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Increasing Clergy Members Awareness, Sensitivity, and Knowledge (ASK) of the LGBTQIA+ Community Improves Health Outcomes

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by

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Abstract

Introduction: Individuals who identify as belonging to the LGBTQIA+ community in the context of religion and faith often experience spiritual discrimination and are made to feel like an outcast (Cole & Harris, 2017). Often, spiritual leaders lack the training, knowledge, and skills necessary to understand and communicate in a way that offers solace and comfort to their LGBTQIA+ congregants (Yarhouse & Sadusky, 2020). Moreover, the church has been at the forefront of leading the discrimination and condemnation of LGBTQIA+ members. This discrimination has led many to leave the church and become involved in self-harming behavior, ongoing mental health struggles, and worst, suicide. Educating clergy members and spiritual leaders can lead to positive health outcomes for the LGBTQIA+ community.

Methods: This project used a convenience sample of clergy members to conduct an educational presentation and post assessment.

Results: The overarching response post of the educational presentation was that the clergy members were more aware of the impact of the church on LGBTQIA+ individuals and were better equipped to recognize at-risk behaviors thus leading to better health outcomes.

Conclusion: There are gaps in the education of clergy members in their educational pursuits during seminary when it comes to LGBTQIA+ congregants. Overcoming the barriers, reducing bias and discrimination, and cultivating a safe space for LGBTQIA+ members can improve health outcomes. This project identifies areas of opportunity for clergy members' training and education that can be improved, e.g., having intentional communities, community resources, and cultural competence versus cultural humility.

Keywords: religious leaders, LGBTQIA+, health outcomes, church, religion, mental illness

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Problem Recognition

"God is love" is a refrain many people in the United States (US), as well as around the world have come to embrace and use as comfort. Yet, many who identify as *lesbian, gay, bisexual, transgender, queer, plus* [plus other sexual minority groups] (LGBTQIA+) would beg to differ. Frequently, when an individual identifies as belonging to the LGBTQIA+ community in the context of religion and faith, he or she often experiences spiritual discrimination and is "damned and cast out" (Cole & Harris, 2017). According to studies conducted on religious leaders, ministers often are reactive to the labels that members of the LGBTQIA+ community use and are often unsure of the meaning themselves, making it difficult to understand and communicate with their "flock" but more importantly their LGBTQIA+ members (Yarhouse & Sadusky, 2020). Sadly, when leaders talk about LGBTQIA+ members, they use terminology that says, "you are not welcome here" not only as a member of the church but also in God's eyes. It is incumbent on religious leaders to right this wrong by becoming more aware of the harm being meted out to their LGBTQIA+ members and creating safe spaces for LGBTQIA+ members, whoever and whatever they identify as or with, to ensure a culture of inclusivity rather than divisiveness (McRay & Ruff, 2021).

Background

The LGBTQIA+ community continues to grow exponentially year after year and makes up a large percentage of the population within the US. Romanelli and Hudson (2017) reported it is estimated that 2.1% to 3.0% of adults identify as LGB and 0.6% as transgender. These gender and sexual minority groups are at increased risk for poor health outcomes, increasing health disparities, and marginalization due to criticism,

discrimination, and prejudices they encounter as a direct result of their perceived violation of dominant social norms (Sumerau, 2016). These social norms have often alienated members of the LGBTQIA+ community.

Even though the LGBTQIA+ population is growing worldwide, the data continuous to be limited. This is due to various reasons such as members of the community not wanting to "out" themselves or not enough research being dedicated to this community. Research shows, as age increases, the number of people who refuse to answer or choose "don't know" when asked about LGBT status increased from 3.2% (30-49 years) to 6.5% (65+ years). In the United States (US):

An estimated 3.4% of the population identifies as lesbian, gay, or bisexual.

- In 2010, approximately 950,000 persons identify as transgender individuals,
- 8.3% of 18–29-year-old women identified as LGBT individuals,
- 4.6% of 18–29-year-old men identified as LGBT individuals,
- 3.2% of 30–49-year-olds identify as LGBT,
- 1.6% of 65+ individuals identify as LGBT, and
- The 2010 US Census found same-sex households are present in 93% of all US counties (Jann et al., 2019).

The data is clear, there is an increasing number of people and especially youth identifying with the LGBTQIA+ community, and many youths affirm their identity and sexual orientation early in life. For many youths from conservative Christian backgrounds, this process can be a long and tedious journey as they navigate religious, familial, as well as communal expectations of heteronormativity behavior (Etengoff, 2020).

Religion is considered one of the cultural norms that impact how the LGBTQIA+ community is viewed and how attitudes are impacted. The non-affirming Christian church adds to the increasing stress of individuals who are navigating the intersection of sexuality, gender, and spirituality. Research indicates that people who identify as LGBTQIA+ will choose to leave the church because of the lack of acceptance and affirmation (Hinman & Lacefield, 2020). Many churches have created position statements and have taken a firm stance preventing people who identify with the LGBTQIA+ from taking a leadership position, requiring them to be celibate, and refusing to recognize or perform same-sex marriages. This has led to many individuals internalizing negative feelings about who they are and their right to exist, causing cognitive dissonance (Hinman & Lacefield, 2020).

Many LGBTQIA+ individuals find themselves at the intersection of gender, sexuality, and religion. In a large national study, 86% of sexual minorities (SM) report being raised in the church from childhood while only 75% of the general population report being raised in the church from childhood. Half of these SMs will leave the church before they are 18 years old which is twice as high as their straight counterpart. In addition, less than one out of five will attend weekly religious services and approximately 40% of SMs identify as atheist, agnostic, or 'nothing in particular." Lots of conflicts have developed over the years as the LGBTQIA+ community continues to grow and expand and become more visible. Conflict arises due to negative personal feelings, theological teachings, scriptural passages, institutional misgivings, and congregational prejudice (Dean et al., 2020).

Religious leaders' knowledge and sensitivity regarding the LGBTQIA+ population are limited at best (Sprinkle, 2017). This lack of knowledge can lead to cultural incompetence and an atmosphere of exclusion among the LGBTQIA+ community. Cultural competency and cultural humility are tools that are needed in religious circles in order to respond effectively and respectfully to members of the LGBTQIA+ community to recognize and affirm their worth and value in the church and the world at large. (Dessel et al., 2017).

Identifying as a member of the LGBTQIA+ does not mean one does not want to identify with their Christian faith. In fact, the opposite is true; many LGBTQIA+ individuals want to identify with their faith but they are often precluded from doing so. In order for LGBTQIA+ members to continue identifying with their faith, the church has to become a place of inclusion and safety. In addition, the church must provide a supportive environment where congregants can escape the fear of homophobia and marginalization (Barbosa et al., 2018). Research shows that having a protective, supportive religious climate can be a protective factor against negative behavior (Schmitz & Woodell, 2018).

In one study 12% of SMs said feeling loved would bring them back to church, 9% asked to be given time, 4% wanted the support of family and friends, 5% desired permission to be their authentic selves, 6% asked for a cessation of attempts to change their sexual orientation, and 8% said their return would require a change in their faith community's theology (Dean et al., 2020). This study revealed that LGBTQIA+ congregants are not asking for radical changes but just to feel acceptance and love for who they are. Afterall, isn't that what we are called to do? "Love your neighbor as yourself."

Statement of the Problem

Clergy members play an important role in caring for members of their congregation, especially their LGBTQIA+ members. Research indicates that religious involvement is a protective factor against poorer physical and mental wellbeing (Dean et al., 2020). However, many clergy members lack the training and education needed to provide competent care and advance their knowledge when it comes to their LGBTQIA+ congregants. This has led to stigmatization by various religious groups. As a result, members of the LGBTQIA+ community experience discrimination, criticism, prejudice, and marginalization. They feel devalued and discredited by their houses of worship (Sumerau, 2016). This stigmatization and discrimination can lead to high suicide rates, especially among teens and young adults who identify as lesbian, gay, bisexual, trans, or queer (Marshall, 2017). They may also experience lower levels of psychological wellbeing and higher levels of distress such as anger, shame, humiliation, and self-blame (Dean et al., 2020). An increase in clergy members' awareness, knowledge, and sensitivity regarding LGBTQIA+ issues and identity can lead to the improved emotional and physical well-being of their LGBTQIA+ members.

Literature Review and Synthesis

Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender identities and groups (LGBTQIA+) continue to face high rates of mental illness and specifically suicidality (Labouliere et al., 2018). Affirmative and safe spaces in the LGBTQIA+ community continue to be elusive. Individuals tend to fare better when they can identify protective factors. Religion is one such factor. However, religious leaders often lack the education and skills to care for these citizens (Sprinkle, 2017). To address

the needs of this community, religious leaders need to have adequate education focusing on the needs of LGBTQIA+ people (Brown et al., 2021).

The purpose of this literature review is to examine the research based on the effect of the education of religious leaders on increasing their knowledge and confidence in providing quality care to members of the LGBTQIA+ community. The literature review gives an overview of the acronyms LGBTQIA+ and examines the current education provided to religious leaders and the impact on members of the LGBTQIA+ community. Throughout the review, themes have been highlighted in the research, which points out limitations in the existing literature and explores potential directions for future research. Keywords for the literature review include mental illness, suicide, LGBTQIA+, education, healthcare professionals, nursing, doctors, religious leaders, Christianity, church, religion, outcomes, inequities, and culture through the use of the database Cumulative Index to Nursing and Allied Health Literature (CINAHL) complete research.

LGBTQIA+ Acronyms and Their Meaning

The term LGBTQIA+ plus will be used throughout this paper to represent the myriad of ways in which sexual and gender groups and individuals identify themselves. Following will be a brief explanation of the terms.

- L: Lesbian, represents a woman who is attracted to other women which include transgender women.
- G: Gay, used to describe men attracted to other men including transgender men.
- B: Bisexual, represents an individual who is attracted to more than one gender.
- T: represents transgender, Transgender refers to a person who experienced or expressed gender differs from the sex assigned at birth. In the United States,

150,000 young people and 1.4 million adults identify as transgender and 24% of transgender individuals report unequal treatment in healthcare environments, 19% report refusal of care, and 33% report they do not seek preventative services (Klein et al., 2018).

