, may lead to greater diversity in the geographical locations and populations they serve (HRSA, 2006). According to Degazon and Mancha (2012) nurses who identify as being of minority status or from socially disadvantaged backgrounds are more likely than their non-minority counterparts to reside in communities that are plagued with chronic nursing shortages. These neighborhoods tend to be where immigrants, racial/ethnic minorities, and the poor reside and represent a disproportionately large segment of the medically underserved in the U.S. (Degazon &

Mancha, 2012; Ho, Brady, & Clancy, 2008; HRSA, 2006; NACECP, 2013; Sullivan Commission, 2004).

In its seminal report, *Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare* (2002), the IOM found that racial and ethnic minorities receive lower quality health care, even if they are insured to the same degree as their non-minority counterparts. According to the IOM (2002), there are two sets of factors associated with disparities in health care- operational and clinical. The first set of factors pertains to the operation of the healthcare system as well as the legal and regulatory context within which healthcare organizations operate. An example of an operational barrier would be a cultural/linguistic barrier that results from the lack of interpretation services for individuals with limited proficiency in English. Research suggests that the racial/ethnic minority population is more likely to be victims of medical errors compared to non-minority patients (AHRQ, 2012; Ho et al., 2008; DHHS, 2006). Evidence suggests that many medical errors in health care stem from deficiencies in communication between healthcare providers and minority patients (Gilliss & Powell, 2010; Ho et al., 2008). A second operation barrier pertains to the incomplete or fragmented health care that racial/ethnic and sexual minorities experience that result from a lack of health insurance or the enrollment of these individuals in health plans that severely restrict healthcare expenditures and available services (HRSA, 2006; IOM, 2002)

The second set of factors associated with disparities in health care emerges from the clinical encounter and may stem from the provider, the patient, or both (IOM, 2002). For example research shows that bias, stereotyping, and prejudice continues to contribute to the unequal treatment and care received by racial, ethnic, and sexual minorities (HRSA, 2006; IOM, 2002, 2011a, 2011b). Biases and stereotyping on the part of the healthcare provider may result in clinical uncertainty, miscommunication, and erroneous assumptions being made about the behavior or health of racial and ethnic minorities (IOM, 2002, 2011a). Biases and stereotyping may also negatively impact the quality of care that the minority patient receives.

The responses of racial and ethnic minority patients to healthcare providers may also be a source of healthcare disparities experienced by this population. Survey research has consistently found that minority patients perceive higher levels of discrimination in healthcare than do non-minority patients (IOM, 2002, 2011a, 2011b). The behavior of both patients and providers may influence each other in a reciprocal manner and reflect the attitudes, perceptions, and expectations that each person has developed over time. For example, if patients refuse treatment, are poorly compliant, or are distrusting of the healthcare provider, the provider may, in turn become less engaged or invested in the treatment and care of the patient (IOM, 2002). The reaction of these patients, however, may be an understandable response to discriminatory experiences that have taken place in other contexts (IOM, 2002). For example, a national survey of racial minorities in the U.S. found that discrimination continues to be a significant and commonplace issue

(Pager & Shepherd, 2008). Nearly one-third of African Americans and 20% of Hispanics and Asian participants reported that they had been passed over for a job or promotion in large part because of their race or ethnicity (Page & Shepherd, 2008). Furthermore, nearly 50% of African American participants reported experiencing overt discrimination in a common social setting (e.g. shopping, work, or school) at least once in the previous month (Page & Shepherd, 2008). High levels of perceived discrimination have been linked to a number of negative outcomes including depression, anxiety, and poorer overall health (Sue et al., 2009).

Increasing Diversity of Nursing Profession: LGBTQ

The heteronormative nature of the healthcare system has led to the widely-held assumption that all patients are heterosexual until they do or say something that negates this assumption (Röndahl, 2011). These heteronormative assumptions have been shown to cause poor communication between healthcare professionals and patients, which may result in inadequate nursing care provided to LGBTQ patients. A nurse's lack of knowledge about the unique needs of the LGBTQ community may cause inaccurate assessments and clinical judgments by these healthcare professionals (Röndahl, 2011).

In its report, *The health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011b), the IOM reported that sexual minorities still face a number of barriers to accessing health care. The IOM defined access to health care as the "timely use of personal health services to achieve the best possible outcomes" (IOM, 2011b, p.4). Structural barriers relate to the health care

system from a macro level and include limitations placed on LGBTQ individuals' access to marital benefits including health insurance, as well as insurance practices that significantly limit the types of care that are covered for LGBTQ individuals (IOM, 2011b). Specific to the health care provided to members of the LGBTQ community, another structural barrier results from providers' lack of knowledge and training in the health needs of LGBTQ patients (IOM, 2011b). Research has shown that inadequate patient-provider communication is strongly correlated with adverse health behaviors such as decreased levels of adherence to provider advice, decreased medication compliance, as well as decreased levels of satisfaction with provider care (Cortes, Mulvaney-Day, Fortuna, Reinfeld, & Alegria, 2009).

