

A SURVEY OF HEALTH ADMINISTRATOR ATTITUDES
TOWARDS AND SUPPORT OF DIVERSITY
THROUGH A FEMINIST LENS

by

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DEDICATION

“Some people ask: “Why the word feminist? Why not just say you are a believer in human rights, or something like that?” Because that would be dishonest. Feminism is, of course, part of human rights in general—but to choose to use the vague expression human rights is to deny the specific and particular problem of gender. It would be a way of pretending that it was not women who have, for centuries, been excluded. It would be a way of denying that the problem of gender targets women.”

Chimamanda Ngozi Adichie, *We Should All Be Feminists*

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	v
LIST OF TABLES	ix
LIST OF FIGURES	xi
LIST OF ABBREVIATIONS	xii
CHAPTER	
I. INTRODUCTION	1
Identification of Terms and Definitions.....	2
Health administrators	3
Women	3
Non-binary	3
Marginalized people.....	3
People of color	4
Intersectionality.....	4
Feminist standpoint theory (FST)	5
Research Questions and Hypotheses	5
Independent and Dependent Variables	6
Significance of Research.....	6
Conceptual Framework.....	7
II. LITERATURE REVIEW	8
Feminist Standpoint Theory (FST)	8
Background	8
Critique and controversy	12
Theory application	14
Healthcare: A Closer Look	18
Demographics	18
History and stereotypes.....	20
Women, Leadership Styles, and Values	22
Modeling feminist leadership	23
Summary	26

III. METHODS	28
Research Questions and Hypotheses	28
Incorporation of FST.....	29
Participants.....	30
Instrument	30
Survey design.....	30
Survey adaptation.....	32
Survey pilot and execution.....	35
Research Design.....	36
Assumptions.....	36
Scale of measurement	36
Random sample.....	37
Independent sample	37
Equal variances	37
Normal distribution.....	38
Process	38
Data organization	39
Data exclusion.....	43
Assumptions and Limitations	43
IV. RESULTS	45
Respondent Characteristics.....	45
Attitude Scale.....	49
Men and women.....	49
White and non-White.....	54
White males and marginalized members	57
Support Scale	59
Men and women.....	59
White and non-White.....	61
White males and marginalized members	62
V. DISCUSSION	65
Attitudes.....	66
Towards the impact of diversity	66
Towards institutionalized discrimination.....	66
Towards gender-based preferential treatment.....	68
Towards non-binary individuals	70
Support.....	71

Of women and racial or ethnic minorities.....	72
Attitudes Towards and Support of Diversity: Answers?	75
Recommendations.....	76
Future Directions	80
APPENDIX SECTION.....	82
REFERENCES	138

LIST OF TABLES

Table	Page
1. Attitude Scale Items	50
2. Items with Significant Differences Between Genders on the Attitude Scale	52
3. Item 8: Frequency of Survey Responses Sorted by Gender	52
4. Item 9: Frequency of Survey Responses Sorted by Gender	53
5. Item 12: Frequency of Survey Responses Sorted by Gender	53
6. Item 16: Frequency of Survey Responses Sorted by Gender	54
7. Items with Significant Differences Between Races on the Attitude Scale	55
8. Item 6: Frequency of Survey Responses Sorted by Race	56
9. Item 18: Frequency of Survey Responses Sorted by Race	56
10. Items with Significant Differences Between White Males and Marginalized Members on the Attitude Scale	58
11. Item 8: Frequency of Survey Responses Sorted by Marginalization Status	58
12. Item 12: Frequency of Survey Responses Sorted by Marginalization Status	59
13. Support Scale Items	60
14. Items with Significant Differences Between Genders on the Support Scale	61
15. Item 27: Frequency of Survey Responses Sorted by Gender	61
16. Items with Significant Differences Between Races on the Support Scale	62

17. Items with Significant Differences Between White Males and Marginalized Members on the Support Scale	63
18. Item 27: Frequency of Survey Responses Sorted by Marginalization Status	64

LIST OF FIGURES

Figure	Page
1. Percentage of women serving in healthcare roles.....	19
2. Percentage of different racial or ethnic minorities serving in health leadership roles	20
3. Survey adaptation flow chart	34
4. Map of independent and dependent variables.....	41
5. Map of data organization and analysis.....	42
6. Gender of survey respondents.....	46
7. Racial identification of survey respondents.....	47
8. Age of survey respondents in years	47
9. Job role of survey respondents.....	48
10. Years spent in current job role of survey respondents.....	48
11. Years spent in health industry of survey respondents.....	49

LIST OF ABBREVIATIONS

Abbreviation	Description
ACHE.....	American College of Healthcare Executives
FST.....	Feminist Standpoint Theory
HRSA.....	Health Resources and Services Administration
MM.....	Marginalized members
WM.....	White males
LGBTQIA.....	Lesbian, gay, bisexual, transgender, queer, intersexual, asexual
IRB.....	Institutional Review Board
ACES.....	Attitudes, Career, Environment, and Social
FMLA.....	Family and Medical Leave Act of 1993
IDHM.....	Institute for Diversity in Health Management

I. INTRODUCTION

In the United States, women's issues have long been topics of great significance and struggle in political, social, and economic spheres. Women have fought for the right to vote, to work, and to fight for the country. There has been a common and enduring misconception that gender equality has been achieved. While it has been true that women have made significant gains in terms of achieving political, social, and economic equity, it has been misguided to believe that women and men are equal in America. The modern era has merely ushered in a new frontier of the women's movement, one that entails new and complex issues.

This new frontier has not been not just about women. Rather, the new movement has recognized the interconnectedness of marginalization, and has fought not only for the lives of women but also for people of color, queer communities, the disabled, and other disenfranchised peoples. This movement has existed because of the lived realities, some shared and some not, these groups have faced in modern America. For example, despite significant policy initiatives and efforts by President Barack Obama like the Lilly Ledbetter Fair Pay Act of 2009, White women have earned, on average, 79 cents for every dollar that a White man has earned (Traub, 2016; National Women's Law Center, 2015). Black women, on average, have earned a mere 60 cents for every dollar that a White man earns (Traub, 2016; National Women's Law Center, 2015). Despite the fact that such discrepancies have been widely recognized as problematic, they have still persisted.

The health care industry in particular has suffered from a lack of demographic representation of traditionally marginalized groups. In this field, women make up 78.4%

of the labor force (Warner, 2014). While this figure suggests that women have largely dominated the healthcare industry in terms of economic participation, they have only filled 14.6% of executive-level health care roles (Warner, 2014). Such a disparity has indicated a lack of representation of women in these top-level management positions, despite more extensive involvement in lower and mid-level management and caregiving roles.

The demographics of the American College of Healthcare Executives (ACHE) have further highlighted a lack of diversity in executive-level health care roles. The ACHE is an organization that has been composed of almost 47 thousand executives from across the health industry (ACHE, 2015). While women have made up almost 43% of ACHE members (still less than half), the most severe membership discrepancy has persisted in the realm of race (ACHE, 2015). More than 80% of ACHE members have identified as White, while only about 8% have identified as Black (ACHE, 2015).

These data have demonstrated that American health care administration has lacked representation in executive-level leadership roles. This thesis has sought to understand these dynamics by applying a feminist framework. It has endeavored to explore health care executive attitudes towards workplace diversity and plurality and, finally, presented recommendations for interventions to achieve greater industry equity.

Identification of Terms and Definitions

Because this research touched on broad and controversial topics, it was important to be explicit in the words and concepts used in this discussion. This section has defined the following terms: health administrators, women, non-binary, marginalized people, people of color, intersectionality, and feminist standpoint theory.

Health administrators. For the purpose of this paper, the population of interest was executive-level health administrators. The term “health administrators” was used interchangeably with “health executives,” “health leaders,” and “top-level managers” to refer broadly to the highest level of leadership roles that exist in health organizations. This included positions such as chief officers and vice presidents of health organizations.

Women. This discussion recognized gender not as a dichotomy, but rather as a spectrum. The word “woman” referred to anyone that self-identified as such, regardless of biological sex. This means that a transgendered woman, someone who identifies as female but may have been born biologically male, was considered and referred to as a woman in this thesis.

Non-binary. This term was explicitly used and defined throughout the survey tool used to examine the research questions of this thesis; non-binary referred to an individual, group, or community that does not subscribe to traditional notions of gender like “male” or “female.” This word was used in accordance with the recognition of gender as a spectrum. This term, too, accounted for those who may identify as transgender but also referred to those who do not identify with heteronormative values (e.g, lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) communities).

Marginalized people. This thesis was interested in the role that marginalization, or historical oppression, played within the dynamics of healthcare. The term “marginalization” was used to refer to any general population of people that has historically been oppressed or socially excluded in the United States. Marginalized groups included often-underrepresented and misunderstood groups, such as individuals identifying as female or male in contrast to their biological sex assigned at birth, non-

binary individuals, Black, Hispanic, and Asian individuals, among a vast many other identifications. The term “marginalization status” was used in the research questions to identify those health administrators that did not identify as racially as White or socially as male.

People of color. The term “people of color” was used to refer to any group that did not identify as White; this concept related to marginalization because people of color have historically been oppressed in the United States but differs in that it excluded White women. Some examples include: African-American bodies having suffered the chains of slavery or, similarly, Japanese-American bodies having endured internment camps. It was important to note that some groups have found the term “people of color” problematic (Morris et al., 2009). For the purpose of this research, however, it was useful to have a singular term with which to discuss broadly the lack of representation of those who are not White because the racial landscape in health administration has been predominantly White (ACHE, 2015).

Intersectionality. The concept of intersectionality, which has not commonly been studied in the field of health administration, was born out of the social sciences and has often been addressed in liberal arts fields like sociology, anthropology, and political science (Murib and Soss, 2015). Intersectionality has referred to the fact that most people do not simply have one identity; humans are multi-dimensional, and human identities are complex. For example, one might self-identify as a disabled man or a Muslim African-American woman or a gay Israeli father. Each of these individuals has multiple identities, and these identities interconnect to produce a unique lived experience.

Feminist standpoint theory (FST). Also emanating from social science is feminist standpoint theory (FST), which was explored in greater depth in Chapter 2. FST, a philosophy, theory, and research methodology, has argued that not all knowledge is created in the same way, and, in contending this, has disputed the existence of classical notions of objectivity. FST has been used across disciplines to analyze and frame discussions about the role that power relations play in different spaces and environments (Harding, 2004).

Research Questions & Hypotheses

The purpose of this research was to examine health administrator attitudes toward plurality and diversity by asking the following questions:

Q₁: To what extent do different genders, races, and marginalization statuses impact health administrator attitudes towards diversity in the workplace?

Q₂: To what extent do healthcare workplaces support diversity in practice as perceived by administrators of different genders, races, and marginalization statuses?

Informed by a literature review and a survey conducted among health administrators, the researcher hypothesized that:

H₁: Membership to different gender, racial, and marginalized groups will impact health administrator attitudes towards diversity in the healthcare workplace; members of different gender, racial, and marginalized groups will adopt different attitudes towards diversity in the workplace.