- Q: Queer/Questioning; Queer is an umbrella term for someone who does not identify with the two genders and Questioning is someone who is still exploring their sexuality.
- I: Intersex is a term for people born with both genitalia.
- A: Asexual or allies; Asexual is a person who does not experience sexual attraction, allies are persons who are not LGBT but who actively support the LGBT community.
- The + sign represents other gender and sexual identity groups that continue to evolve (Daley, 2017).

Gender Dysphoria

It is important that gender dysphoria be discussed here to understand the context of someone who identifies as transgender. Gender dysphoria is a term that refers to a condition in which an individual has marked incongruence between their expressed or experienced gender and the sex they were assigned at birth (Kaltiala-Heino et al., 2019). Gender dysphoria varies from individual to individual and must meet certain criteria. It can be diagnosed by a mental health professional or a primary care doctor. Gender dysphoria can cause significant distress in an individual especially when they are prohibited from experiencing their preferred identity/gender (Yarhouse & Sadusky, 2020).

Clergy Training and Experiences

The United States theological seminary schools rarely if ever teach on the topic of LGBTQIA+ individuals. In fact, in 2016, not so long ago, Brite Divinity School in Fort Worth, Texas made the news in their fall semester when they tackled the topic and had a class entitled "Ministry in the LGBT Community" (Sprinkle, 2017). There is still a vast divide between religious organizations and what is being taught on Christian school campuses. In fact, it is difficult to find literature representing what is being taught to new religious leaders on this topic. What is known is that many Christian schools have responded to the challenges of sexual and gender diversity by adopting position statements on sexual orientation and gender identity (SOGI) defining marriage as between one man and a woman (Smith, 2021).

Smith (2021) reported that the Alliance Defending Freedom (ADF) which is a legal group that has influenced conservative Christian schools, published documents urging churches to adapt statements and positions against sexual and gender ideology. Following these published documents, the Association of Christian Schools International (ACSI) which has over 3,000 member schools and over 24,000 internationally, mandated its members to adopt statements based on the ADF's statements and positions against sexual and gender ideology (Smith, 2021). These stances that the Christian schools have adopted have been detrimental to sexual and gender minorities.

Many of the schools in which ministers are trained are Christian colleges and universities and as such are under no obligation to accept LGBTQIA+ students. In fact, in 1980 a court ruled against students at Georgetown University (a Catholic university) who had sued the college for refusing to recognize an LGBTQIA+ group. The ruling stated

that religious institutions have the ability to discriminate against students on the basis of their sexual orientation (Coley, 2020). Gender and sexual minority students in Christian institutions reported higher rates of suicidal ideations and self-harm behaviors due to the discrimination and negative behaviors they experience on campus (Yarhouse et al., 2021).

Theology schools across the globe have been having a difficult time addressing the LGBTQ+ agenda. In fact, Princeton Theological Seminary (PTS) barred the ordination of "out" homosexuals for 28 years until it was changed by the General Assembly in 2006 (Wall, 2018). While student groups on college and university campuses have brought about significant changes through student-led groups and organizations, there is still much more work to be done on Christian school campuses. Studies show that students who identify as LGBTQIA+ on non-affirming campuses face bullying, harassment, and rejection often leading to mental health issues and poor social, psychological, and health outcomes (Coley, 2020).

In addition, Etengoff (2020) cites that an estimated 200 American college campuses continue to bar students who openly identify with the LGBTQIA+ community. In fact, some students are asked to choose between suspension/expulsion or conversion as well as mobility and /or housing restrictions. These policies according to Etengoff may lead to social isolation/marginalization, violence, bullying, risky sexual behavior, depression, anxiety, and suicide (Etengoff, 2020).

Creating safe spaces within Christian colleges, universities, and yes, churches is important for the wellbeing of the LGBTQIA+ individuals who chose or felt called to these spaces. It is imperative that ministers and church leaders who provide care to members of the LGBTQIA+ population through their ministry have the training they

need to reduce disparities, stigma, discrimination, and create a space where members of the LGBTQIA+ community feel valued and respected. Studies reveal that homophobic behaviors can lead to negative consequences and self-destructive behaviors in the LGBTQIA+ population (McDermott et al., 2008).

LGBTQIA+ Individuals and the Church

Persons who are at the intersection of LGBTQIA+ and Christianity often experience discrimination and marginalization in the church in which they grew up and called home. While there has been some progress made on legal equality, in terms of the marriage equality act in the United States; there is ongoing disagreement, division, and fracturing over the understanding of the scriptures and society's positions on their long-held belief (Harris et al., 2020). In fact, there are still African, Caribbean, Asian, and Pacific nations who still criminalize same-sex marriages and relationships (Williams et al., 2020).

An extensive literature review has affirmed religion has a strong influence on society's attitude and views toward the LGBTQIA+ community. Studies have demonstrated that the more religious a person is, the more opposed they are to same-sex marriages (Perry & Schnabel, 2017). In fact, these deeply religious persons often disagree on biblical interpretations, understandings of God, human sexuality, and what it means to live a moral life (Marshall, 2017). The old adage by Martin Luther King Jr. comes to mind and is probably still true today, that there is no greater segregated time in Christian America than Sunday mornings at 11:00 AM.

Gender and sexual minority groups are at increased risk for poor health outcomes, increasing health disparities, and marginalization due to criticism,

discrimination, and prejudices they encounter as a direct result of their perceived violation of dominant social norms (Sumerau, 2016). Religion is considered one of the cultural norms that impact attitudes toward the LGBTQIA+ community. The Christian church that is non-affirming adds to the stress of individuals who are navigating the intersection of sexuality, gender, and spirituality. Many sexual and gender minority Christian individuals will leave the Church due to a lack of acceptance and affirmation leading to the internalization of negative feelings and cognitive (Hinman & Lacefield, 2020).

This internalization of negative feelings often leads to a plethora of physical and emotional pain, including stigmatization, stress, anxiety, depression, and even suicide. Many members of the LGBTQIA+ community live in fear of being "outed." This fear causes them to live in hiding, preventing them from receiving education, prevention, and treatment for Human Papilloma Virus (HPV) and other diseases. Studies indicate that LGBTQIA+ individuals have higher rates of sexually transmitted infections, higher rates of disordered eating behaviors, higher rates of obesity, lower rates of mammograms, and pap tests than their heterosexual counterparts (Nagata, 2017). Additionally, members who identify as Christians often feel rejected by the one place they felt they would be accepted: the church.

Another phenomenon that contributes to the negativity faced by LGBTQIA+ individuals is Sacramental Shame. Shame can be a very painful emotion as members of the LGBTQIA+ community feel a sense of fear of rejection from their community and they do not feel "good enough". Sacramental shame is a spiritualized form of shame that grows out of a need to protect theologies. When sacramental shame becomes internalized

it causes LGBTQIA+ individuals to become disabled from seeing who they are and from trusting what they are seeing in front of them. Sacramental shame can be very complicated as it poses on one hand as love while locating shame in the LGBTQIA+ individual to change who they are to be loved and welcomed and to be called a "child of God" (Moon & Tobin, 2018)

Religion and Medicine

Religion and medicine have historically been intertwined and share similar functions of caring. Both religion and medicine foster ways of coping with suffering, despair, and death, and seek to find hope, meaning, and purpose. Both are concerned about healing across the life span (Norko, 2021). Norko (2021) wrote that there are serious risks to the well-being of LGBT youth such as depression, suicidal thoughts and attempts, lower levels of education achieved, and lower income when ministers attempt to change the young person's sexual orientation. This is one of the main reasons conversion therapies were rejected by the American Psychological Association (APA) among others (Norko, 2021).

Studies have demonstrated that negative attitudes toward gender and sexual minorities are often internalized and can lead to psychological stress such as depression and suicide due to internalized homophobia and personal conflict between religious and sexual identity (Minton et al., 2017). Minton et al. (2017) conducted a literature review to explore the conflict between marketplace inclusion (for LGBT consumers) and freedom of religion (for religious providers). They found that often religious and LGBTQ+ identities clash causing the individuals to change service providers. The researchers created a conceptual framework to stimulate quantitative and qualitative research at the

intersection of the LGBTQ+ marketplace and freedom of religious conflicts in services. They suggest that for future research, researchers should examine other constraints as it relates to LGBTQ+ and other freedoms (Minton et al., 2017).

In older sexual minorities, religion has been cited as a source that may improve or protect their wellbeing, especially during stressful times and using adaptive coping skills such as religion. This may be explained through the sense of community and social connectedness offered through religious involvement which can lead to more satisfaction, greater optimism, greater self-worth, lower death anxiety, and a deeper sense of meaning to life in the older sexual minority (Escher et al., 2018).

LGBTQIA+ Experience of Religion and Its Outcome

Christian sexual minorities often face tremendous criticism, discrimination, and prejudice, and feel devalued, discredited, stigmatized, marginalized, and rejected (Sumerau, 2016). Researchers have found that religious and spiritual communities that openly affirm sexual minority individuals could reduce homonegativity and improve sexual health outcomes (White et al., 2019). In one study conducted by Yarhouse et al. (2021), a sample of 31 undergraduate transgender students completed an online survey. They were from nine Christian institutions in which staff was affiliated with the Association for Christians in Student Development. The participants reported high levels of religiosity, negative perceptions of campus climate, diversity in their attitudes about gender identity, lower levels of social support for gender identity than in general, moderate to high levels of psychological distress, and low to moderate levels of psychological well-being. One sample in the study conducted by Yarhouse et al. (2021) reported high rates of suicidal ideation and self-harm behaviors. The limitation of this

study is that it was a small sample size and therefore limited generalizable. In addition, since the recruitment email was sent from student development this may have impacted recruitment. The researchers recommended that future research could add a comparison group of transgender and gender-diverse students who attend non-faith-based colleges and universities (Yarhouse et al., 2021).