Despite increasing social tolerance of sexual minorities in the U.S., the LGBTQ community continues to experience discrimination, homophobia, or heterosexism within the healthcare system (Bowers, Plummer, McCann, McConaghy, & Irwin; 2006; Röndahl, Inala, & Carlsson, 2006). Bowers and colleagues (2006) used qualitative methodology to investigate the heterosexism and homophobia within healthcare. A total of 67 participants (60% clients belonging to the LGBTQ population and 40% members of the medical or nursing profession) from Sydney, Australia participated in the study. Findings indicate that many of the medical and nursing professionals who identified as LGBTQ elected not to disclose their sexuality for fear of harassment, rejection, or discrimination from colleagues (Bowers et al., 2006). Furthermore some of these

participants believed that identifying as being LGBTQ would negatively impact their career and job prospects (Bowers et al., 2006).

Carabez and colleagues (2015) explored RNs prior education and current knowledge and attitudes about working with LGBTQ patients using structured interviews from 268 nurses working in the San Francisco Bay area. Results of the study indicate that 29% of participants reported feeling "uncomfortable" or "unsure" of their comfort level with regard to caring for LGBTQ patients. A number of the respondents indicated that their discomfort stemmed from the fear that the patient would attempt to "hit on them" (Carabez et al., 2015). Such views appear to relate to the stereotype that LGBTQ individuals are predatory and oversexed (Carabez et al., 2015).

Eliason and colleagues (2011) collected anonymous survey data from nurses on the Gay and Lesbian Medical Association mailing list. A total of 261 RNs participated with 43% identifying as lesbian, 43% gay, 6% bisexual, 3% heterosexual, and 5% identified as "other" (Eliason et al., 2011). Results indicate that 27% of participants (*n*=68) did not report their working environment as being LGBTQ friendly. Participants reported a variety of issues including being the subject of or witnessing homophobic comments and behaviors from co-workers, as well as being restricted by a number of non-inclusive policies in their facilities (Eliason et al., 2011). Some participants also reported serious consequences from being "outed" in the workplace. For example a small number of participants indicated that they had lost their jobs after years of exemplary

personnel reviews, while other participants reported receiving anonymous negative emails from colleagues (Eliason et al., 2011).

Increasing Diversity of Nursing Profession: Gender

There remains a dearth of evidence regarding the relationship between healthcare provider-patient gender concordance and health outcomes (HRSA, 2006). The vast majority of studies that investigated health professional service patterns were limited to examining the physician-patient dyad in general. Franks and Bertakis (2013) conducted a secondary analysis of data obtained from encounters of 41,292 adult patients and 1470 primary care physicians. Results indicate that physicians were more likely to have longer visit durations, perform more gender-specific preventative procedures, and make more follow-up referrals and arrangements for their gender concordant patients when compared to gender discordant physician-patient interactions (Franks & Bertakis, 2013).

A similar research study was undertaken by Gross et al. (2008) who analyzed data obtained from 8,258 questionnaires from the New Zealand National Primary Care medical Care Survey. The researchers aimed to investigate the association of gender concordance and primary care physicians' perceptions of their patients (Gross et al., 2008). Results indicate that in gender concordant patient-physician dyads, physicians reported higher rapport with their patients and less uncertainty in diagnosis (Gross et al., 2008).

Evidence that speaks to the concordance hypothesis in healthcare is lacking and studies that speak specifically to concordance of patients to healthcare providers other

than physicians are nonexistent (HRSA, 2006). Further research is needed to explore the impact of concordance between patients and other primary care professionals including nurse practitioners and nurse midwives (HRSA, 2006). Similarly, investigation is also warranted regarding the concordance of patients and RNs as nurses provide the majority of direct patient care (HRSA, 2006).

Increasing Diversity of Nursing Profession: Age

The relationship between healthcare provider-patient age concordance and patient health outcomes has not been studied empirically. This is largely due to the fact that a patient's perception of similarity to one's healthcare provider is a multidimensional construct that involves a number of social characteristics including gender, age, and education (Street, O'Malley, Cooper, & Haidet, 2008). Given the complexity and interrelatedness of shared social characteristics, it is difficult to identify which specific demographic characteristic is more strongly related to patient outcomes than others (Thornton, Powe, Roter, & Cooper, 2011). The very nature of social relationships that develop between healthcare providers and patients is more complex and rich than what is represented by a single demographic variable such as age (Thornton et al., 2011). In general terms, research suggests that patients who believed they are more concordant with their physician with respect to personal beliefs, values, and ways of communicating are more trusting in the physician, more satisfied with care, and report a stronger intention to adhere to physician recommendations (HRSA, 2006; Street et al., 2008).