H₂: Members of different gender, racial, and marginalized groups perceive that healthcare workplaces are supporting diversity in practice on a marginal level;

members of different gender, racial, and marginalized groups will not adopt different perceptions of workplace support of diversity.

Independent and Dependent Variables

This study employed three independent variables and two dependent variables. Two of the three independent variables, race and gender, were unidimensional variables, meaning that information gathered and stratified by each of those two variables accounted for a single dimension of the human experience; that is, for these particular variables, the dimensions were gender *or* race (Gophaldas and DeRoy, 2015). The third independent variable, marginalization status, was an intersectional variable, meaning that information gathered from this singular variable accounted for more than one dimension of the human experience; in this case, the variable marginalization status referred to the intersection of gender *and* race (Gophaldas and DeRoy, 2015).

The dependent variables employed in this thesis were attitudes towards and workplace support of diversity. Each of these dependent variables was analyzed by examining the quantitative difference between empirical survey data based on gender, race, and marginalization status.

Significance of Research

This investigation sought to examine and better understand attitudes towards and support of diversity in the healthcare administration environment based on race, gender, and marginalization status. Little known research of this nature has been previously documented. With the evolving landscape of the American workplace and the diversifying social dynamics of American communities, understanding administrator attitudes towards and workplace support of plurality will be imperative for the survival of

successful healthcare firms. In the future, inflexible healthcare workplaces that do not support diversity in practice or diversify their staff will have a difficult time remaining competitive in the marketplace (American Psychological Association, 2016).

Conceptual Framework

The scope and methodology of this investigation was supported by a quantitative examination. The first research question and corresponding hypothesis sought to examine and answer the extent to which narrow perceptions of diversity exist in healthcare workplaces; similarly, the second research question and corresponding hypothesis sought to measure the extent to which health workplaces have been supporting diversity in practice. These questions essentially sought to *measure* the persistence of attitudes towards diversity as well as the extent of support for diversity, which supported the use of quantitative methodology (McCusker and Gunyadin, 2015). Empirical data was collected through a survey of health administrators.

Further supporting the use of a quantitative investigation was the research principle that quantitative methods may be well suited to initial examination or early-stage analysis of a problem (McCusker and Gunyadin, 2015). Because these research questions have not been previously examined in any known research, this investigation was characterized as an initial examination of attitudes towards and support of diversity in health administration (McCusker and Gunyadin, 2015).

II. LITERATURE REVIEW

Feminist Standpoint Theory (FST)

Background. Feminist standpoint theory (FST) emerged in the late 1970s, born out of Marxian ideology. Early proponents of FST argued that the knowledge of women is necessarily created in a different space than the knowledge of men (Harding, 2004). Specifically, women's experiences of marginalization and oppression have impacted how their collective knowledge has been created. That is, as Sandra Harding writes, "women as culturally diverse collectivities [can] produce knowledge that [answers] *their* questions about nature and social relations" (Harding, 2004, p.4). Over time, the threads of FST have emerged, one oriented towards activism, the other, academia. These distinct activities have interacted to produce an analytical and methodological system that is different from distinctly *non-feminist* standpoint theories (Landau, 2007; Mosedale, 2014).

While early FST theorists have focused significantly on the concept and epistemological advantages of women's lived experiences with their own bodies and responsibilities, the idea of FST has since expanded to address the problems associated with the assumed gender dichotomy and also to include the perspectives of other oppressed peoples. This theoretical expansion has supported the notion that oppression both enables and restricts knowledge. Experiences of oppression have enabled certain knowledge by unlocking certain experiences that oppressors likely do not experience (e.g., when people have referenced the concept of "street smarts," this phrase has referred to knowledge for survival based on lived experiences in an oppressive social system); similarly, experiences of oppression have restricted certain knowledge via exclusion (e.g.,

socioeconomically disadvantaged persons have often been excluded from higher education opportunities, typically due to high cost barriers). Consequently, there has been no single system of thought that embodies true objectivity. Donna Haraway (1988) has referred to this idea of false objectivity by disputing the existence of an omnipotent, all-seeing objective framework; the real world has been so complex that no framework of knowledge production can be disarticulated from the politics or society in which it was formed (Haraway, 1988). Haraway has called this recognition of no real objectivity *feminist objectivity* or *situated knowledge* (Haraway, 1988, p.581).

Harding (2004) has discussed some of the means by which oppression shapes the way one interprets or experiences the world. In healthcare, women have historically had limited opportunities to participate in the highest levels of health administration. Today, although women are included in executive positions, the structure of such roles still tend to dissuade or exclude those women who might have familial obligations, like raising a child or taking care of a sick parent, by requiring long work days, offering little time off, and not providing sufficient time for family leave (Hauser, 2014; Pesonen, 2015). These barriers have been instances of oppression in healthcare that have become an epistemic resource for the lived experiences of women working in the field. Another example of an aspect of oppression in healthcare has been the use of stereotypes, like female leaders being characterized as “bossy” or “overly aggressive,” which have prevented women from achieving their full potential as leaders (Sandberg and Chavez, 2014). This thesis aims to learn more about what types of attitudes and behaviors are exhibited in the field.

For Haraway (1988), dominant social frameworks (e.g., patriarchy, science, capitalism, Eurocentrism) have suppressed the validity of alternative frameworks. For

example, in declaring to represent “true” objectivity, science has implicitly claimed to transcend beyond the limits of human knowledge, thereby dismissing alternative systems of knowledge. Perhaps this idea is best illustrated through an example. In Paul Nasdady’s (2003) ethnography on aboriginal relations in the Yukon, he encountered a government-requested sheep-counting expedition by two groups: biologists, who came from a background in Western science, and a First Nations tribe, who came from a background in indigenous knowledge. The biologists counted sheep in a particular area by systematically tracing them at the same time each year in a helicopter; the First Nations people counted the sheep over time. Nasdady (2003) wrote that the “biologists felt that because First Nations people do not systematically count sheep at the same time every year, they do not have an adequate basis for identifying changes in the population” (Nasdady, 2003, p.193).

In this example case, as well as in many other instances, positions of authority have privileged mainstream science at the expense of alternative knowledge systems. Haraway (1988) has argued that since all knowledge systems are created and implemented in a particular social location, the knowledge produced by each system must necessarily be partial. Sandra Harding (2004) has posited further that science, while able to overcome individual biases, cannot divorce itself from the political society in which it exists and thusly contains systemic biases that the scientific community as a whole may share.

This theory was important to this research because it has established that there is not a single lived experience for executive-level health administrators. Rather, individuals’ intersectionalities, or complex identities, have impacted both their

experiences and their interpretations of these experiences within the field. This acknowledgement of different experiences and systems of knowledge became important and relevant in this investigation's discussion of ways to achieve greater industry equity.

It is imperative to note that feminist standpoint theory has not spoken for single individuals' experiences of oppression; rather, these theoretical ideas have centralized around community-based knowledge (Haraway, 1988). Therefore, in FST, the collective knowledge of women in healthcare leadership roles, for instance, was a situated knowledge system formed from the experiences of the group. This type of group classification has been critiqued as being essentialist, which the Oxford English Dictionary defines as "the view that categories of people, such as women and men, or heterosexuals and homosexuals, or members of ethnic groups, have intrinsically different and characteristic natures or disposition" (Oxford University Press, 2016a). Feminism has traditionally rallied against essentialism, so this characterization of FST has become a prime argument against its usefulness. However, the point of FST has been to understand and address communal perspectives; this paper applied FST to understanding why the traditional role of women in healthcare as supporting caretakers has remained dominant, and helps to explain their underrepresentation as managers or overseers. Thus, FST has helped to explain why the disparities of women in leadership roles are a product of the dominant power structure.

The process of collectivizing perspectives has created a model of power and knowledge in which many groups with particular situated knowledges can come together to create a more objective vision of the world. This controversial model, versatile in many respects, has been used as a theory of explanation as well as a methodology,

specifically in the area of social science research (Crasnow, 2009; Harding, 2004). For the purpose of this thesis, FST was used in a methodological, positional, and analytical way by guiding the development and exploration of research questions about diversity in practice in health management.

Critique and controversy. To say that feminist standpoint theory has been riddled with critique and controversy in its almost half-century of existence would be an understatement. Harding (2004) has argued that FST has had one of the most contentious histories in feminist theory. This statement has been evidenced by the fact that many of the theorists who subscribe to FST have not always agreed with each other despite personal validation of FST. For those who have not agreed with the usefulness of feminist standpoint theory, three critiques of its validation as a theory have stood out: essentialism, fragmented knowledge, and its problematic hierarchy of knowledge.

The original FST did, in fact, delineate two distinctive categories of standpoints – that of the female standpoint and the contrasting male standpoint (Weeks, 1998). This early conception of FST privileged the female standpoint as somehow intrinsically better than the male standpoint (Weeks, 1998). While this early conception has been accurately described as essentialist, FST has evolved into something more palatable for anti-essentialists through the years.

Following the genesis of feminist standpoint theory, a critical conversation about the nature of a standpoint has ensued among activists, academics, and scholars. Many founders and prominent feminist scholars have acknowledged that the concept of a single standpoint of women is too broad (Hekman, 1997). Therefore, these scholars have generally agreed that women's experiences are diverse and should be recognized as such

– for example, Patricia Hill Collins, a prominent feminist author and thinker, has written from what she classifies as a distinctive Black feminist standpoint (Bhambra, 2015; Collins, 1986).

However, the addition of further distinguishing modifiers has not fully addressed the problem and may lead to fragmented knowledge. FST critics have contended that the subdivision of knowledge into parts based on groups of humans is futile and superfluous; scholars like Margareta Hallberg (1989) and Iddo Landau (2008) have worried that there is no true end in splintering knowledge, arguing that this process is not only perpetual but too subjective to be useful.

Two implications of fragmented knowledge should be addressed: that of shared experiences and a hierarchy of knowledge. Critics who have interpreted FST in this manner argue that, because knowledge is categorized into discrete parts, the opportunity to account for shared experiences across different groups has been lost (Landau, 2008). Landau (2008) has contended that FST fails on this account because it has not allowed for different social circumstances to permeate groups in similar ways.

On an even broader level, theorists have challenged FST because in American culture, discrete categories have often resulted in hierarchies. Such hierarchies have emerged in practice in American attitudes towards race, religion, and gender, even in places where hierarchy is not meant to be institutionalized. For example, while the United States constitution protects freedom of religion, there has been an unspoken religious hierarchy. In a study on religion in the United States, 43% of respondents disagreed with a statement that Muslims played an important role in the de facto American religious community (Jones et al., 2011). The argument against FST here was that to privilege one

group's knowledge over another was essentialist, reductionist, and represented the kind of social phenomena that feminists themselves have discouraged.