Another study conducted by McGraw et al. (2021) among LGBTQ+ youths attending The Church of Jesus Christ of Latter-day Saints (LDS) found that participants reported higher family conflict and lower parental closeness which was linked to higher levels of depression, self-harm, and substance misuse. These three factors were associated with higher levels of suicidal thoughts and behaviors (STBs) for LGBTQ youth in Utah. The representative sample in the study by McGraw et al. (2021) consisted of 73,982 middle and high school youths in Utah. The limitation of this study was that the cross-sectional and observational design used makes it impossible to determine any causal relationships and therefore recommends follow-up and multiple waves of data collection. The strengths of this study included the large sample size and using best practices regarding missing data they were able to reduce any chances of survey bias (McGraw et al., 2021).

LGBTQIA+ and the Church

Studies have shown that individuals who are active churchgoers experience lower rates of morbidity and mortality than those who are not (White et al., 2019). For members of the LGBTQIA+ community who consider themselves Christians, they may, however, not find these spaces to be welcoming and in fact, could be detrimental to their health. White et al. (2019) conducted a study to explore the role of LGBT-affirming churches in

the lives of Black sexual minority men (BSMM). They conducted nine focus groups in Baltimore Maryland. Three themes were identified:

(1) preferring traditional church environments over LGBT-affirming churches,
(2) experiencing the LGBT-affirming churches as a space of acceptance, emotional healing, and modeling loving same-sex relationships, and
(3) perceiving LGBT-affirming churches as opportunities to engage community members to promote the wellbeing of BSMM.

White et al. (2019) concluded from their study that their results supported other research on the topic that calls for culturally congruent peer-based interventions for BSMM. They stated that future research exploring how LGBT-affirming churches could better support BSMM is important. The limitations of the study included the fact that the study was a purposive sample of BSMM selected in a single urban city who were primarily of Christian denominations. Different organizations may have yielded different results and therefore the study could not be generalized (White et al., 2019).

As more and more churches grapple with the increasing numbers of LGBTQIA+ congregants, many churches have sought to undergo a period of discernment to consider the way forward. Harris et al. (2021) conducted a qualitative research study of 97 interviews in 20 congregations across the United States in three denominations. These denominations included the Cooperative Baptist Fellowship (CBF), Alliance of Baptists, and Southern Baptist Convention (SBC) traditions. The researchers interviewed one minister, one leader, and one congregant from each congregation. The researchers used a convenience sample followed by a snowball sample. The researchers found that the importance of faith and the identity of the church was important to the congregants. In

addition, they found that congregants believe that a commitment to social justice included advocacy for those with mental illness. The respondents in this study also reported the challenge of making difficult decisions that would result in the loss of members who did not agree and also financial losses. The strengths of this study included diverse research team members, checks and balances provided through more than one person to limit bias, and the completion of 97 interviews. Limitations of the research included the use of a convenience sample resulting in a sample of churches and participants who closely mirrored the religious affiliations of the research team as well as a lack of diversity among the participants. The implications for this study and ongoing research are that there is a greater need for lessons learned and resources available as well as the fact that there is growth and change and that there can be positive outcomes to balance the losses of some members and revenues (Harris et al., 2021).

Dean et al. (2020) noted that sexual minorities (SM) are not unchurched and in fact, 86% report being raised in the church while only 75% of the US population reports the same. The researchers also noted that 50% of SMs will leave the church by the age of 18, a rate twice as high as their heterosexual counterparts. Many will end up leaving their faith and 40% of SMs identify as atheist, agnostic, or “nothing in particular.” They are probably leaving due to the conflict between their faith, their sexual and gender identities, and the Church’s difficulties in helping them navigate this conflict. The conflict stems from negative personal experiences, theological teachings, scriptural passages, institutional misgivings, and congregational prejudices (Dean et al., 2020).

Barriers to Change

The churches in the United States are having tremendous conflict between Christian fundamentalists and members of the LGBTQ+ community now more than ever before. Levand and Dyson (2020) noted four main barriers that prevent the church from changing and accepting its LGBTQ+ members. They include:

(1) Fear (i.e., fear of the administration, fear of job termination, or fear of the local bishop),

(2) Conservative constituents (i.e., faculty/administration, student groups, donors, parents, public defenders of Catholic orthodoxy),

(3) Administrative resistance, and

(4) Organizational barriers (i.e., language issues and poor organization (Levand & Dyson, 2020).

Levand and Dyson conducted qualitative, semi-structured interviews with 31 employees of Catholic colleges and universities who were attempting to affect change at their schools around sexuality. They used an ecological-psychological framework that focused on human behavior in relation to their environment. The researchers obtained participants by using a snowball sampling method; there were 31 participants from 17 different institutions of Catholic colleges and universities. Limitations of this study involved the sampling method used which resulted in participants connecting to like-minded people and limiting individuals with different views (Levand & Dyson, 2020).

Religious conflict abounds because of the different viewpoints faced in many churches today due to diverse religiosity. Religious conflict can cause hurt and pain between people and groups who hold different religious views. In its extreme forms, it

may even lead to violence and war in the church community, different views over same-sex marriages, and ordination of sexual and gender minorities can lead to division and conflict within the church (Zhang et al., 2015). It is therefore important for clergy members to identify factors that can help their congregants resolve conflicts and to alleviate the negative effects of religious conflict.

At the Intersection of Christianity, LGBTQIA+, and Black

One may ask, why single out one race in the discussion over another? The simple answer is that black churches have been shown to have more homonegativity and stigmatization than some of the other churches (White et al., 2019). There has been a disproportionate rate of discrimination, harassment, and marginalization within racial/ethnic minority groups and those who identify as LGBTQIA+ in the United States (Kuper et al., 2013). When it comes to the church, the homonegativity, stigmatization, and discrimination faced by LGBTQIA+ African American members have led to reduced self-acceptance, increases in sexual risk-taking, and poor health outcomes (White et al., 2019).

In the black community, church attendance is an integral part of their lives. The church has been a place of emotional and spiritual healing, political activism, and cultural pride and has provided a sense of community and support against racism (White et al., 2019). However, when it comes to gender and sexual minorities many black churches have drawn a line. The stigma these black LGBBTQIA+ Christians encounter often causes them to withdraw from otherwise positive protective factors and therefore undermine their overall health and well-being (White et al., 2019).

Being black in the United States comes with its own set of challenges. Being at the intersection of race, sexual minority, and Christianity, increases those challenges and stressors experienced by the LGBTQIA+ black population. This intersectionality makes them more susceptible to mental health concerns (The Trevor project, 2020). In a survey conducted by The Trevor project in 2020, the results indicated that LGBTQ black youth had a rate of depression and suicidality similar to all LGBTQ youth. Sixty-six percent reported depressed mood, 35% reported seriously considering suicide in the past 12 months and 19% reported a past year suicide attempt (The Trevor project, 2020). However, when it came to transgender and /or non-binary youth, black transgender and/or non-binary youth reported twice the rate of seriously considering (27% vs. 59%) and attempting suicide (15% vs. 32%) (The Trevor project, 2020). As if it could not get worse, black LGBTQIA+ youths were significantly less likely to receive professional care (47% vs. 39%) (The Trevor project, 2020).

Clergy Attitudes About Ways to Support Mental Health of Sexual and Gender Minorities

The data is clear that a non-affirming church can have devastating consequences for the lives of LGBTQIA+ individuals. Clergy members play an important role in guiding their church and bringing awareness, sensitivity, and knowledge about the impact of the church on the health outcomes of Christian LGBTQIA+ members. Clergy members' attitudes can help to decrease the stigma and discrimination LGBTQIA+ members faced which in turn can lead to a reduction in the rates of mental illness, substance abuse, and suicides (Raedel et al., 2020). Obviously, mental health issues that

are associated with a non-affirming church for LGBTQIA+ individuals in the United States are a public health crisis that needs to be addressed.

It is believed that a partnership between the public health community and clergy members is an important vehicle for addressing public health concerns with the LGBTQIA+ community. Church communities have been shown to be effective in improving access to healthcare services, promoting healthier lifestyles such as smoking and weight loss, as well as reducing substance abuse and rates of HIV/AIDs through collaboration with public health organizations (Raedel et al., 2020). Clergy members are thus a vital part of deciding whether the church serves as a protective factor or a risk factor to members of the LGBTQIA+ community.

In a study conducted by Raedal et al. (2020), 78 clergy members from various denominational backgrounds were participants. The purpose of the research was to expand on possible resources for sexual and gay minorities provided to religious clergy and in places of worship. What they found was that clergy members thought that workshops, data summaries, and individual meetings among others would be helpful in their quest to provide a more welcoming and affirming space. Suicide prevention information was found to be more significantly helpful followed by resources on homelessness and in-person workshops on transgender people (Raedel et al., 2020). The researchers recommend that psychologists and physicians should designate a trusted provider within the community to educate clergy members and the broader faith community and serve as a resource to clergy members (Raedel et al., 2020).

There were limitations identified by the researchers in this study; one was the small sample size which made it difficult to generalize the study to other denominations.

In addition, Christianity was the only faith represented by the participants and therefore conclusions could not be drawn for other faith communities. The researchers suggest that the current research should be expanded to address the mental health issues of sexual and gender minorities and develop effective programs to address these issues. They concluded that clergy members are an important part of the local community who provide the spiritual and religious needs of their parishioners who are sexual and gender minorities as well as their families. In addition, social networks and other allies need the education and tools to support positive health outcomes and benefit the health and wellbeing of the LGBTQIA+ community (Raedel et al., 2020).

Ministry Recommendations

For churches and congregations who choose to establish an affirming congregation for the LGBTQIA+ community, Yarhouse and Sadusky (2020) suggest the following: (1) minister to the person rather than the label, (2) minister to questions associated with milestone events, (3) emphasize relationships in ministry to youth navigating sexual identity and faith, (4) co-create a ministry climate that is emotionally and spiritually safe, (5) emphasize multiple pathways for holiness, (6) emphasize discipleship in ministry to youth navigating sexual identity and faith, and (7) move towards a stewardship model.