Thornton and colleagues (2011) used quantitative methodology to determine whether social concordance (i.e. race, gender, age, and socioeconomic status) can be used to predict medical visit communication and patients' perceptions of heath care. Social concordance scores were obtained using additive composite scores across four social characteristics: race, gender, age, and education. Three items from the Participatory Decision Making tool were used to determine the patients' degree of satisfaction with regard to their visit (Thornton et al., 2011). Results indicate that 55% of the patient-physician dyads who were highly socially concordant were age concordant.

Limitations of the Study

There are a number of limitations identified in the current study. First, the sample size was small relative to the population from which it was obtained. The target population was all undergraduate nursing students currently enrolled full-time in a baccalaureate nursing program at one of the four target universities in Wisconsin; of the approximately 1500 potential participants, only 27.5% completed the survey. Perhaps a more robust sample of minority participants would have yielded statistical significance with a number of demographic variables including sexual orientation and age.

Another consideration is that, although the sample obtained for the study is believed to be representative of the larger population, the sample size for minority participants across all demographic categories (i.e. race/ethnicity, sexual orientation, gender, and age) was small. The small sample size makes it difficult to make sweeping recommendations for curricular or policy change based on the findings of this research.

Further studies should be conducted with larger, more diverse samples so that comparisons can be made and recommendations brought forth to leadership in education. For example, although three participants identified as both Caucasian and Native American, the sample did not capture any participants who identified solely as Native American. A review of literature reveals a dearth of studies that have investigated the experiences of Native American students in colleges and universities in the U.S., and no studies have been conducted that look at the marginalization of Native American nursing students.

The sample used in this study also did not yield data from international nursing students in Wisconsin. According to a survey conducted by the WCN (2013) less than 1% of the baccalaureate student population reported being an international student, yet that number is expected to rise. A study put forth by the U.S. Department of State's Bureau of Educational and Cultural Affairs (2014), revealed that the U.S. enrolled a record breaking 886,052 international students in colleges and universities across the nation during the 2013-2014 academic year. Failing to capture the voices of this population does not allow researchers to gain a better understanding of the full picture of marginality experienced by the undergraduate nursing student population.

Another limitation related to the sample used in this study is the lack of representation of nursing students who self-identify as transgender or queer. Research suggests that the number of college students who either identify as transgender or are questioning their gender identity has increased over the last decade (Dugan, Kusel, &

Simounet, 2012). As the number of transgender students increases, so too, does the need to understand the unique educational experiences of this population (Dugan et al., 2012). Unfortunately, the literature on college students who identify as transgender is scant. In one of the only recent studies conducted with this population, Dugan and colleagues (2012) explored transgender students' perceptions, engagement, and educational outcomes related to their experiences in college. Results of the study suggest significant differences exist between transgender and non-minority students with regard to perceptions of campus climate (Dugan et al., 2012). Transgender students reported more frequent encounters with discrimination and harassment, as well as a significantly lower sense of inclusion and belonging when compared to non-minority students (Dugan et al., 2012).

The currently body of nursing literature is nearly devoid of research pertaining to the queer population. Part of the issue is that prior to 1990, the term "queer" was largely used as an insult to refer to anyone who was deemed outside of society's heterosexual norm (University of California Berkeley Gender Equity Resource Center [GENEQ], 2010). As such, many of the older generations who belong to the LGBTQ community are uncomfortable identifying with the term "queer" (GENEQ, 2010). The development of Queer Theory in the early 1990s provided the impetus for many younger members of the LGBTQ community to reclaim the word as both a political statement and descriptor of sexual orientation (GENEQ, 2010).

Another limitation identified pertains to the ability to generalize the findings to other populations. Data were collected from students enrolled in baccalaureate programs within the state of Wisconsin. Given the fact that the scope of this study is specific to one setting (i.e. baccalaureate nursing programs in Wisconsin), the findings from this study may not be transferrable to undergraduate nursing students in other states. Similarly, the results are limited to baccalaureate programs and are not generalizable to students enrolled in other nursing programs such as Associate degree or Graduate programs.