Theory application. The critiques of feminist standpoint theory have remained valuable and important to acknowledge. This thesis remained, however, committed to the use of FST as a theory and method for analyzing administrator attitudes towards diversity. One of the benefits of a broad theory like FST was its versatility; indeed, FST has been and can be applied in a variety of contexts. Though much of the literature surrounding FST has focused on the experiences of women versus men, it should be noted that many feminist authors and scholars have generally acknowledged this problematic dichotomy and have recognized gender as a spectrum. Feminist standpoint theory has remained, however, a useful framework from which to ask questions about the existence of diversity in health leadership and how the dominant power structure might impact diversity initiatives.

In an article on the evaluation of women's empowerment in an international non-governmental organization (INGO), Sarah Mosedale (2014) used FST to assess power relations and to evaluate conflicting goals and action plans. This assessment noted that INGOs, which often claim to be apolitical in essence, were always inherently rooted in some kind of political power structure, the most prominent of which was the power binary of "benevolent aid work/grateful beneficiary," or insider/outsider dichotomy and resulting hierarchy (Mosedale, 2014, p.1123). That INGOs were inherently political despite assertions to the contrary exemplified the struggle between claims of objectivity and the reality that power structures have been invisibly embedded even in that which seems classically objective, as recognized and explained by FST.

Upon observing dysfunction in INGO operation and failure to achieve the goal of women's empowerment, Mosedale (2014) proposed FST as a potential solution to streamlining processes and inspiring real change. She argued that FST offers an inclusive alternative to the existing power binary and proposed to remedy the existing organizational culture by developing a unique standpoint; that is, the INGO workers should learn from their beneficiaries' lived experiences and become acutely aware of the structural processes of power that impact the beneficiaries. In short, this call for developing a unique standpoint was a call for bona fide empathy. Such a process has been challenging and has required a reversal of the existing hierarchy of power to the insider over the outsider, not the other way around. This process meant that, instead of setting abstract goals and then sending aid in efforts to achieve the goals, the INGO should have been listening to the experiences of the oppressed and then translating this information into organizational goals.

Another area in which feminist standpoint theory has been applied as a methodology was in the study of power relations. In her 1998 editorial, Amy Allen defined power in three discrete ways: power-to, power-with, and power-over.

According to Allen (1998), power-to essentially meant empowerment on an individual level. As an example, Allen (1998) explained power-to by describing how feminism, as a political process, has been keen to disentangle and understand acts of individual resistance despite experiences of oppression. Power-with also referred to empowerment, but this term accounted for the empowerment of a collective group of people rather than a single individual (Allen, 1998; Arendt, 1969). Where power-to has referred to the empowerment of an individual through principles of feminism, power-with

has referred to a group of feminists acting in solidarity with each other. Finally, the term power-over referred to “the ability of an actor or set of actors to constrain the choices available to another actor or set of actors in a nontrivial way” (Allen, 1998, p.33). Power-over has not always involved an intentional domination or conscious effort to exert power over a particular individual or group (Allen, 1998).

The study of power relations has often focused on power-over relationships because these have been the kind of relationships that often inhibit people and that also have had the potential to “conceal or distort relevant evidence” (Rolin, 2009, p.219). In other words, people at the top of hierarchies have had the power to change evidence or make important decisions on the behalf of others. Take, for example, a parent-child relationship and the myth of Santa Claus. The parent has been at the top of the hierarchy in a power-over relationship and may or may not choose to reveal evidence regarding the existence of Santa Claus to his or her child. The parent has known that the man in the red suit does not exist, but he or she may still elect to perpetuate the idea that Santa does exist for the benefit of the child. Regardless of intent, the parent has exerted his or her power over the child.

Not all examples of power-over have been so benevolent. Consider, for example, modern police relations with the Black community. The shootings of young unarmed Black men like Michael Brown and Tamir Rice, to name a few, have shown a glimpse of a potentially harmful power-over relationship. In the United States, many citizens have freely given the police power over their communities because they have believed such power is for their own good and protection. The police have played a different role within those Black communities that have been more resistant to the police power-over

relationship (Brunson et al., 2015). These communities have not exhibited the same trust in police and have not always felt protected in the same ways that other communities have (Brunson et al., 2015).

Rolin (2009) argued that the dominant party in power-over relations suppresses evidence via intimidation and discomfort as well as through an imposition of asymmetrical informational, experiential, and educational knowledge (Cirne, 2012).

Miranda Fricker (2007) and Alyssa Cirne (2012) have referred to this power imbalance as hermeneutical injustice, which has described a situation in which an individual (or group) lacks an epistemological framework with which to interpret his, her, or their experiences. That is, for hermeneutical injustice to have occurred, discriminatory practices and biases have been inherently built into a social system in which a marginalized group of people lacks the educational, inferential, and linguistic tools to interpret certain experiences (Fricker, 2007; Cirne, 2012). An example of hermeneutical injustice was the historical practice of requiring Native American children to attend mission schools as mandated by the Indian Civilization Act. Not only did this institutionalize prejudices, but also Native American children were torn from their culture and placed in a foreign environment in which they lacked the necessary tools to interpret their lived experiences.

In a healthcare setting, hermeneutical and epistemic injustices have occurred frequently (Carel and Kidd, 2014). For example, a practitioner likely has not taken seriously a sick patient's interpretation of his or her experiences or has reduced that interpretation to a single point of data, which may be used (or not) at the will of the physician (Carel and Kidd, 2014). In this relationship, the practitioner's knowledge was privileged by the system while the patient's experiences were reduced as subjective. This

example mirrored the preceding case of the biologists' scientifically-produced knowledge being privileged over First Nations' indigenously-produced knowledge (Nasdady, 2003).

Feminist standpoint theory stood as a useful and relevant methodology for the study of power relations because of its inherent recognition of “unequal positions, conflicting interests, and participants who are likely to be selective in telling stories about their social experiences” (Rolin, 2009, p.224). This was important because FST has attempted to strip away prejudicial lenses that may result from power relations and has sought to address deeper, more complex questions by accounting for different perspectives. Not only has FST addressed different interpretations of the world, but, Rolin (2009) argued, it also has conferred a “moral and political commitment” to the research in addition to perspective (Rolin, 2009, p.224). In coupling FST with a traditional scientific framework, this thesis aimed to reveal aspects of health leadership culture and provide recommendations for achieving greater gender and racial equity.

Healthcare: A Closer Look

Demographics. With about three quarters of the workforce identifying as female, the American healthcare workplace is demographically distinct from other industries (Hauser, 2014). Although healthcare in the United States has long included women, females have historically been restricted to supporting and caretaking roles rather than positions with distinct decision-making power (Group and Roberts, 2001). As shown in Figure 1, this pattern has persisted. Despite the overwhelming number of women working in the healthcare industry, one study showed that only 24% of women in the industry held senior executive positions and even fewer, 18%, held hospital chief executive positions (Hauser, 2014). Society seems to have accepted women in the role of caregiver; this

matter is neither revolutionary nor surprising, as many cultures, both traditional and modern, across the world expect women and girls to carry out the majority of this kind of work (both paid and unpaid) (Barker, 2014). While it is true that there is a significant number of women in the field of healthcare, there is not yet see equal representation at the top of the workplace hierarchy.

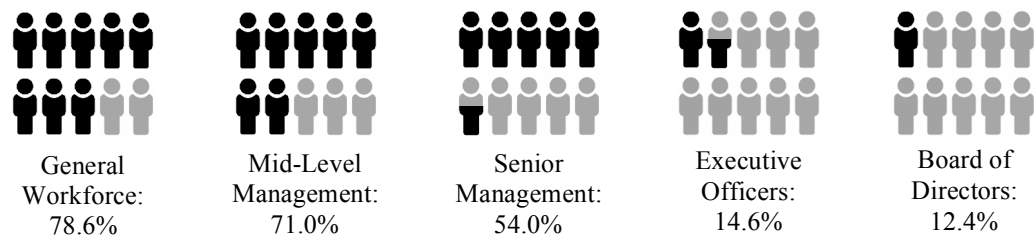


Figure 1. Percentage of women serving in healthcare roles. This figure illustrates the percentage of women serving in various healthcare roles all the way from the general workforce to the board of directors. Data from ACHE (2015) and BLS (2014).

The question of underrepresentation is not limited to women, however. A study done by the US Department of Health and Human Services and the Health Resources and Services Administration (HRSA) (2015) showed that, in a population that identified as non-Hispanic, more than 80% of healthcare managers were White. This number aligned with the demographics of White members reported by the ACHE. Furthermore, as recently as 2015, the ACHE reported that its membership included a Black member population of only 8.2% and a Hispanic member population of only 4.3%. These statistics are illustrated in Figure 2.

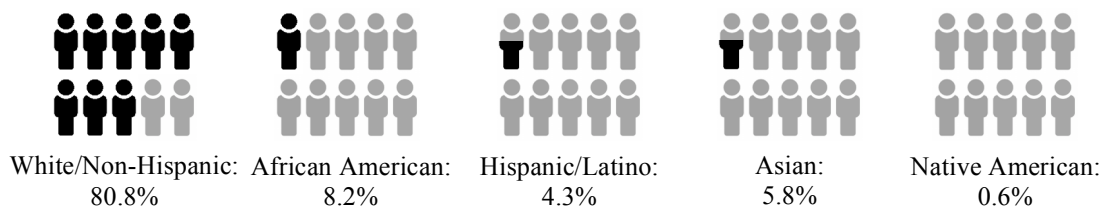


Figure 2. Percentage of different racial or ethnic minorities in serving health leadership roles. This figure illustrates the percentage of different racial or ethnic minorities in health management and leadership positions. Data from ACHE (2015) and HRSA (2015).

These statistics do not reflect the demographics of the American populace. The population of the United States is 13.2% Black and 17.4% Hispanic, and both of these current minority groups are expected to grow in the next few decades (Bureau of Labor Statistics, 2014; Brown, 2014). These numbers make it clear that people of color have been underrepresented in health leadership.

History and stereotypes. Concepts of gender in medicine reach far back in history. Aristotle, the ancient Greek philosopher still widely respected and admired in the scientific community, defined a woman as a “deformed male” (Allen, 1997, p.97). Not only did Aristotle theorize women’s physical bodies as deformity, but he also wrote that men and women were distinctly marked by ability – that is, men were able, and women were unable (Allen, 1997). These concepts have persisted through history with other scientists, physicians, and philosophers noting the perceived abnormality and inferiority of the female body (Lindemann, 2012). Most, if not all, of these theories were both created and perpetuated by prominent men.

Because of the perceived inferiority of the female body and mind, women were excluded from participating in the practice of medicine for most of history. Further, when women did eventually join the ranks of physicians, they experienced overt sexism and discrimination. Although there were already female doctors by the start of the twentieth century, Dr. Lawrence Irwell wrote in 1896 about the horrors of allowing women to work as physicians because of the interference of women's menstrual cycles (Fry, 1983).

Though women have found a legitimate and valued place in medicine today, sexism remains. The issue of sexism in medicine (and in society at large) is widely misunderstood because it has been oversimplified and misconstrued. The problem is systematic (Bird, 2011; Hopkins, 1980). This does not mean that the problem rests on the shoulders of a single individual or even a single group; rather, the problem of sexism has been embedded in the established, highly complex, and interconnected system that is American society (Bird, 2011; Hopkins, 1980).