Dean et al. (2020) conducted three national studies, one with the Council for Christian Colleges and Universities (CCCU), the second with the Association of Christians in Student Development (ACSD), and the third was a larger, longitudinal investigation. The longitudinal sample consisted of 160 students; all participants were Christians and currently enrolled at CCCU and experienced same-sex sexual attraction

(SSA). The study lacked diversity and was mainly made up of Caucasian individuals making it difficult to generalize. In addition, as the sample was self-selective, only some students were willing to participate. The themes that emerged from the study included:

- Faith matters,
- Complexity of identity integration (some students held both identities separately),
- Supportive relationships are important in navigating conflicts and integrating identities,
- Self-acceptance was important in a sense of being accepted and supported; social support seemed to lessen the experience of microaggression,
- Intentional communities that "hold" persons where they are in their current identity development while encouraging the next steps in the process,
- Intentional relationality creates the conditions for Christian fellowship and companionship through social support and positive relationships,
- Intentional security that provides security and safety for all, and
- Intentional formation is where the goal is to develop the "whole" person (Dean et al., 2020).

Cultural Competence Versus Cultural Humility

Many churches and organizations often embark on cultural competency training to bring their congregants, leaders, or employees to meet the standards for diversity training. Many organizations today are realizing that cultural competence alone is not enough when dealing with minority groups who are often marginalized and stigmatized. Greene-Moton and Minkler, (2019) wrote that cultural competence ensures an understanding, appreciation, and respect for cultural differences and similarities. On the

other hand, cultural humility is a process of critical self-reflection and lifelong learning resulting in mutually positive outcomes (Foronda, 2019; Green-Moton & Minkler, 2019).

It is imperative that clergy members embark on a quest to not only be culturally competent but also to have cultural humility especially when it comes to members of the LGBTQIA+ community. The following assumptions correspond with the cultural humility theory.

- All humans are diverse from each other in some way yet part of a global community.
- Humans are inherently altruistic.
- All humans have equal value.
- Cultural conflict is a normal and expected part of life.
- All humans are lifelong learners (Foronda, 2019).

Project Design

PICOT Question

Among spiritual leaders caring for LGBTQIA+ parishioners (P), how does a targeted psychoeducational learning experience (I) compared to usual training (C), impact confidence levels in caring for LGBTQ+ members (O) after an educational presentation (T)?

Setting

The setting for this quality improvement project is a local church located in the Southeastern United States. The church location employs seven clergy members with various titles and responsibilities. There is a senior pastor, two executive pastors (Executive Minister of Community and Engagement and Executive Minister of

Caregiving and Leadership), two associate pastors (Campus Administrator and Associate Minister of Spiritual Growth and Outreach), a youth minister (Minister for Youth and College Ministries) and a Minister of Music.

Target Population/Community

The population of interest in this project is clergy members at the practice site. The practice site currently employs seven clergy members. The inclusion criteria required that clergies are currently employed by the practice site and engaged in congregational care. The setting of this project was a church in the Southeastern United States. The project site provides pastoral services for members of the congregation. The congregation consists of members from various economic, cultural, spiritual, and racial backgrounds.

The stakeholders in this project are the senior pastor, church leaders, project leaders, and support groups. Refer to Table 1 for a list of stakeholders.

Table 1

Stakeholders

Internal	External
• Senior Pastor • Church leaders • Project leader • Church members and families	• Support groups • Social Networks and Allies

The senior pastor was a vital part of the project and was a project partner, to address any foreseeable barriers and help with navigating the project setting. The senior pastor was the lead pastor of the Church in which the project was implemented. Other church leaders were key stakeholders as they are impacted by the training they received, in caring for members of their LGBTQIA+ members. The project chair was important in

helping to guide the project and provide valuable feedback during the project formulation. The LGBTQIA+ members and their families are the main ones who will benefit from the church leaders having this increased knowledge, sensitivity, and awareness. Support groups also benefit in their aim of reducing negative outcomes in the LGBTQIA+ population. The interests of LGBTQIA+ members and their pastors were given priority as their needs are weighed more heavily.

In carrying out a project, one has to bear in mind many factors that could impact the project such as time constraints, the views of the wider society, and the views of other members of the church congregation involved. Stakeholders may use the information from the training to bring awareness and cultural humility to its members in order to reduce negative physical and mental health concerns for the LGBTQIA+ community. Developing awareness, sensitivity, and knowledge for the church leaders will be crucial to thwart the negative experiences of LGBTQIA+ churchgoers. During the design stages of the project, there was frequent collaboration and engagement among the various stakeholders for the successful completion of the project.

SWOT Analysis

This project utilized the Strengths (S), Weaknesses (W), Opportunities (O), and Threats (T), SWOT analysis method, a tool developed in the 1960s as a business strategy to assess and analyze the similarities and differences between an organization and its competitor (Williams et al., 2020). The SWOT analysis provides awareness and identifies critical problems that may impact the project, focuses on both the positive and negative facets of the internal and external environment, and aids in the recognition of opportunities in conducting the study (Williams et al., 2020). Strengths and opportunities

are facilitators to help in achieving goals whereas weaknesses and threats are barriers to achieving goals (Williams et al., 2020). These strengths, weaknesses, opportunities, and threats are highlighted in Table 2 below for this project.

Table 2

SWOT Analysis

Strengths	Weaknesses
• Some programs already exist • Effective models from other sources (CDC) • Effective community-level programs and initiatives (PFLAG) • Existing standards of care • Mental Health service hotlines	• Lack of culturally sensitive educational material • Mental health is not as readily available for the underserved. • Not enough county and LGBTQIA+-specific data • Time constraints of spiritual leaders • Lack of necessary level of professional expertise
Opportunities	**Threats**
• Provide ongoing educational opportunities for church leaders • Involve and coordinate with other organizations • Increase counselors in churches • Increase diversity in church leaders • Influence attitudes and broaden acceptance	• Lack of personnel • Society's lack of support and stigmatization • Lack of effective policies • Time constraints • Legislators uneducated on issues • Personal biases, attitudes • Available resources

Available Resources

Resources are a crucial part of the implementation of any project. The educational presentation was carried out at the project leader's dwelling where all the major electronics such as computers, large screen television, and other necessary equipment were readily available. There was minimal financing for printing materials and marketing

supplies. In addition, there was a small financial cost for lunch/snacks for the participants. Essentially, the out-of-pocket cost was minimal.

Desires and Expected Outcomes

The desired and expected outcomes of the intervention are:

- To increase church leaders' knowledge, awareness, and sensitivity to LGBTQIA+ challenges.
- To decrease bias against the LGBTQ+ community.
- To create cultural competency and cultural humility for church leaders on LGBTQ+ topics.
- To improve health outcomes and wellbeing of Christian LGBTQIA+ members.

Team Selection

Team selection and formation are important for the success of the project and proceeded through four phases: forming, storming, norming, and performing. The team and project leader will ultimately be responsible for the outcome (Zaccagnini & Pechacek, 2021). The team selected are listed below:

- Project Leader
- Project Chair
- Senior Pastor at the project site

Cost/Benefit Analysis

The cost/benefit of this project cannot be understated. As mentioned in the available resources section, most of the resources needed will be readily available and on-hand, and there was a minimum cost associated with the project to include the participants' time, a small meal/snack, and incidentals such as printing materials. The

benefits far outweighed the costs associated with the project. Some of these benefits included increased awareness, decreased bias, decreased minority stress, increased knowledge and sensitivity, the creation of allies for the LGBTQ+ population, and the creation of safe spaces for LGBTQ+ members.

Scope of Project

This project was undertaken to increase spiritual leaders' knowledge of the unique needs of members of the LQBTQIA+ community in an effort to reduce stigmatization and mental health and wellbeing in the LGBTQIA+ population. The project is not designed to change one's views on homosexuality or gender and sexual minority issues. Instead, the project is aimed at helping religious leaders to become aware of their implicit bias and allow them to become comfortable caring for LGBTQIA+ individuals.

Goals, Objectives, and Mission Statement

Goals of the Project

The overall goal of this project was to increase religious leaders' knowledge and understanding of the needs of members of the LGBTQIA+ population thus reducing bias and fostering a more caring congregation which may translate into a reduction in stigmatization, mental illness, and suicidal behaviors faced by members of this community. The purpose of this project was to improve the experiences that LGBTQIA+ congregants experience within their house of worship through the education of members of the clergy.

Outcome Objectives

After participating in the educational presentation, the religious leaders who participate will:

- have a better understanding of the mental health needs and risk factors of the LGBTQ+ community as evidenced by the post-intervention questionnaire,
- become more aware of their implicit bias in caring for members of the LGBTQIA+ community,
- have increased knowledge of what the acronyms in LGBTQIA+ represent evidenced by the post-intervention questionnaire, and
- Church leaders will be able to appreciate the need to create safe spaces within their church.

Mission Statement

This project is intended to serve as an educational tool for spiritual leaders who care for LGBTQIA+ individuals and their families to reduce bias and stigmatization as well as decrease health disparities and inequality in the care they receive. In reducing bias, and stigmatization, better health outcomes among LGBTQIA+ individuals will be possible. Religious leaders will achieve and sustain a caring environment for all the people who come into their care.

Project Timeline

The project leader met with the project chair, senior pastor, and other stakeholders to discuss the project implementation in the last week of July 2022. The project leader reiterated the goals of project, the format, as well as measurements for the project. The team had the ability to ask questions and finalize any details prior to the implementation of the project. Prior to the implementation of the project, a flyer was emailed to the participants regarding the date, time, location, project objectives, and post survey.

The workshop was implemented in the second week of August 2022. The project leader created a packet to include the PowerPoint, a thank you letter, consent, and a brochure to be handed to the participants on the day of the presentation. The project leader sent a reminder a week before the project was to be implemented and again 2 days prior to the implementation.