A final limitation is the attrition experienced with regard to study participants. Of the 357 participants who consented to participate in the study, 26 completed less than half of the KMI-70 and had to be excluded from the study. Furthermore, the KMI-70 is a 70-item tool that uses a Likert scale; the length of the tool may make it difficult to use multiple quantitative measures in one study. However, the KMI-5 is an abbreviated form of the KMI-70 and has been used in more recent studies; the KMI-70 has been found to be reliable with an alpha of .84 (Gonzales et al., 2015; Koci, 2012). Finally, as the results suggest, the KMI-70, a measure of personality may not be the most effective means by which to measure marginality in nursing students who are male.

Recommendations for Further Study

The results of this study suggest that more research must be done in order to glean a better understanding of the marginalization faced by minority students. Specifically, more research should be conducted in a number of areas including: 1) sampling of

minority nursing students across the U.S., and from diverse educational environments such as associate degree, baccalaureate, and graduate schools; 2) the investigation of marginality in international, LGBTQ, and non-traditional students; 3) the development of a short marginality tool more specific to the realm of nursing education; and 4) further explore the individual subconcepts of marginalization that underlie the KMI-70 as they relate to the population of nursing students.

Robust Sampling of Minority Nursing Students

Results of the study indicate that further research needs to be implemented using minority nursing students across a variety of geographic and educational domains. Specifically, studies should be performed with undergraduate students enrolled in baccalaureate programs located in geographical areas characterized by varying degrees of racial and ethnic diversity. Similarly, it would behoove researchers to conduct studies using students enrolled in associate degree and graduate programs. Marginalization is a complex, multi-faceted issue that is influenced by a number of institutional, social, and personal factors (Wong et al., 2008). Further research needs to be done to better elucidate this longstanding issue.

International Students

A review of the extant literature reveals that most of the studies pertaining to the experiences of racial and ethnic minority nursing students do not delineate between international and non-foreign born students (Junious, Malecha, Tart, & Young, 2010). It is further posited that in the majority of studies published that investigated the stressors

that nursing students experience, the plight of international students is vastly underrepresented (Junious et al., 2010). Junious and colleagues (2010) conducted a phenomenological study to describe the essence of stress and perceived faculty support that international students (*n*=10) experience while enrolled in the baccalaureate nursing program at Texas Woman's University. Respondents reported experiencing marginalization in the form of discrimination, devaluing, and pressure to conform (Junious et al., 2010). The findings from this study coupled with the dearth of evidence that speaks to the marginality of international students suggest that more research needs to be conducted using this student population.

LGBTQ Students

The needs of LGBTQ students is gaining attention with more campuses including gender expression and gender identity in the nondiscrimination and mission statements (Levesque, 2015); however, the literature pertaining to the experiences of LGBTQ students at colleges and universities is scarce (Carabez et al., 2015; Levesque, 2015; Schmidt et al., 2011). What does exist in the literature suggests a lack of peer, faculty, and institutional support, as well as limited resources available to this student population (Levesque, 2015; Schmidt et al., 2011). Nurse educators are in a vital position to facilitate the academic success of LGBTQ students, yet little is known about the marginalization this population experiences in the educational environment.

Non-Traditional Students

The purpose of this study was to investigate the relationship between marginality and minority status in undergraduate nursing students in Wisconsin. Many of the attributes associated with non-traditional students such as marital status, completion of previous degree, employment status, and number of dependents were beyond the scope of this study. Investigating marginalization in non-traditional students with families (i.e. spouse and/or children), full-time employment, and/or those students with a previous college degree warrants further investigation.

Marginality Research Tool

The KMI-70 is a lengthy tool that can be time-consuming for participants to complete. Similarly, the KMI-70 evaluates marginalization based on a number of personality indicators; for individuals such as males who do not tend to be a marginalized class outside of the domain of nursing, such a tool may not be the most effective means by which to gather data from this population. The results of this study illuminate the need for the development of a marginality tool that speaks specifically to the various institutional, social, and personal factors that influence marginality within the domain of nursing education.

Subconcepts of Marginalization

Hall and colleagues (1994) introduced a conceptual framework for the study of marginality within the field of nursing. As a part of their framework, the researchers ascribed seven key properties or subconcepts to marginality: 1) intermediacy; 2)

differentiation; 3) power; 4) secrecy; 5) voice; 6) reflectiveness; and 7) liminality. Working with a measurement expert, Koci (2004) explored the subconcepts of marginality put forth by Hall and colleagues (1994) and identified a scale from the MMPI-2 that reflected each subconcept. Further research could be conducted that investigates each subconcept of marginalization individually and how it is manifested in each population subset (i.e. racial/ethnic, LGBTQ, gender, and non-traditional students).