American healthcare has been a particularly complex and nuanced niche of American society because, in the clinical realm, it has directly engaged the analysis of anatomy in ways that other parts of society have not. In healthcare, physical sex traits are often treated as the sole indicator of gender identity (Miller et al., 2013; Mari, 2016). For example, when a baby is born, it is deemed to be a girl or a boy based on its genitals. While it is true that the sexes, male and female, do have differing biologies, *gender* manifests itself through a very different vein – culture (Mari, 2016). Gender is considerably more complex, though it has often been ignored in favor of reproductive anatomy in medical school classrooms (Miller et al., 2013). Healthcare, by nature, has a preoccupation with sex classification that other industries do not.

Unfortunately, this preoccupation with anatomy has created a hierarchy through history in which being female has been treated as pathology (Lindemann, 2012). And though society no longer collectively has treated women's bodies as diseased, a rigid hierarchy, with men at the top and women at the bottom, has persisted. This hierarchy has been evident in clinical trials where the White male body has been treated as the default example of *human*, the lack of funding for women's health, the wage gap for male and female physicians, and the lack of women in healthcare leadership roles (Lindemann, 2012). Despite significant progress, women in healthcare still seem to have been stuck in more subordinate roles with less decision-making power than their male counterparts. Further, those who identify as non-binary have been even less effectively represented and recognized.

Women, Leadership Styles, and Values

Emerging in the late twentieth century, analysis of how gender might impact leadership has been a niche for social science research. Several studies have classified the differences between the ways in which male and female leaders lead; ultimately, many of the findings have pointed to men as transactional leaders, meaning they tend to focus more on quantifying, correcting, and rewarding employee performance in a systematic way (Van Engen and Willemsen, 2004). Women, however, have tended to be classified as transformational leaders, focusing on employee development through inspiration, relationships, and motivation to work towards a common goal (Lantz, 2008). Some researchers have pointed to these differences in leadership style as a possible explanation for why women are underrepresented in leadership roles.

How important are these alleged gender-related differences in leadership? Both gender and leadership styles have existed on a spectrum; they have not been dichotomous, as many in society have chosen to believe. Meta-analyses on the topic have shown that differences in leadership style are not always distinct between men and women, and, in fact, overlap significantly to the point where such disparities in style are often insignificant (Van Engen and Willemssen, 2004; Eagly, 2013). In other words, so-called gender-based leadership has not sufficiently or accurately explained why there have been fewer female leaders (Eagly, 2013).

Perhaps a more telling dimension of female leadership, rather than style, has been values and attitudes. One meta-analysis study found that the values and attitudes may be more gender-polarized than leadership style (Eagly, 2013). This study did not suggest that all women have the same values; these still exist on a spectrum. However, the findings in the study indicated that women, more than men, tend to emphasize the promotion of social values and social justice projects (Eagly, 2013). The benevolence practiced or promoted by female leaders has had ramifications for ethics and responsibility, which has been important in the field of healthcare. Several studies have shown that women tend to operate more ethical businesses and are more sympathetic to the public good (MSCI ESG Research, 2014; Eagly, 2013).

Modeling feminist leadership. The concept of feminist leadership originally arose from scholars in social work that noticed a potential link between feminism and leadership practice. Since the late twentieth century, researchers have modeled feminist leadership in the field of social work, which has been identified as a discipline that is “inherently feminist” in ethics and values (Lazzari et al., 2009, p. 349). While the concept

has been recognized and applied in social work, it has been adopted in few other fields and has not been explored in depth in health leadership practice.

One distinction that is important to note here is the difference between *feminine* and *feminist*. The previous section on leadership style referred to the perceived apparent femininity of female leaders – that is, traits that have been perceived to be inherent to women like nurturing, caring, and emotion. Most of the literature published on women and leadership has focused on this perceived femininity. The term *feminist*, however, has referred to a political position, an attitude, and a worldview. Feminist has implied a stance that is actively chosen – this contrasts with femininity, which infers some inherent and unchangeable trait.

One study characterized feminist leadership as “a process that is collaborative, relational, and has a constant awareness of gender and power” (Christensen, 2011, p. 255; Lazzari et al., 2009). Feminist leaders, having often chosen their feminist positionality, have been distinctly aware of the power-to, power-with, and power-over relations they see in the workplace; further, these leaders have recognized the ways in which different manifestations of human bodies (e.g., skin color) dictate lived experiences (Christensen, 2011).

Lazzari et al. (2009) created a multi-step working model for the practice of feminist leadership. The Lazzari et al. (2009) model laid out a systematic process that focuses broadly on deconstruction and reconstruction. The first step toward applying a feminist approach to leadership was to analyze and deconstruct the patriarchal power structure of the organization, the purpose of which was to “reconstruct power as empowerment, for example, making decisions with others, sharing control of

resources...and generating ideas or ideologies and knowledge” (Lazzari et al., 2009, p. 352). An important part of this process was to foster a warm, welcoming environment in which employees felt comfortable to engage in discourse with their colleagues and leaders and ask questions of their peers and superiors (Lazzari et al., 2009).

Not only was it important to share power and create a safe space for critical conversation, but Lazzari et al. (2009) found that feminist leaders must also recognize the intersectionality of their employees. Lazzari et al. (2009) recommended doing so by avoiding labels and promoting principles of feminism as opposed to self-identifications as “feminist.” The basis for such actions was that in order to embrace intersectionality and break down hierarchies, it was important not to include or exclude based on identity characteristics or categories. They also suggested that feminist leaders should be “open to self-reflection and to honest feedback from others” (Lazzari et al., 2009, p. 356).

A final, and important, practice of feminist leadership has been that of reflexivity. Reflexivity has simply been a reminder to the individual feminist leader that his or her experiences are subjective and not necessarily shared amongst his or her colleagues (Lazzari et al., 2009; Badwall, 2016). In leadership and problem solving, the process of reflexivity, which is perpetual and ongoing, has required the feminist leader to reflect on his or her interpretations of problems, analyses, goals, and solutions; such reflection has served to remind the leader of “the multiplicity of truths and identities” in his or her colleagues’ interpretations of the very same factors (Badwall, 2016, p. 4).

Though Lazzari et al. (2009) were writing to their peers in social work, there have been some thought-provoking parallels between social work and healthcare that should be mentioned. First, both industries have been characterized by providers whose primary

goal is, at least in theory, to help people, often with great mental, emotional, or physical strains to the provider. The demographic parallels between social work and healthcare, too, have been striking. Though 81.9% of workers in the social work field are women, evidence has shown that there are still more men than women holding positions of power in the social work industry (Bureau of Labor Statistics, 2014; Lazzari et al., 2009; Sakamoto et al., 2008). A third similarity has been the irony that both social work and healthcare workers strive “toward the empowerment and self-actualization of others, as well as toward the realization of social justice” but also serve to “support systems that are destructive” (Lazzari et al., 2009, p. 356). Because these traits and trends have been striking in resemblance to what has existed in healthcare, a feminist model of leadership lends itself to adaptation to health leadership.

Summary

In using FST as a research methodology, it was particularly important to understand the history, context, and stereotypes that have often been associated with women, the healthcare workplace, and health leadership. Feminist standpoint theory served as a useful methodology for research because of its inherent focus on the lives of the marginalized, which have been underrepresented in the healthcare workplace and which have been too often ignored in research. This study employed FST while also incorporating other inductive and deductive research methods. This study sought to examine the following questions about health leader attitudes towards diversity and plurality:

*Q₁: To what extent do different genders, races, and marginalization statuses impact health administrator **attitudes** towards diversity in the workplace?*

Q₂: To what extent do healthcare workplaces support diversity in practice as perceived by administrators of different genders, races, and marginalization statuses?

Further, the researcher hypothesized that:

H₁: Membership to different gender, racial, and marginalized groups will impact health administrator attitudes towards diversity in the healthcare workplace; members of different gender, racial, and marginalized groups will adopt different attitudes towards diversity in the workplace.

H₂: Members of different gender, racial, and marginalized groups perceive that healthcare workplaces are supporting diversity in practice on a marginal level; members of different gender, racial, and marginalized groups will not adopt different perceptions of workplace support of diversity.

The academic scope of this thesis lay within the intersection of health administration, anthropology, and sociology. Little existing literature has addressed how power structures penetrate the healthcare industry, has discussed the state of disenfranchised groups in health leadership roles, or has provided recommendations for achievement of greater equity in leadership. As the American healthcare industry undergoes substantial systematic changes, now is the time to fill this void in the literature. This thesis sought to do just that as well as to ignite a discourse about the state of diversity and potential for feminist leadership in the healthcare industry.

III. METHODS

The purpose of this investigation was to examine health administrator attitudes towards diversity and plurality in a new way – through a distinctly feminist lens, with feminist standpoint theory (FST) serving as a basis for that lens. FST as a methodology has begun with the recognition that not all people share the same lived experiences (Harding, 2004). The author of this research was interested in investigating certain marginalized populations within health leadership roles. This study focused on diversity, inclusion, and plurality in practice and also looked at general attitudes towards such practices. To collect data for this analysis, a survey was conducted. For the purposes of explicitness in describing the methodology, the author of this research will refer to herself as “I” in some explanations in Chapter 3.

Research Questions and Hypotheses

The research questions examined using the methodology outlined in Chapter 3 included the following questions and corresponding hypotheses:

Q₁: To what extent do different genders, races, and marginalization statuses impact health administrator attitudes towards diversity in the workplace?

Q₂: To what extent do healthcare workplaces support diversity in practice as perceived by administrators of different genders, races, and marginalization statuses?

Further, the hypotheses were:

H₁: Membership to different gender, racial, and marginalized groups will impact health administrator attitudes towards diversity in the healthcare workplace;

members of different gender, racial, and marginalized groups will adopt different attitudes towards diversity in the workplace.

H₂: Members of different gender, racial, and marginalized groups perceive that healthcare workplaces are supporting diversity in practice on a marginal level; members of different gender, racial, and marginalized groups will not adopt different perceptions of workplace support of diversity.

Incorporation of FST

The point of this research was to explore health administrator attitudes as well as to examine the perceived state of inclusion in healthcare. An important and distinctive facet of this study was its connection to FST. As a methodology, FST has supported researchers in beginning their studies by looking at the lives of the marginalized, who often have their own unique worldview and knowledge as a result of being historically oppressed (Harding, 2004).

While the survey questions did not exclusively focus on the lives of the marginalized, as FST research, questions were included about experiences to which historically oppressed groups might be more sensitive. An example of this was the question about institutionalized racial discrimination and its sister question about institutionalized sexism. Not only were such questions incorporated in the development of survey, but also, in Chapter 2, the deconstruction of power relations in the field of healthcare was explored in order to better understand the historical and social context in which the data from the survey was gathered. Consequentially, this awareness of power relations and social context should “contribute to a more transparent and thus potentially ethical result” of this methodology (Naples and Gurr, 2013, p. 13).