On the day of the implementation of the project, the project leader welcomed the participants at the door and offered a light refreshment. The project leader gave the stakeholders a tour to find the amenities they may need during the implementation of the project. Once all the participants were seated, the project leader gave some basic ground rules and expectations for the project. The project leader explained the post survey and explained it was voluntary and anonymous. The survey items were handed out to the participants after the presentation and they placed them in a basket that was close to the exit door. A meal was provided during the presentation and participants were allowed breaks during the presentation.

After the presentation, the post-educational questionnaire items were collected and placed in a locked and secured drawer. The questionnaire was later scanned into a file-protected computer. Data aggregation began in the middle of September and results were shared with the project chair.

The tools utilized in this project included educational materials and a survey developed by the project leader and was determined to be valid by the project leader and project chair. The educational material consisted of a PowerPoint presentation, one brochure, and a guide for clergies in increasing awareness, sensitivity, and knowledge on LGBTQIA+ topics. These items were created by the project leader with guidance from

the project chair and contained evidence-based content on the LGBTQIA+ population to train the clergy members. The duration of the educational session was approximately 45 minutes and included one 5-minute stretch break. Participants were given a meal at the beginning of the presentation.

The following process was followed for the presentation:

(1) Welcome group.

(2) Informed consent was discussed and opportunities for questions were provided.

(3) Provided participants with instructions to include where the bathroom is located, cell phone etiquette, and survey at the end of the presentation.

(4) Provided meal.

(5) Post meal, provide a presentation and entertain the question

(6) Post-presentation, thank the participants, and administer the survey to participants.

(7) Collect surveys.

Table 3 outlines the process objectives, responsible party, process participants, and expected date of completion.

Table 3

Project Timeline

Major Process Objectives	Responsible Party	Process Participants	Expected Date of Completion
1. Development of PowerPoint presentation talking points for Clergy Members	Project Leader	Project Leader	08/01/2022
2. Development of packets for presentation	Project Leader	Project Leader	08/03/2022
3. Meet with the senior pastor to discuss implementation dates	Project Leader	Project Leader and Senior Pastor	08/05/2022
4. Send Flyer to the senior pastor	Project Leader	Project Leader	08/07/2022
5. Develop a menu for dinner post-presentation	Project Leader	Project Leader	08/10/2022
6. Implement Educational presentation	Project Leader	Project Leader Clergy Members	08/17/2022
7. Obtain and analyze post-questionnaire results	Project Leader	Project Leader	08/20/2022

Project Budget and Resources

Budgeting is an important part of the project implementation stage and is often overlooked as one conducts a project. The project cost for this project was able to be kept

at a minimum as the project site had most of the materials that would be needed to complete the project. To keep costs at a minimum the project leader utilized existing resources to create a brochure, PowerPoint, and guide for the clergies. The clergies are all local and are given this time to participate in the project as a part of their community service and will obtain knowledge to improve their leadership in the LGBTQIA+ community. Capital costs to include the hardware, copy machine utilities, and copy paper and operational costs to include heat and electricity will be present and will add no additional costs to the project. Lunch will be provided during the implementation of the project at $10 per person for a total cost of $100.

Theoretical Underpinnings

Two theories that guided the project are The Minority Stress Theory and the Theory of Cultural Marginality. The Theory of Minority Stress was conceptualized from various social-psychological stress model theories and can be described as the traumatic experience minority groups encounter as a result of their minority status (Meyer, 1995). Meyer (1995) later expanded on the minority stress model to include the LGBTQIA+ community and was based on the premise that gay people, like other minority groups, are subjected to minority stress due to their stigmatization. Meyer (1995) posits that the sources of minority stress experienced by this community include rejection, discrimination, and violence also experienced by other minority groups (Meyer, 1995). Meyer (1995) suggests three processes of minority stress as it relates to the LGBTQIA+ community:

(1) external, objective stressful events and conditions (chronic and acute),

(2) expectations of such events and the vigilance this expectation requires, and

(3) the internalization of negative societal attitudes.

Meyer (2003) suggests that there may be a fourth stress, the process-concealment of one's sexual orientation. Meyer (2003) theorized that health disparities arise due to distal and proximal stressors that these individuals face. Distal stressors (external) include external events such as workplace harassment, discrimination, and physical and sexual violence; and proximal stressors (internal) include anticipation and expectations that future negative events will occur, and include negative beliefs about oneself (Meyer, 2003).

Minority Stress Theory (MST) was endorsed by the National Academy of Medicine and Healthy People 2020 and purports that the discrimination, violence, and victimization that LGBTQIA+ individuals experience as a result of a pervasive homophobic culture (i.e., minority stress) are predictors of poor mental health and suicide among sexual minority populations (Fulginiti et al., 2020). While initially MST was focused on sexual minorities, it was later expanded to include gender minorities such as transgender and genderqueer (TGQ) individuals. Fulginiti et al. (2020) found that TGQ individuals experienced harassment, bullying, and relationship abuse along with victimization as a direct result of their gender. These stressors are theorized to produce poorer mental health and physical outcomes such as anxiety, depression, psychological distress, social anxiety, eating concerns, and suicidality.

The other theory that guided this project is the Middle Range Theory of Cultural Marginality. This theory was developed to increase understanding of the unique experiences of individuals who are straddling distinct cultures and to offer direction in providing culturally relevant care (Smith & Liehr, 2018). Cultural Marginality Theory

was first introduced in 1928 when the “marginal man concept” was introduced. The marginal man was considered as experiencing conflicts of the divided self, the old and new self, a lack of integrity, spiritual instability, restlessness, malaise, and moral turmoil between two cultural lives (Smith & Liehr, 2018). While this theory was first postulated for immigrant populations, it can be extrapolated to the LGBTQIA+ community as well as those who are feeling marginalized from mainstream society because of their gender and sexuality leading to inequities and poor outcomes. The major concepts of the theory are across culture conflict recognition, marginal living, and easing cultural tension (Smith & Liehr, 2018).

Applicability of Minority Stress Theory and Theory of Cultural Marginalization to Current Practice

The MST and Theory of Cultural Marginalization act upon individuals who are marginalized and stigmatized in the broader society which leads to a higher prevalence of mental disorders and poor outcomes (Pitoňák, 2017). A study conducted by Pitonak (2017) revealed that non-heterosexuals are about 2.5 times more likely to have a lifetime history of mental disorders and two times more likely to have a current mental disorder. Pitonak also reported an elevated risk of suicide attempts and ideations as well as substance abuse among non-heterosexual groups and adults. The use of MST and the Theory of Cultural Marginalization guided the quality improvement project to allow the church leaders to engage their own emotions in the caring relationship of this marginalized group and see the impact the religious doctrine is having on these individuals and utilize strategies that focus on the LGBTQIA+ needs, to become better allies for these individuals and improve outcomes. These theories provide a useful

approach to understanding the relationship between pervasive prejudice and discrimination and health outcome (Meyer et al., 2008).

Evaluation Planning

Evaluation is an important part of any project. The purpose of this project was to increase the clergy's awareness, sensitivity, and knowledge of members of the LGBTQIA+ community in order to improve health outcomes through the use of a formalized education plan. The primary outcomes of this project are that clergies will have:

- increased knowledge about LGBTQIA+ health/social service needs,
- an increase in LGBTQIA+-affirming attitudes and behavior
- a better understanding of the trauma endured by members of the LGBTQIA+ by the church, and
- appreciate the need to create safe spaces within the church.

The project leader along with the project chair formulated the survey items for the post-evaluation survey. There was no available instrument that measured what the project leader was seeking to measure. There are many survey items that addressed attitudes in general about the LGBTQIA+ community but none that addressed clergies. The survey consisted of 15 items to evaluate how well the objectives were met. The first 11 items used a Likert scale to measure the responses from strongly agree to strongly disagree. The next items, 12-15 were open-ended questions. The project leader administered the survey after the presentation to the clergies. The participants were given instructions that they could choose to not answer any or all of the items without penalty. There was no identifying data on the questionnaires in order to maintain the anonymity of the data.

Ethics and Human Subject Protection

The project was conducted in the community and the project site does not have a formal Internal Review Board (IRB). As such, they do not require IRB oversight and/or permission to complete the project. The lead pastor gave permission for the project to be conducted at their site. The project was aimed at using quality improvement measures to develop education for clergies on strategies to reduce stigma, and discrimination, and improve the mental health and wellness of members who identify as LGBTQIA+ in their congregation and beyond. The quality improvement project was sanctioned by the School of Nursing Evidence-Based Practice and Research Council the educational institution.

Implementation

The project intervention of an LGBTQIA+ training program for clergy members was successfully implemented with five clergy members at the agreed-on practice site. The findings indicated that there was an improvement in the awareness, sensitivity, and knowledge of the clergy members after the training program. The senior pastor referred to the project in one of his sermons and asked that the information be shared with his deacon board once the project is completed. The findings indicated that the program had a significant impact on clergy members' understanding of the needs of the LGBTQIA+ population and the ways in which clergy members can address those needs in a culturally sensitive manner.

The purpose of this project was to increase clergy members' awareness, sensitivity, and knowledge of the LGBTQIA+ community in an effort to lead to better health outcomes. The primary feedback as reported by the clergy members was that the presentation was beneficial and can assist them in caring for their LGBTQIA+ members.

There was buy-in from the participants in regard to this project and they felt this project would be very useful for the lay leaders of their churches, as well as other congregations. The participants viewed the project in a positive light and agreed that the recommendations from the project were achievable. The participants were very interested to learn how they can be a part of the solution rather than the source of the problem for LGBTQIA+ members. They were also enthusiastic to learn how they can help to sustain the project.