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Appendix A

Demographic Data Questionnaire

1. In which semester of the undergraduate nursing program are you currently enrolled?
   First semester
   Second semester
   Third semester
   Fourth semester
   Fifth semester
   Sixth semester or more

2. In what category does your current age fall under?
   18-24
   25-33
   34-41
   42-49
   50-55
   56+

3. Which term best describes your gender?
   Female
   Male
   Other (Please specify)_____

4. Which term best describes your race?
   White or Caucasian
   Hispanic or Latino
   Black or African American
   Asian / Pacific Islander
   Other (Please specify)_____

5. Which term best describes your sexual orientation?
   Heterosexual
   Lesbian
   Gay
   Bisexual
   Transgender
   Queer
   Other (Please specify)_____

6. Are you currently an international student?
   Yes
   No

If yes, what is your nationality?_____

7. Is English your primary/native language?
   Yes
   No

Appendix B

Koci Marginality Index-70

(ID#)_____

Anne Koci, Texas Woman's University, Nelda C. Stark College of Nursing, Houston, Texas

Please respond to the following questions by marking in front of the answer that reflects how you feel about the question. There is no right or wrong answer.

1. My feelings are easily hurt. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
2. I feel sure of myself. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
3. Strangers look at me critically. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
4. I worry a great deal. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
5. I often cross the street so I will not have to meet someone I see. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
6. I have difficulty telling others about myself. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
7. I sometimes feel like I want to scream, "I have had it!" ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
8. There have been times I done things without knowing later what I had been doing. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
9. I spend most of my spare time by myself. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
10. I feel so full of energy at times. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
11. I would make a good leader of people if given half a chance. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
12. I remember good stories to pass them on to other people. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
13. I like to let people know what I think about things. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
14. I go out of my way to win a point with someone who does not agree with me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree
15. No one seems to understand me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

16. I cry easily. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

17. I feel lonely much of the time even around a lot of people. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

18. Some people think it is hard to get to know me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

19. I have trouble thinking of the
20. right things to talk about when I am in a group. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

21. I have more trouble thinking than others seem to have. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

22. I have strong views about politics ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

23. I have often had to take orders from someone who did not know as much as I did. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

24. Many people make too much of the bad things that happen to them to gain the pity and help of others. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

25. Most people would lie to get ahead. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

26. I like parties and socials. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

27. I often wonder what hidden reason another person may have for doing something nice for me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

28. It is not safe to trust others. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

29. Most people dislike putting themselves out to help other people. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

30. Whenever possible I avoid being in a crowd. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

31. People expect more respect for their own rights than they are willing to allow for others. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

32. Others are jealous of my good ideas, just because I thought of them first. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

33. People will use unfair means to get ahead in life. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

34. I have often lost out on things because I could not make up my mind soon enough. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

35. I count things that are not important such as bulbs on ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

electric signs, and so forth.

36. Sometimes I get worried beyond reason over something that really did not matter. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

37. I often have trouble deciding what to do. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

38. I feel helpless when I have to make some important decisions. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

39. It bothers me a lot to think of making changes in my life. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

40. Having to make important decisions makes me nervous. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

41. I am an important person. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

42. I am liked by most people who know me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

43. I seem to be about as able an smart as most others around me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

43. I do not mind meeting strangers. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

44. Several times I have given up doing a thing because I thought too little of my ability. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

45. I often pass up something I want to do when others feel that it is not worth doing. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

46. I do not feel I can plan my own future. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

47. It bothers me when people say nice things about me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

48. At times I think I am no good at all. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

49. I pass up things I want to do because others feel that I am not going about it in the right way. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

50. I cannot do anything well. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

51. Friends can pretty easily change my mind even when I have made a decision. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

52. Often I get confused and forget what I want to say. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

53. People do not find me good-looking. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

54. I often feel that I am not as good a other people ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

55. When problems need to be solved, I usually let other people take charge. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

56. I know of several faults in myself that I will not be able to change. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

57. I get angry with myself for giving in to other people so much. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

58. I know I am a burden to others. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

59. It is hard for me to accept praise from others. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

60. I prefer to pass by people I know but have not seen for a long time, unless they speak to me first. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

61. It makes me uneasy to act funny at a party. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

62. Meeting new people is hard for me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

63. I wish I were not so shy. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

64. I am likely not to speak to people until they speak to me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

65. I seem to make friends about as quickly as others do. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

66. I dislike having people around me. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

67. I dislike going into a room by myself where other people have already gathered and are talking. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

68. At parties I am more likely to sit by myself or with just one other person than to join in with the crowd. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

69. I am never happier than when alone. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree

70. I have problems winning arguments. ___Strongly Disagree ___Disagree ___Agree ___Strongly Agree