Participants

There were 78 individual respondents to the survey. Participants were recruited from a list of 264 email addresses provided by the Texas State University Department of Health Administration and also from the Texas State University Health Administration LinkedIn webpage, which had a potential audience of 990 members. The individuals polled were from diverse healthcare environments, including: university-affiliated medical centers, inpatient and surgical centers, outpatient care, hospital associations, federal and state facilities, specialty centers, and public health agencies. Organizations represented ranged in size from small, medium, and large; some were rural, some urban, and some sub-urban. Both for-profit and non-profit organizations received the survey. All participation was on a voluntary basis, and respondents were not compensated in any way. The response rate for this study was 6.22%. A study that analyzed response rates to online surveys recommended that a sample size of approximately 1,000 should have at least 26 respondents or a response rate of 3% in order to adequately represent the population (Nulty, 2008). The response rate for this study met that requirement.

Instrument

Survey design. Because the point of this thesis was to explore attitudes towards and support of diversity in practice across many health roles and organizations, a survey was the most feasible and efficient way to investigate the research questions. Before exploring potential survey tools and techniques, I presented a research proposal to the Institutional Review Board (IRB). As an anonymous survey, the investigation met the criteria for IRB exemption, approval for which can be found in the Appendix E, Figure E1.

Because the study was grounded in the two very different fields of health administration and feminist theory, a definitive survey tool did not exist. Therefore, I expanded my search and discovered a tool called Attitudes, Career, Environment, and Social (ACES), which was developed by four authors in the field of education (Ng et al., 2013). The ACES tool was designed to assess higher education faculty attitudes towards diversity and university goals (Ng et al., 2013).

ACES covered four dimensions of a person's lived experience in the workplace (Ng et al., 2013). The first dimension, attitudes, measured individual perspectives on general principles of diversity (Ng et al., 2013). Career, the second dimension, measured how diversity is incorporated into specific career or professional development activities (Ng et al., 2013). The environmental dimension looked at the workplace as a whole, and the last dimension, social, measured social interaction and inter-personal relationships with diverse peers (Ng et al., 2013).

The purpose of the study developing ACES was to construct a "valid and reliable instrument" that captured a multi-dimensional picture of the state of faculty and university support of diversity both in theory and in practice (Ng et al., 2013, p. 36). The resulting tool included 100 items, where each item included a statement to be ranked by respondents on a Likert-scale from Strongly Disagree (1) to Strongly Agree (5) (Ng et al., 2013).

In an adapted form, the ACES tool fit this investigation for a number of reasons. First and foremost was the multi-dimensional approach, which originally broke the ACES survey tool down into four categories of lived experiences. Because I explored the research questions through a feminist lens, acknowledging and capturing lived

experiences of different groups was a key component of this research. Further, the ACES survey tool was specifically developed and tested to measure attitudes towards diversity, which was an overarching topic in this investigation, too.

Moreover, the results of the Ng et al. (2013) study that developed the ACES tool indicated, when tested, that an individual's personal membership within certain demographic categories influenced each of the ACES dimension. These results showed that the tool had the capability to highlight places where different demographics might have impacted a person's reaction to diversity, which was a cornerstone piece of the research design of this thesis.

Survey adaptation. ACES was designed to be a reliable tool, but it was not originally developed for distribution in health administration nor is it the gold standard in the field. Due to this fact, as well as time constraints, some changes were required in order to use the tool in this research. I requested and received permission to use the ACES tool and to make the appropriate changes from the editor of the Research and Practice in Assessment journal. This correspondence is shown in Appendix E, Figures E2 and E3.

A flow chart of the survey adaptation process is shown in Figure 3. I adapted the ACES tool first by eliminating items that could not be amended for relevance in healthcare. I determined an elimination coding system that included three reasons for exclusion: (1) the item had poor adaptability to the healthcare industry; (2) the item had tangential or no relevance to my research questions; and (3) the item duplicated information already gathered in another question. One such example using this system was an item on the attitude scale that read, "A diverse student body enhances the

educational experiences of all students.” Because the central focus of this item was the student body, and there was not a comparable group or duty like this for health administrators, this question was eliminated. Appendix B shows each survey item that was eliminated (Table B2) and a code for why it was excluded from this study (Table B1).

Following item exclusion, I adapted and modified the questions using a similar coding system. My modification process included five reasons for change: (1) the item was modified for relevance in the healthcare workplace; (2) the item was adjusted to reflect a current state of workplace practice rather than opinion about the way it should or should not be; (3) the item was duplicated and asked a second time in order to address another demographic group; (4) the item was modified to reduce bias in one direction or another; and (5) a ranking scale was added to the item in order to measure the strength of an answer. Every item included in this investigation was modified at least once in order to reference healthcare. Many were modified in other ways, too. Appendix C (Tables C1 and C2) shows each survey item and the modifications made for it to be included in this study.

I also adapted and modified the dimensions of ACES for this study. This investigation explored two dependent variables: attitudes and support. While these dimensions were inspired by the original ACES survey, they were developed to be more specific to both this research and the healthcare industry itself. The survey that was distributed to respondents is shown in Appendix A; the survey items are also listed by dependent variable (attitudes and support) in Appendix D. Note that the numbering between the survey that was distributed and the list of survey items was different – this

was because SurveyMonkey consolidated sets of questions as part of its analytics. The numbering in the survey item list presented in Appendix D (not the numbering from the SurveyMonkey tool) was used consistently throughout this thesis.

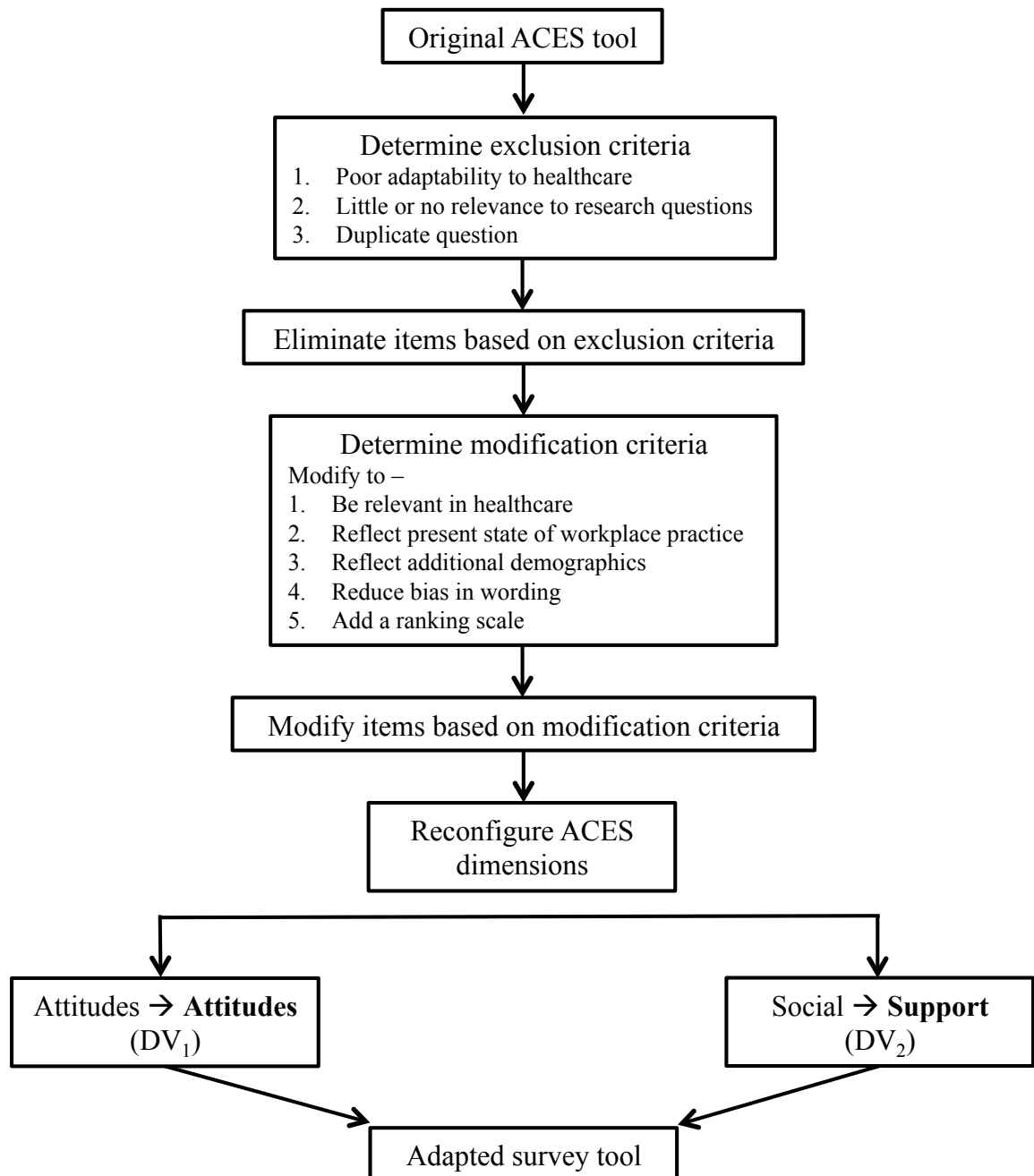


Figure 3. Survey adaptation flow chart. This illustrates the process taken in adapting the ACES survey, including the processes of elimination and modification. Adapted with permission from “ACES: The Development of a Valid Instrument to Assess Faculty Support of Diversity Goals in the United States,” by J. Ng, W. Skorupski, B. Frey, L. Wolf-Wendel, 2013, *Research and Practice in Assessment*, 8, 29-41. Copyright 2013 by RPA Journal.

Survey pilot and execution. SurveyMonkey was used as the survey implementation tool because of its accessibility and its anonymity capabilities. After eliminating and modifying questions, I designed a survey containing six demographic questions and 35 items (Appendix D, Tables D1, D2, and D3). The demographic questions included items related to gender, identification of race and ethnicity, job role and length of time served as well as years of experience within the healthcare industry.

SurveyMonkey had more than 15 types of question frameworks in its data bank, including some open-ended and some closed-ended question formats. For the purpose of this investigation, I used multiple-choice formats for almost all demographic questions, with the exception of the question on race, which was left open-ended. The Likert-style scale was selected for 32 of the survey items. Three survey items were ranking questions, where respondents could fill in an answer from one to ten based on how strongly they felt about the item. The full survey, as presented to the respondents, is shown in Appendix A.

Before dispersing the survey, I conducted a small, informal pilot of four female health managers on February 2, 2016 to reduce the impact of technical problems, spelling and grammar errors, and potential bias in questions. Feedback received from the pilot study confirmed that the survey was functional both on a computer and also worked on a mobile device. One of the respondents recommended clarification of the item stating, “Attention on diversity can divide the workplace community.” Accordingly, I modified and split that item into two new items that read, “Attention to diversity in the workplace has a positive/negative impact on the workplace community.”