The literature indicates that educating clergy members regarding the LGBTQIA+ community enhances their understanding of the needs and concerns of this population which may lead to an improvement in the care provided to LGBTQIA+ congregants (McRay & Ruff, 2021). Yarhouse and Sadusky (2020) discussed the importance for LGBTQIA+ believers to have an emotionally and spiritually safe environment in their churches for LGBTQIA+ members, especially for the youth, to ask questions and question assumptions (Yarhouse & Sadusky, 2020). The attitudes of the leaders and especially the clergy members have an impact on the establishment of a safe space for LGBTQIA+ members to feel they belong. Belongingness is one of the key tenets of our basic needs. In addition, the clergy members are crucial in the establishment of a therapeutic relationship with their LGBTQIA+ members. Therapeutic relationships between clergy members and their LGBTQIA+ congregants are important to identify and address the needs of LGBTQIA+ members in order to have better health outcomes such as reduced depression and anxiety (Dean et al., 2020).

Threats and Barriers

Quality improvement projects by their very nature have a potential for threats as well as barriers. It behooves project leaders to be aware of these in order to avoid pitfalls many projects face such as not finishing on time. In addition, being able to describe the threats and barriers will assist others who will conduct similar projects to minimize project obstacles and save on resources. There were many threats and barriers during the implementation of the project. Just prior to the implementation of the project two of the seven clergy members resigned as they accepted positions with another congregation. This was very frustrating as the sample size was already small. The small sample size was also another barrier that made it difficult to generalize the project. In addition, since all the clergy members were coming from different places there was one of the clergy members who was 30 minutes late which delayed the start of the presentation.

Not having a tool with established reliability to measure the outcome of the presentation should also be considered. Reliability ensures the instrument or test measures what it is supposed to on a consistent basis (Zaccagnini & Pechacek, 2021). The project chair along with the project leader validated the instrument.

Another concern was that the participants would lose interest over time as the project was being developed. The participants were asked to be a part of the project very early in its development of the project. As the project unfolded, there was a time gap when there was no communication with the participants. One of the participants was also going on a 6-month sabbatical and there were concerns that in addition to losing the two clergy members, the sample size would drop even lower.

Technology challenges were also another threat to the project. The project leader had no experience in the use of a smart television to give a presentation prior to this project. There was a legitimate concern even with preparation ahead of time that it would not work the way it should. The fact of the matter was, it was a huge success, and the presentation was clear.

Successes of the program included many questions being asked of the project leader indicating participants' interest in the project. At the end of the presentation, the senior pastor asked that the project be shared with his deacon board. In addition, in one of his sermons, he cited statistics he had heard during the presentation and made reference to the project. Another success of the program was in the presentation of the folders containing the written information used in the project presentation. The participants exclaimed how organized everything was. They were given folders that included the presentation, the informed consent, a brochure, the evaluation survey, and a pen. Even though the sample size was small, the survey was conducted in such a way that it was impossible to discern who responded to the survey. The project leader was out of the room and each person answered all the questions and placed them in a basket.

Monitoring of Implementation

The project leader was responsible for monitoring the implementation of the project and measuring the progress against the goals, objectives, mission statement, evaluation plan, and timeline (Zaccagnini & Pechacek, 2021). It is important that the project leader has a clear vision of the project and show enthusiasm for the project in order to get buy-in from the participants. The implementation phase is when the project leader gets to show all the hard work that has gone into the preparation of the project.

When a project has closure, it helps to promote sustainability after the implementation (Zaccagnini & Pechacek, 2021).

In monitoring the implementation, it is important that participants are aware of and will use findings to inform their awareness, knowledge, and sensitivity to influence their decision-making regarding the LGBTQIA+ population. It is important that the information being shared is current, that the information is suited for the right audience, and that the project leader is trustworthy and credible (Zaccagnini & Pechacek, 2021). In addition, the transfer of knowledge needs to be planned and should examine potential barriers to knowledge translation. This was a huge concern during the presentation. The participants were all highly educated, and it was assumed that some of the health care jargon was understood by all. It was apparent from the survey, that many did not understand them.

Throughout the project implementation, the project leader kept the project chair informed of the process and kept deadlines in place. The project was implemented in a timely manner and was conducted based on the objectives that were established to be achieved. The information shared was current and relevant to the audience and was well received. It is believed that the information shared with this group would be able to be transferred to similar clergy groups and lay Christian leaders. The material was a little dense and maybe sharing less data would have shortened the time for the presentation.

Project Closure

The saying, “all good things must come to an end” is true even for projects. The project leader still has a responsibility to ensure that all final details and loose ends are identified and addressed. The project leader for this project created a checklist to ensure

all the requirements have been met. The project leader ensured all deliverables were handed off to the stakeholders, that all work was completed, that all the participants were aware of the consent form, that approval was obtained prior to implementation, and that the project was completed and implemented in a timely manner. In addition, looking at lessons learned, what was done well and can be repeated in the future based on the survey questions, and what could be better are important.

After the implementation of the project, the project leader provided a meal to the participants and thanked them for their participation. The overall consensus was that it was a great project. There was an acknowledgement that the project was completed and plans for sustaining the project were discussed. The participants showed exuberance and shared their thoughts on what went well and what they would change for future presentations. Things that they thought went well were the statistics shared on the health concerns of LGBTQIA+ members; also, they particularly liked the information shared on cultural humility as well as the information on gender dysphoria.

Interpretation of Data

Projects are not considered complete until the information gleaned from the project is assimilated and examined to facilitate future decision-making and practice change (Zaccagnini & Pechacek, 2021). Systematic and accurate data collection enables the project leader to better evaluate outcomes based on the objectives set forth (Christenbery, 2020). In evaluating the project, two types of data collection were used: (1) qualitative data and (2) quantitative data.

Qualitative data are important as it allows the project leader to consider the context of the situation, note difference, and allows for individual differences to be

valued and critically considered to inform clinical decisions (Zaccagnini & Pechacek, 2021). In other words, qualitative projects contain data and information about the quality of and the way humans behave. The data is usually derived from interviews and questions and may be observable as well. Qualitative data are non-numeric and can be difficult to quantify and measure (Christenbery, 2020). Qualitative data seems to align well with the phenomenon of patient-centered care as it helps us to understand people's lived experiences and be able to communicate the insights gained in a meaningful way in the project.

Questionnaires are an important method for compiling and evaluating qualitative data. They are often used in quality improvement projects as they are inexpensive and offer a sense of anonymity. On the other hand, questionnaires do not allow the project leader the ability to clarify a response to a question and often can be difficult to generalize outside of the intended audience (Zaccagnini & Pechacek, 2021).

The post-implementation survey questionnaire developed for this project included 15 questions that were easy to follow and read. They were developed and designed to be read at a sixth-grade reading level. To increase validity, the instruments were thoroughly reviewed with the project chair. The project leader and project chair acknowledged factors that could skew the results such as differing knowledge levels between learners, the small sample size, and the project leader not being in the room when the questionnaires were being filled out, hence the project leader left the room prior to the questionnaires being filled out and did not return until after the meal when all the questionnaires were compiled in a basket provided.

The Likert scale method of data collection was used to gauge the participants' attitudes in response to the educational presentation. Likert scales are relatively easy to produce, reasonable in cost, easy to conduct, and allow for anonymity. A disadvantage of using a Likert scale is that there is an assumption of linear thinking. This project utilized the Likert scale on the post-training survey, items one through eleven, to measure the participants' perception of education and its usefulness with regard to the increase in knowledge, awareness, and sensitivity of the LGBTQIA+ community. Items 12-15 were open-ended questions that allowed the participants to provide open feedback for further studies and improvement of the project.

The quantitative responses from the questionnaire and Likert scale survey were collected and analyzed using Microsoft Excel for Windows 2020. The data for each quantitative question on the questionnaire was entered into the Excel program with the resulting information displayed as a bar graph, displaying the various responses. The bar graph was selected as the preferred method of displaying information for the simplicity of obtaining and understanding the results. Refer to the Appendix to view the bar graphs.

Quantitative data collection typically utilizes instruments such as surveys, questionnaires, and/or observational tools. In this project, a questionnaire was developed to gauge the level of understanding post implementation of the project. A 5-point Likert scale was used to assess the participant's change in awareness, knowledge, and sensitivity of the LGBTQIA+ population with the goal of improving the LGBTQIA+ congregants' health outcomes. The scale ranged from 1 strongly disagree to 5 strongly agree.

The quantitative analysis of this doctorate of nursing practice (DNP) project was completed using Microsoft Word. For questions 1, 7, and 9, 100% of the respondents

answered that they strongly agreed they were more aware of the impact of the church on LGBTQIA+ congregants, they feel confident after the presentation in assisting LGBTQIA+ congregants and their families find community resources, and that they understood the impact of the stigma associated with mental illness, behavioral health services and health-seeking behaviors among LGBTQIA+ youth and their families within cultural communities.

Process Improvement

Process improvement requires a process that facilitates continuous improvement that produces a change in practice. As changes are made they need to be continuously evaluated for their impact. When data has been generated and analyzed, areas of gap and/or problems can be discerned (Zaccagnini & Pechacek, 2021). Process improvement is particularly important for nursing practice as it allows the nurse to use empirical evidence to effect outcomes (Zaccagnini & Pechacek, 2021). Many DNP projects use the Institute for Healthcare Improvement (IHI) Model for Improvement known as the “Plan, Do, Study, Act” or PDSA” cycle (Bradshaw & Vitale, 2020). This project was no exception and also utilized the PDSA cycle for performance improvement.

The purpose of the project was to increase clergy members' awareness sensitivity and knowledge about the LGBTQIA+ community in order to improve health outcomes for this population. The prediction was that all seven clergy members would participate in the project. However, unforeseen circumstances prevented two of the clergy members from participating. In the planning phase, meetings with the senior pastor were conducted to gauge his interest, weekly meetings were held with the project chair to ensure the project stayed on track. During the “Do” phase the PowerPoint, brochure, folders, and

implementation of the project were carried out. After the project was implemented, it was time for studying the data from the questionnaires. Bar graphs were created to analyze the data from the questionnaire. The final phase is the Act cycle, based on the data from the project future opportunities exist to share the information with other clergy members to continue to improve health outcomes in the LGBTQIA+ community.