I dispersed the survey electronically and in two ways. On February 3, 2016, I sent a cover letter and survey link, which are shown in Appendix E, Figure E4, via email to a

list of 264 email addresses of health managers provided by the Texas State University Department of Health Administration. On February 3, 2016, the same cover letter and survey link were posted to the Texas State University School of Health Administration LinkedIn webpage, which had 990 connections at the time of posting. Because every participant was provided with the same link, the anonymity of each participant was preserved. On February 10, 2016, I sent a reminder email, which is shown in Appendix E, Figure E5, to the same list of 264 email addresses, and I closed the survey link on February 15, 2016.

Research Design

This study employed an independent t-test technique as its primary method for analysis. A t-test was selected because it allowed comparisons between the differences of the means of two groups in order to identify statistically significant differences in responses between groups (Emory University, n.d.). The means between the following groups were compared (all self-identified by respondents to the survey): men and women, White and non-White, and White men (WM) and members of some marginalized group (MM). I chose these groups in order to examine potential differences in responses to diversity between the marginalized and the non-marginalized based on gender, race, and marginalization status.

Assumptions. In order to use the independent t-test, this research met five assumptions.

Scale of measurement. A general principle of the independent t-test technique has held that the scale of measurement for data analyzed via t-test be either interval or ratio (Emory University, n.d.). In this thesis, the use of the Likert-style survey questions was

treated as an interval scale of measurement, which shows “the order of things, but with equal intervals between the points on the scale” (Brown, 2011, p.10). This classification of Likert-style survey data followed protocol established in other social science research (Brown, 2011).

Random sample. The random sample assumption has held that the sample for a study represents a small subset of a larger, defined population (Yale University, 1997). In this investigation, random sampling was utilized by polling respondents (the sample) from across a wide variety of healthcare environments and roles (the healthcare population).

Independent samples. This assumption has held that the two samples examined with an independent t-test technique must be independent of each other; that is, a member of one group may not also be a member of the other group (Emory University, n.d.). For this thesis, the independent samples were sorted based on the independent variables of gender, race, and marginalization status. Each variable consisted of two independent groups: men and women (gender), White and non-White (race), and WM and MM (marginalization status).

Equal variances. Not every survey item presented with equal variances, so precautionary steps were taken within the free trial version of SPSSStatistics, the IBM-owned analytical software that was used for extensive data analysis. For each item, SPSSStatistics conducted a Levene’s test to determine the variance as shown in each of the tables in Appendix I. The analysis resulted in two potential results, which were (1) that equal variances were assumed and the analysis could proceed normally or that (2) equal variances were not assumed and the data had to be corrected (Van Der Berg, 2014).

As per SPSSStatistics guidelines, if the significance for Levene's test was greater than 0.05, then equal variances were assumed and the assumption was met (Van Der Berg, 2014). If the significance for Levene's test was less than 0.05, however, then equal variances could not be assumed and the formula had to be corrected (Van Der Berg, 2014). SPSSStatistics analytics presented the corrected data, which is shown Appendix I.

Normal distribution. Though normal distribution has been an assumption for the use of the independent t-test, no official test for normality was run. According to a tenet of the Central Limit Theorem, "in large samples (> 30 or 40), the sampling distribution tends to be normal, regardless of the shape of the data" (Ghasemi and Zahedial, 2012, p.487). Further, research has shown that the normal distribution assumption can be violated without adversely impacting the statistical results (Ghasemi and Zahediasl, 2012; emory). Therefore, since this research had a sample size of 78, which has been deemed large enough to lend itself to a normal sampling distribution, a normal distribution was simply assumed.

Process. A statistical analysis software package, SPSSStatistics Standard, which was owned by IBM, was used to examine the data. The data was exported from the SurveyMonkey server into a Microsoft Excel spreadsheet and then directly imported into SPSSStatistics. Using the function for an independent t-test, SPSSStatistics calculated the means for each survey item and then compared each mean based on gender, race, and marginalization status. The independent t-test function tested each survey item for a statistically significant difference between the means of the two comparison groups for each independent variable (gender, race, marginalization status), which are presented in Appendices F, G, and H.

For each comparison, SPSSStatistics calculated a confidence interval of 95% (alpha-level $p=0.05$). This meant that the p-value for those items that were statistically significant must have been less than 0.05. I looked at the data for each independent variable – gender, race, and marginalization status – individually and determined statistical significance first by determining equal or unequal variance and then looking at the adjusted p-value. Additionally, in order to better analyze the responses to the questions and examine potential polarization, I also ran an SPSSStatistics descriptive statistic tests to determine frequencies on items that were statistically significant (and on some items that were very close to being statistically significant) according to their p-value. The SPSSStatistics descriptive statistic tests measured the mean, mode, median, and frequency of each response from “strongly disagree” to “strongly agree” for each statistically significant item.

Data organization. The data were strategically organized based on the independent and dependent variables presented in the study. Figures 4 and 5 show maps of variable and data organization. The dependent variables were attitudes towards diversity and practical support of diversity; the data tables shown in Appendices F, G, and H were separated by items which measured attitudes (Tables F1, G2, and H1) and those that measured support (Tables F2, G2, and H2).

The comparison groups selected for this study were the following:

1. Male responses compared to female responses (unidimensional independent variable), which examined the difference between responses towards diversity based on self-identified gender. Because there were only two genders, male and female, identified by the respondents, this binary was used to compare responses.

2. White responses compared to non-White responses (unidimensional independent variable), which examined the difference between responses towards diversity based on self-identified race. The demographic item for race on the survey tool was open-ended. In assigning these categories, I consolidated and categorized these open-ended responses. Those who identified as White, Anglo, or Caucasian were classified for this purpose as White; similarly, those who identified as Hispanic, Latino, Mexican-American, Black, African, African-American, Pacific Islander, or Asian American were classified for this purpose as non-White. The purpose of this classification was not to strip self-identified races of their unique identities and affiliations, but rather to determine the role that any kind of racial marginalization might play in responses to diversity.

3. White male (WM) responses compared to responses from those identifying with membership to any marginalized group (which was referred to as marginalized members or MM) (intersectional independent variable), which examined the difference between responses towards diversity based on self-identified membership to any historically marginalized group.

Appendix F shows the responses for each dependent variable, attitudes and support, sorted by the independent variable for gender, which was broken down into two groups: male and female. Similarly, Appendix G shows the responses for each dependent variable sorted by the independent variable for race, delineated in this study as White and non-White. Finally, Appendix H shows the responses for each dependent variable sorted by the independent variable for marginalization status, which was separated into WM and MM.

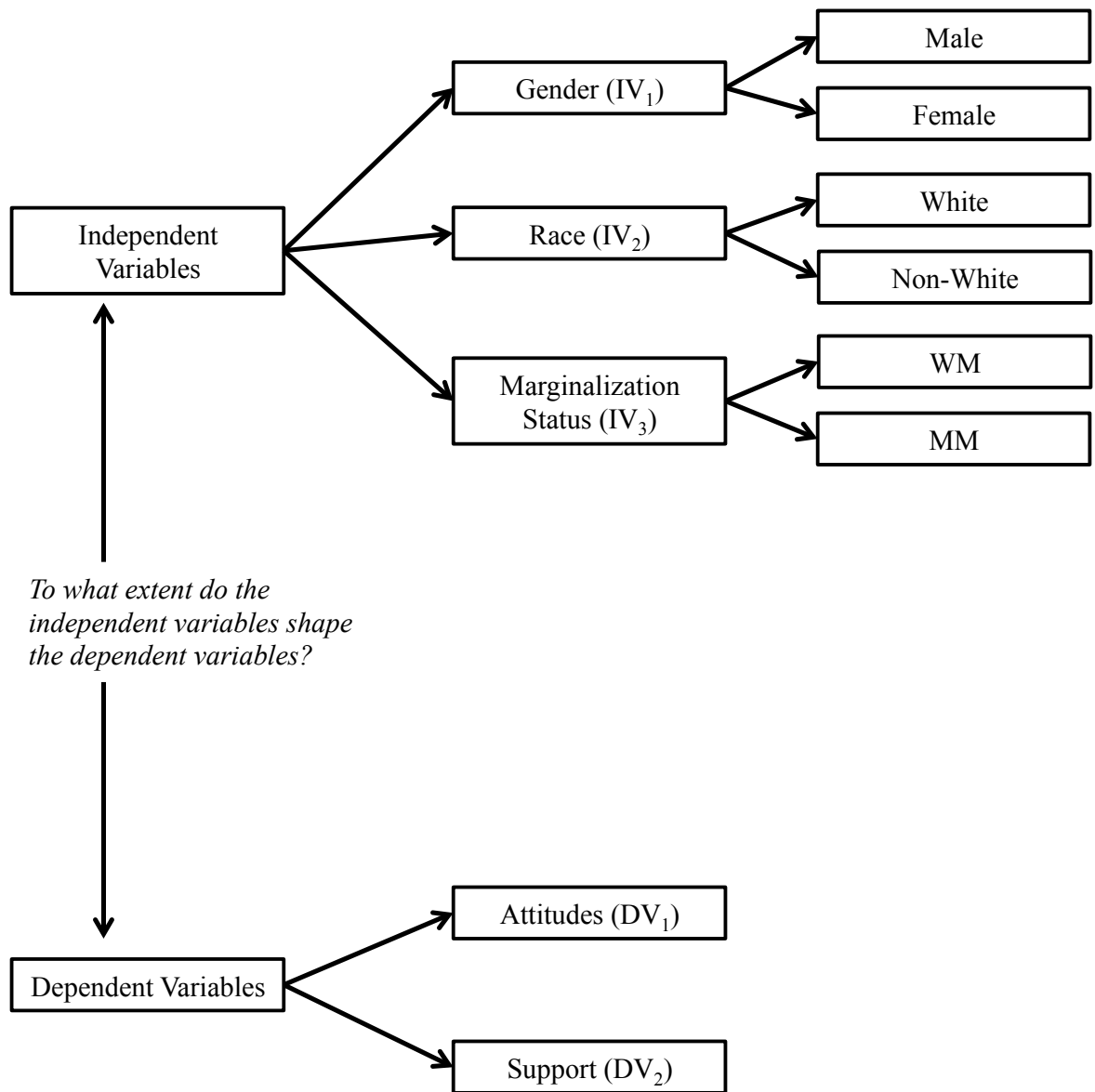


Figure 4. Map of independent and dependent variables. This map illustrates the independent variables (gender, race, and marginalization status) and the dependent variables (attitudes and support).

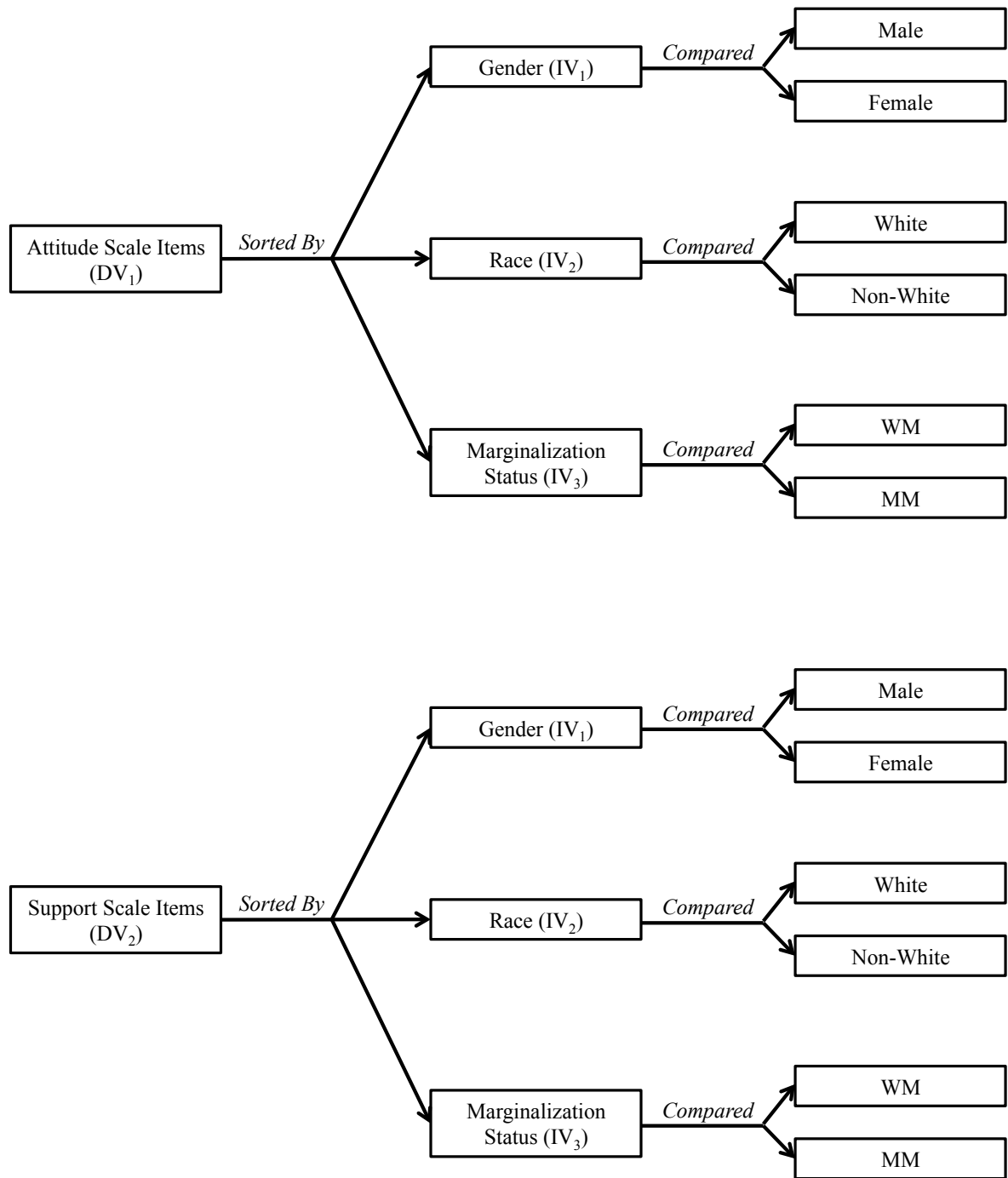


Figure 5. Map of data organization and analysis. This map illustrates the ways in which data was sorted and analyzed. For each dependent variable, the data was sorted by gender, race, and marginalization status, and then the means between the groups for each independent variable were compared for statistical differences.

Data exclusion. Items 20 and 29 through 35 were excluded from analysis. These questions were originally developed to answer a third research question about health administrator with diversity. This research question, which asked “Does a health administrator’s own membership in a marginalized group impact his or her engagement with diversity?” was determined to be beyond the scope of the study because of its qualitative nature. As a result, this research question and its respective survey items were eliminated from this investigation. These excluded survey items, which were presented to respondents in the original survey (Appendix A), are shown in Appendix D, Table D2.

Item 21 was also excluded was from analysis. This item, which was designed to measure workplace support, stated that, “accrediting bodies affecting my workplace state that diversity is a priority” and was excluded from the study because it was too ambiguous. That is, the item did not specify whether accrediting bodies state that diversity is a priority in workforce hiring decisions or in patient care. Because the specificity of the item was not clear, the responses could not accurately be analyzed.

Assumptions and Limitations

This thesis employed several additional assumptions and limitations. First, the study assumed that the only subjects reached were, in fact, health managers. Because the survey was administered via an open link, someone other than a direct recipient of the link could have potentially accessed the survey.

The survey itself was also a source for limitation. It has already been noted that the ACES tool is not the gold standard for surveying on the topic of diversity in the field of healthcare, nor does a gold standard exist for this purpose. Therefore, a variety of sources were used to adapt the ACES tool to answer the research questions. The

reliability and validity of such an adapted tool can only be determined through further testing and use in the future.

The success of the survey was also entirely dependent on voluntary participants' responses and submission of those responses; this presents risk for non-response bias, which occurs when those selected for a survey choose not to participate (Oxford English Press, 2016). Because my response rate was 6.22%, there is likely non-response bias present in this study.

Further, the integrity of the survey was also dependent on honest answers. Because social issues regarding diversity, gender, and race may be a somewhat sensitive topic for some people, some respondents may have offered answers that they believed would be "correct" or more socially acceptable than their true feelings. This phenomenon is commonly referred to as response bias.

Another limitation was the generalizability of the research. There were relatively few participants overall and each representative group (e.g., women, men, White respondents, non-White respondents, WM, and MM) was quite small. Therefore, generalizability from such a small sample may be limited. Further, the survey was distributed to health managers in Texas, so there may be geographic, political, or social biases that limit the generalizability to the United States as a whole.

A final limitation was potential researcher bias. My personal education, background, and perceptions likely colored, influenced, and limited the ways in which this study was conducted. FST has held that objectivity in its most classical form does not exist and that all human thought is partial – acknowledging that, this research must have necessarily been conducted from a particular standpoint.

IV. RESULTS

This chapter presents the statistical analyses performed on the survey data collected for this study. The results of the survey examined the research questions and corresponding hypotheses:

Q₁: To what extent do different genders, races, and marginalization statuses impact health administrator attitudes towards diversity in the workplace?

Q₂: To what extent do healthcare workplaces support diversity in practice as perceived by administrators of different genders, races, and marginalization statuses?

H₁: Membership to different gender, racial, and marginalized groups will impact health administrator attitudes towards diversity in the healthcare workplace; members of different gender, racial, and marginalized groups will adopt different attitudes towards diversity in the workplace.

H₂: Members of different gender, racial, and marginalized groups perceive that healthcare workplaces are supporting diversity in practice on a marginal level; members of different gender, racial, and marginalized groups will not adopt different perceptions of workplace support of diversity.

Respondent Characteristics

This study included 78 participants, including 47 females, 29 males, and no individuals identifying as “other,” as shown in Figure 6. Of the respondents, 51 identified as White or Caucasian, seven identified as Black or African American, six identified as Hispanic or Mexican-American, one identified as Asian American, and one identified as Pacific Islander, as shown in Figure 7. Figure 8 shows that subjects represented every age

group from 18 to 74 years and that there were no respondents over the age of 75 years. Respondents working in administrative health careers ranging from entry-level management through board members were represented, as shown in Figure 9. Thirty-six subjects responded that they worked within the industry for more than 15 years, and 38 responded that they worked within the industry for less than 15 years, as shown in Figure 10. Most respondents identified that they have served in their current role for less than five years, as shown in Figure 11. Not every participant answered every demographic question, so there remain some gaps in the demographic data.

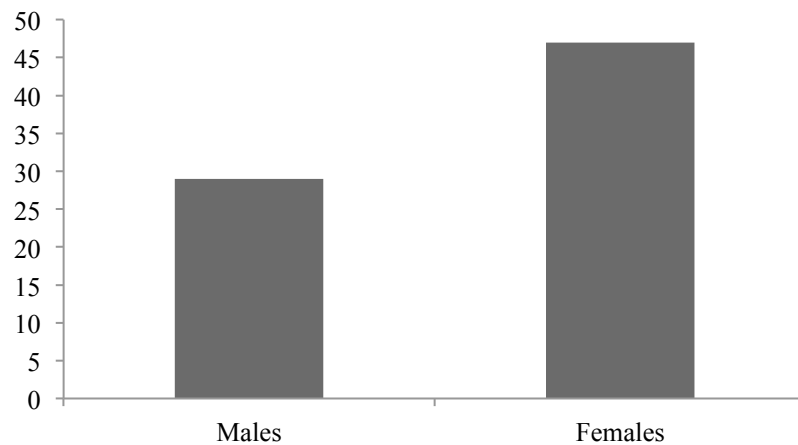


Figure 6. Gender of survey respondents. This figure illustrates the number of respondents' self-identified gender.

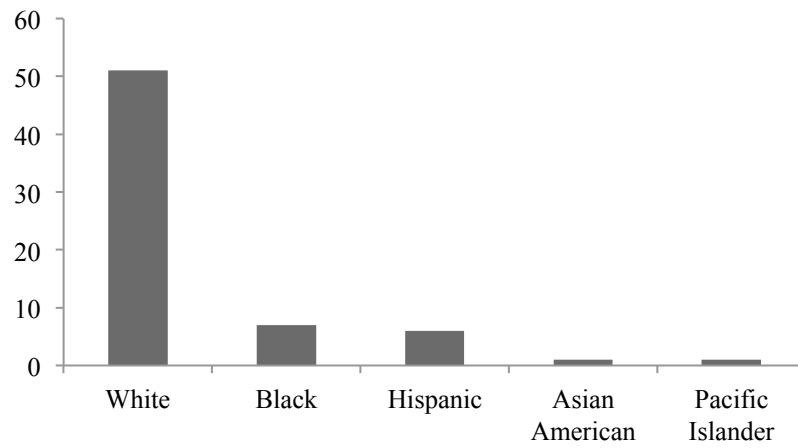


Figure 7. Racial identification of survey respondents. This figure illustrates the number of respondents by racial or ethnic minority identification.

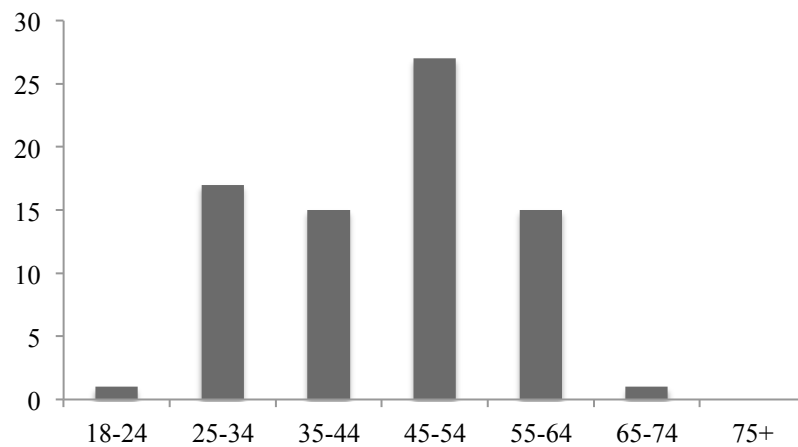


Figure 8. Age of survey respondents in years. This figure illustrates the number of respondents by age group.