The outcome showed an increased awareness, sensitivity, and knowledge based on the presentation shared. The clergy members showed an eagerness to learn and to share this information with other leaders in their midst. The change that was brought to bear on the clergy members was the impact the church can have on the health and well-being of LGBTQIA+ members. The impact was measured using the post-educational questionnaire. The project will be sustained through engaging with other clergy members and leaders to share this education with them. In the future, what could be measured is how many new members of the LGBTQIA+ community joined the church after the clergy members were educated versus the rate at which they left prior. In addition, measuring the new programs impacting the LGBTQIA+ clergy members added to the programming.

Results

The participants in this study included five (n=5) clergy members who were employed by the same church. Initially, it was anticipated that seven clergy members would participate; however, by the implementation of the project, two of the ministers resigned and accepted jobs at other churches. The post-educational questionnaires were distributed prior to the educational session in a folder containing materials for the project. The post-educational questionnaires were collected after the educational presentation.

The participants were notified at the beginning of the presentation that this was going to take place and in order to provide anonymity, the project leader would leave the room while they were answering the questionnaire. One hundred percent of the participants completed the questionnaire. After the questionnaires were completed they were placed in a basket. No participant-identifying information was included in the questionnaires. The post-educational questionnaires were immediately secured by the project leader after they were placed in the basket. The questionnaires were then secured in a locked drawer and later scanned into a protected file. The data was reviewed the following week after the presentation. The quantitative data collected from the questionnaires was analyzed and supported the efforts of the project and provided data for sustainability and continuous improvement.

After the presentation, based on the questionnaire response to question 1, 100% of the participants were more aware of the impact of the church on LGBTQIA+ individuals. Only 80% (4/5) of the participants responded they strongly agreed they were more aware of resources and community referrals for LGBTQIA+ individuals in question 2 while 20% (1/5) slightly agreed. Question 3 “I am more aware of the health disparities the LGBTQIA+ community experiences, 60% of the respondents strongly agreed, while 40% agreed which was slightly different from the response to question 4 which asked about a specific understanding of the difference between cultural competence and cultural humility, 80% of the respondents stated they strongly agreed they understood the difference while 20% agreed they understood the difference. Questions 6, 10, and 11 also revealed the same 80/20% split with strongly agreed and agree. The responses to question 5, “I feel I am more confident in my ability to recognize at-risk behaviors in congregants

in the LGBTQIA+ community" were enlightening to the project leader. Only 40% strongly agreed that they were confident in recognizing at-risk behaviors, while another 40% agreed and 20% only slightly agreed. This information was very beneficial to the project leader. The responses suggest that the project can be sustained over time as it would have been difficult to teach everything there is in a one-time presentation to feel very confident in the at-risk behaviors of congregants. This was also carried out in the open-ended question in question 15 which asked for recommendations regarding what could have been improved in the presentation. Participants shared they "would love to have time for more conversation in small groups, pairs, or trios." For questions 7 and 8, 100% of the respondents strongly agreed they were more confident in assisting LGBTQIA+ individuals and families in utilizing family and community resources to reach their goal and they understand that LGBTQIA+ identity has different connotations within different racial, ethnic, and cultural groups. One hundred percent of the participants strongly agreed to question 9 that after the presentation they understood the impact of the stigma associated with mental illness, behavioral health services, and help-seeking behaviors among LGBTQIA+ youth and their families within cultural communities. In the open-ended questions, participants shared that some of the most useful information they heard during the presentation were:

- Statistics of premature death, homelessness, and adverse health outcomes for LGBTQIA. Recommendations on how to create a more intentional church community for LGBTQIA+ members,
- Expanded terminology that educates and promotes understanding of LGBTQIA+ youths and families and congregations,

- Cultural humility,
- Percentage of suicide for LGBTQIA+ youth, and
- The “Do’s” for clergy and the hard data about the impact of sacramental shame on LGBTQIA+ youth.

Likewise, the participants stated overwhelmingly to question 3 that all the information was useful and there were no least useful items. In addition, 100% of the participants stated that they would be incorporating what they learned into their practice. The participants also shared on the post-educational survey that they would incorporate the following in their churches:

- Terminology, awareness, understanding,
- Planning more events to affirm, and celebrate the children and youth who identify as LGBTQIA+,
- Develop workshops for members of the church,
- Relational; connecting with families, not just youths,
- Recommendations for ministers and becoming more intentional, and
- Resources for LGBTQIA+ people facing harm or distress,

Discussion

The purpose of this project was to increase clergy members' awareness, sensitivity, and knowledge of the LGBTQIA+ community in order to have better health outcomes for these individuals and families. Results indicated that the objectives were achieved and that by educating clergy members they can become better stewards in caring for their LGBTQIA+ members. Results indicated that clergy members are willing to act on the information they received to become better allies for the LGBTQIA+

community. The impact of the performance improvement project could be felt immediately after the presentation through the resounding applause from the participants. During the meal, the participants stated that every church leader should hear this information. The senior pastor mentioned during one of his sermons after the presentation, data that was presented during the presentation. One of the clergy members asked, “how can I help to keep this going?” The change in the clergy members' attitudes about the need to take better care of their LGBTQIA+ was evident when posting the presentation, the senior pastor brought in an expert group to educate the church on various LGBTQIA+ topics to bring awareness and also was willing to discuss findings during his sermon. There is more engagement with the LGBTQIA+ members and the church is creating a space for their LGBTQIA+ members.

The project will be sustained by engaging with other faith communities. One of the participants suggested small group discussions; this is definitely worth looking into as often, changing one person’s awareness, sensitivity, and knowledge at a time, can send a ripple effect. The project leader will work to build relationships with other clergy members and church leaders to keep the project going. The senior pastor suggested he would like the information to be shared with his deacon boards.

Conclusion

Religion continues to play a huge role in the lives of the LGBTQIA+ community. The more informed clergy members are the more they will be able to impact the health and well-being of their LGBTQIA+ congregants. Increasing clergy members' awareness, sensitivity, and knowledge can lead to a better understanding of the stigma, internalized homophobia, and minority stress which impacts this community. It is hoped that

problems related to gaps in the literature can be addressed by this project and that others use this information to address the gaps identified in the education of clergy members on LGBTQIA+ topics. The use of this project can give guidance and direction for future projects and for improving the health outcomes for LGBTQIA+ Christians.

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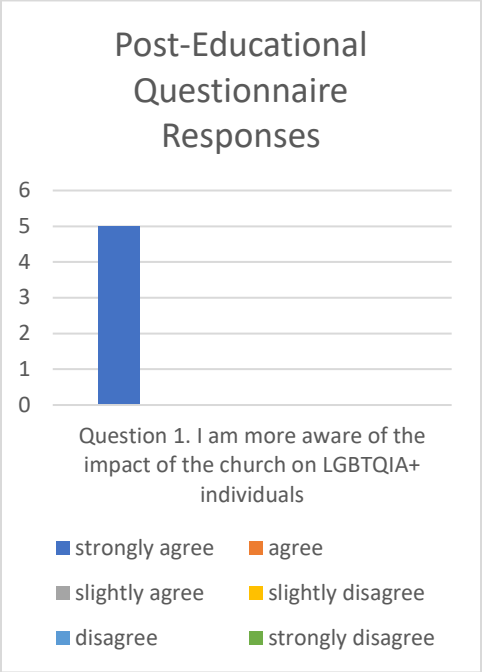
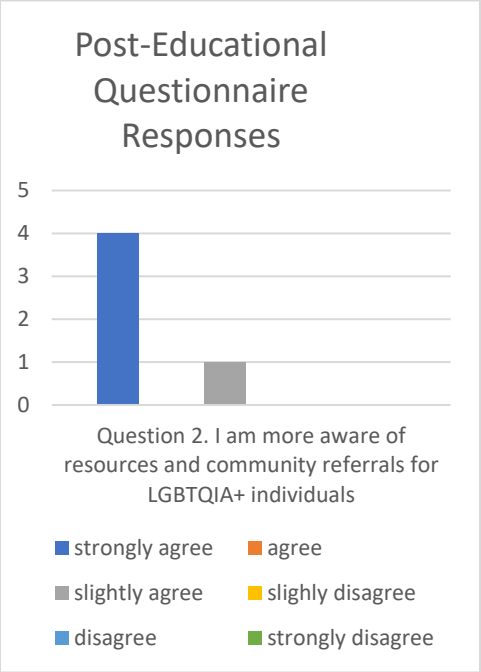
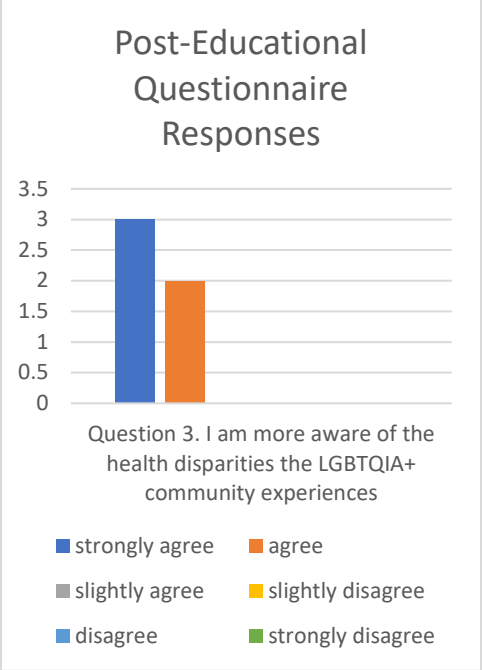
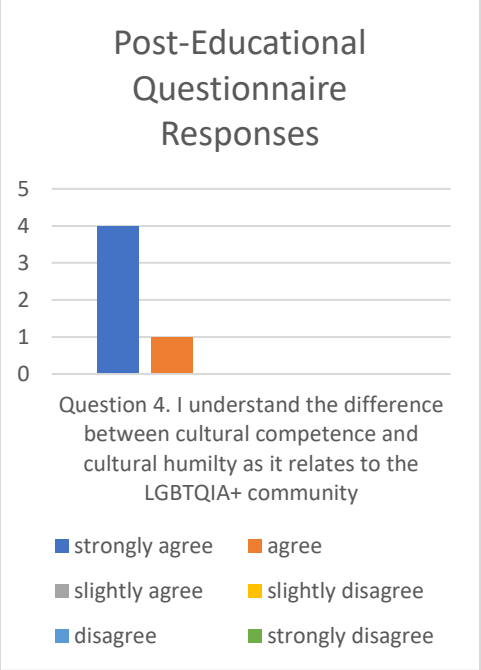
Appendix

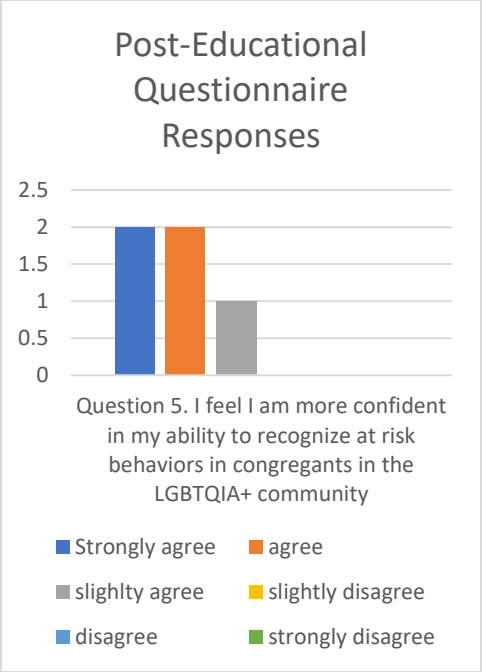
Post-Educational Questionnaire Responses

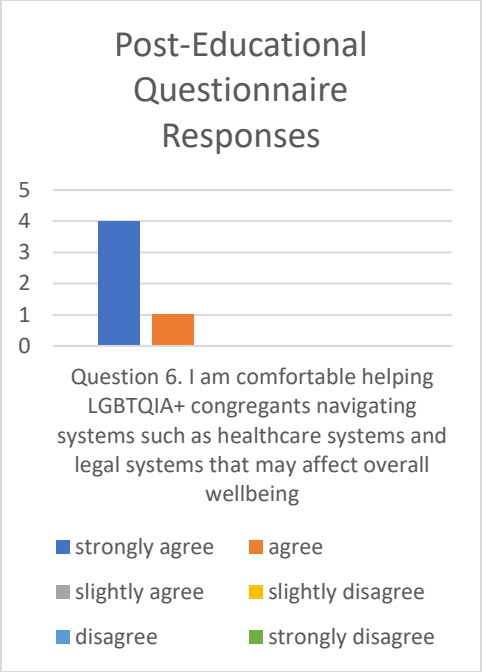


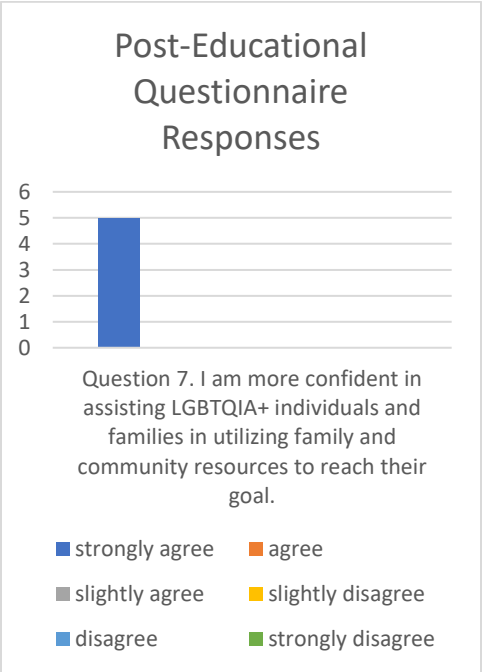


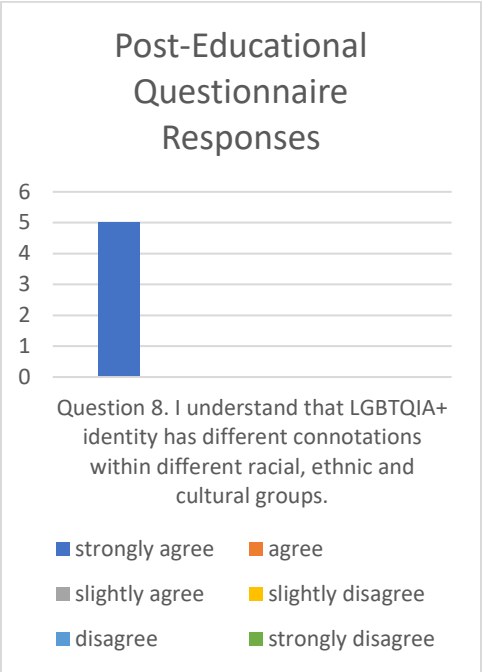


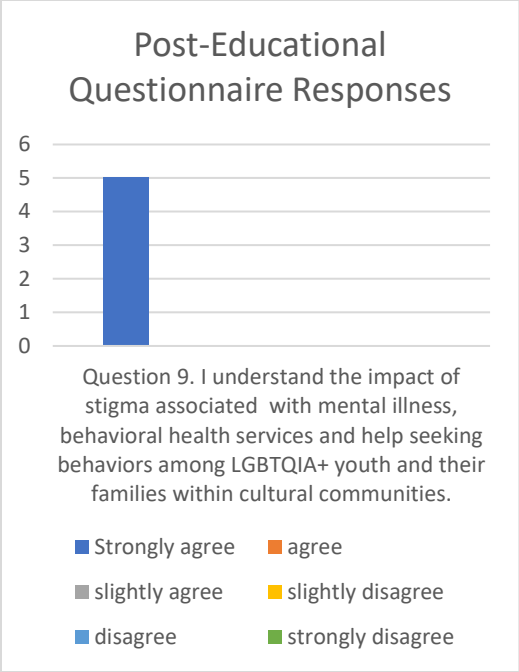


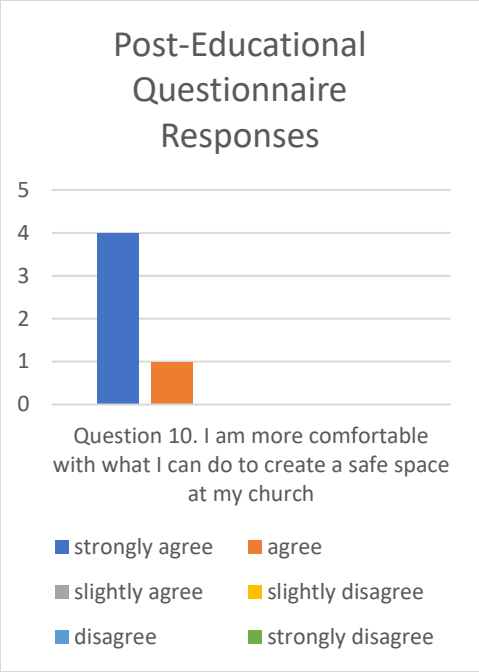

Post-Educational Questionnaire Responses
2.5
2
1.5
1
0.5
0
Question 5. I feel I am more confident in my ability to recognize at risk behaviors in congregants in the LGBTQIA+ community
Strongly agree
agree
slighlty agree
slightly disagree
disagree
strongly disagree

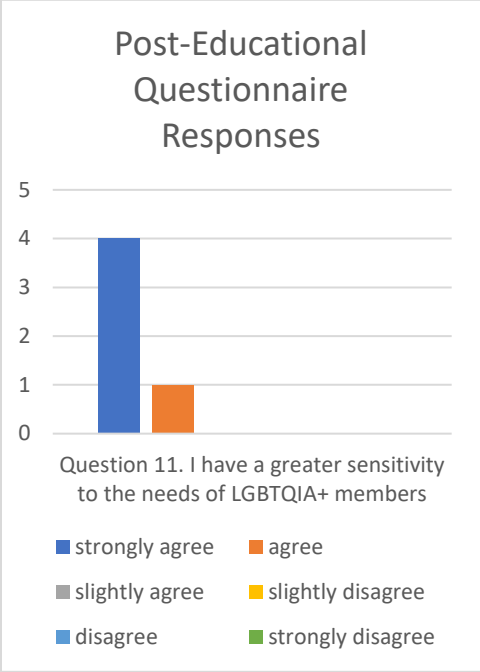

Post-Educational Questionnaire Responses
5
4
3
2
1
0
Question 6. I am comfortable helping LGBTQIA+ congregants navigating systems such as healthcare systems and legal systems that may affect overall wellbeing
strongly agree
agree
slightly agree
slightly disagree
disagree
strongly disagree


Post-Educational Questionnaire Responses
6
5
4
3
2
1
0
Question 7. I am more confident in assisting LGBTQIA+ individuals and families in utilizing family and community resources to reach their goal.
strongly agree
agree
slightly agree
slightly disagree
disagree
strongly disagree


Post-Educational Questionnaire Responses
6
5
4
3
2
1
0
Question 8. I understand that LGBTQIA+ identity has different connotations within different racial, ethnic and cultural groups.
strongly agree
agree
slightly agree
slightly disagree
disagree
strongly disagree


Post-Educational Questionnaire Responses
6
5
4
3
2
1
0
Question 9. I understand the impact of stigma associated with mental illness, behavioral health services and help seeking behaviors among LGBTQIA+ youth and their families within cultural communities.
Strongly agree
agree
slightly agree
slightly disagree
disagree
strongly disagree


Post-Educational Questionnaire Responses
5
4
3
2
1
0
Question 10. I am more comfortable with what I can do to create a safe space at my church
strongly agree
agree
slightly agree
slightly disagree
disagree
strongly disagree


Post-Educational Questionnaire Responses
5
4
3
2
1
0
Question 11. I have a greater sensitivity to the needs of LGBTQIA+ members
strongly agree
agree
slightly agree
slightly disagree
disagree
strongly disagree