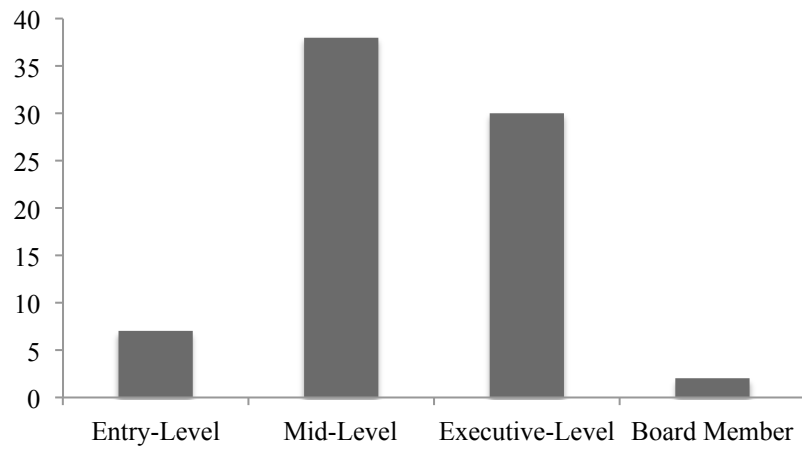


Figure 9. Job role of survey respondents. This figure illustrates the number of respondents by management job role.

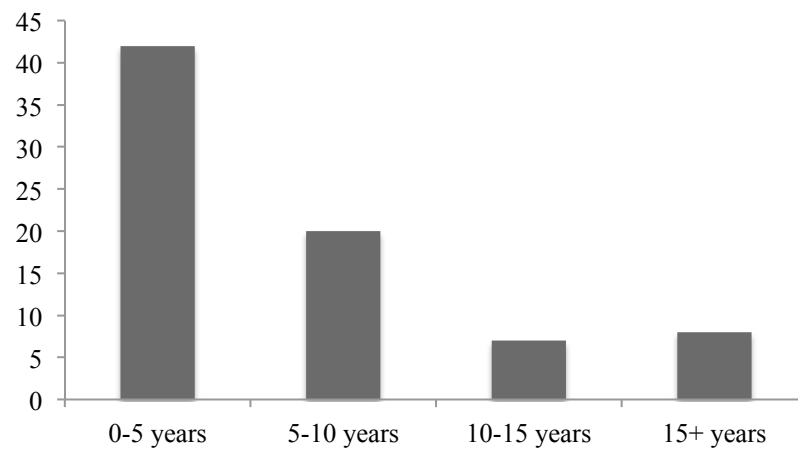


Figure 10. Years spent in current job role of survey respondents. This figure illustrates the number of respondents by years spent their current job role.

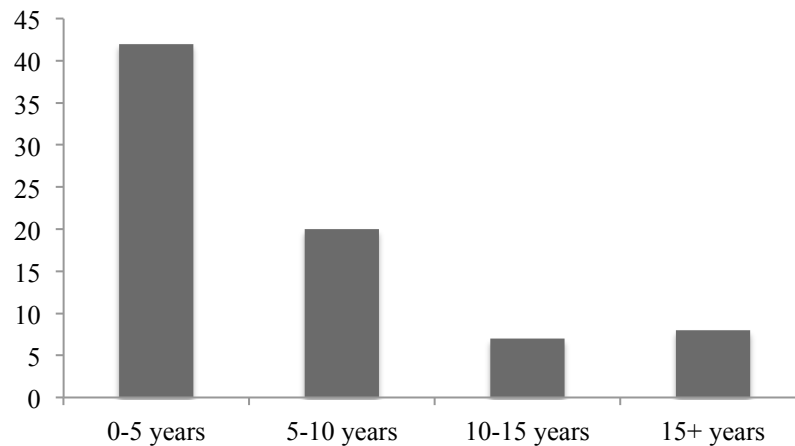


Figure 11. Years spent in health industry of survey respondents. This figure illustrates the number of respondents by years spent in the healthcare industry.

In order to examine potential differences in attitudes towards diversity and support of diversity between demographic groups, three points of comparison were identified, including:

1. Male responses compared to female responses (gender);
2. White responses compared to non-White responses (race);
3. White male (WM) responses compared to responses from those identifying with membership to any marginalized group (MM) (marginalization status).

Attitude Scale

Men and women. A complete set of results for responses of men and women on the attitude scale are shown in Appendix F, Table F1. Items 1, 6 through 9, and 11 through 18 measured attitudes, as shown in Table 1 (these items were included in item numbers seven and eight on the SurveyMonkey tool as shown in Appendix A). On this scale, both men and women agreed that having more diversity at the executive level

enhances the workplace (Item 1) and also that having female leaders in their field is important (Item 15). However, despite this apparent agreement with the importance of diversity, neither women nor men expressed sensitivity towards institutionalized discrimination or towards gender or racial discrimination as a contemporary problem (Items 6, 17, and 18).

Table 1

Attitude Scale Items

Item
1. Having more diversity at the executive level enhances my workplace.
6. Discriminatory practices still exist in the workplace because they have been institutionalized.
7. The leadership of my workplace is representative of the racial and ethnic diversity of the United States.
8. Attention on diversity in the workplace has a positive impact on the workplace community.
9. Attention on diversity in the workplace has a negative impact on the workplace community.
11. Female executives are given preferential treatment in my workplace.
12. Male executives are given preferential treatment in my workplace.
13. Racial and ethnic minority executives are given preferential treatment in my workplace.
14. I am sensitive to the existence of institutionalized discrimination.
15. It is important that female executives serve as leaders in my workplace.
16. It is important that non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') executives serve as leaders in my workplace.
17. Gender discrimination is a contemporary problem. (ranking)
18. Racial discrimination is a contemporary problem. (ranking)

While there was substantial agreement across genders on the attitude scale, there were also some differences, which are presented in Table 2. For example, women were more likely than men to agree or strongly agree that attention on diversity has a positive impact on the workplace (Item 8); similarly, women were more likely to disagree or strongly disagree that attention on diversity has a negative impact on the workplace (Item 9). Further, males were more likely to strongly disagree or disagree that male executives are given preferential treatment in the workplace (Item 12). Finally, though not statistically significant according to a confidence interval of 95%, males were slightly more likely to disagree that having non-binary executives is important (Item 16).

Table 2 details the significant differences in responses between men and women on the attitudes scale. Statistical significance was determined by confirming a p-value less than 0.05. Further, descriptive statistics, including frequencies of responses (from strongly disagree to strongly agree), were analyzed for each of these statistically significant items. Tables 3, 4, 5, and 6 show these frequencies for each identified item that was statistically significant. Table 3 details the participant responses, stratified by males and females, for Item 8, which had a p-value of $p=0.008$. Similarly, Table 4 shows the participant responses for Item 9, which had a p-value of $p=0.025$. Table 5 delineates participant responses for Item 12, which had a p-value of $p=0.023$. Finally, Table 6 highlights the participant responses for Item 16, which had a p-value of $p=0.052$. This p-value did not fall within the 95% confidence interval, but it was only 0.002 from the identified $p < 0.05$, so it was included in the analysis.

Table 2

Items with Significant Differences Between Genders on the Attitude Scale

Item	Question	Gender	Mean	P-Value*
8	Attention on diversity in the workplace has a positive impact on the workplace community.	M	3.60	0.008
		F	4.24	
9	Attention on diversity in the workplace has a negative impact on the workplace community.	M	2.28	0.025
		F	1.82	
12	Male executives are given preferential treatment in my workplace.	M	1.96	0.023
		F	2.58	
16 ⁺	It is important that non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') executives serve as leaders in my workplace.	M	2.72	0.052
		F	3.24	

Note. M = male; F = female.

⁺Lies just outside the confidence interval of 95%.

*p < 0.05.

Table 3

Item 8: Frequency of Survey Responses Sorted by Gender

Response	Gender	Frequency	%
1 Strongly Disagree	M	1	4.00
	F	0	0.00
2 Disagree	M	2	8.00
	F	0	0.00
3 Neutral	M	8	32.00
	F	6	18.18
4 Agree	M	9	36.00
	F	13	39.39
5 Strongly Agree	M	5	20.00
	F	14	42.42

Note. M = male; F = female.

*p < 0.05.

Table 4

Item 9: Frequency of Survey Responses Sorted by Gender

Response	Gender	Frequency	%
1 Strongly Disagree	M	4	16.00
	F	12	36.36
2 Disagree	M	11	44.00
	F	15	45.45
3 Neutral	M	9	36.00
	F	6	18.18
4 Agree	M	1	4.00
	F	0	0.00
5 Strongly Agree	M	0	0.00
	F	0	0.00

Note. M = male; F = female.

* $p < 0.05$.

Table 5

Item 12: Frequency of Survey Responses Sorted by Gender

Response	Gender	Frequency	%
1 Strongly Disagree	M	8	36.00
	F	4	12.12
2 Disagree	M	13	52.00
	F	15	45.45
3 Neutral	M	3	24.00
	F	6	18.18
4 Agree	M	1	4.00
	F	7	21.21
5 Strongly Agree	M	0	0.00
	F	1	3.03

Note. M = male; F = female.

* $p < 0.05$.

Table 6

Item 16⁺: Frequency of Survey Responses Sorted by Gender

Response	Gender	Frequency	%
1 Strongly Disagree	M	3	12.00
	F	2	6.06
2 Disagree	M	8	32.00
	F	2	6.06
3 Neutral	M	9	36.00
	F	17	51.52
4 Agree	M	3	12.00
	F	10	30.30
5 Strongly Agree	M	2	8.00
	F	2	6.06

Note. M = male; F = female.

⁺Lies just outside of the confidence interval of 95%.

*p < 0.05.

White and non-White. For this comparison, responses from those identifying as White were compared to those identifying with another racial category. The full data set is shown in Appendix G, Table G1. Table 1 shows the attitude scale survey items. White and non-White individuals agreed that having more diversity at the executive level enhances the workplace (Item 1) and that attention on diversity has a positive impact on the work community (Item 8). Both groups also agreed that it is important to have female executives (Item 15). Furthermore, these groups disagreed with each question stating that certain groups of people (e.g., males, females, racial and ethnic minorities) are given preferential treatment in their workplace (Items 11, 12, and 13).

There were two points of statistical difference between White responses and non-White on the attitude scale, which are shown in Table 7. White respondents were more

likely to disagree, and non-White respondents were more likely to agree, that discriminatory practices still exist in the workplace because they have been institutionalized (Item 6). Similarly, White respondents were more likely to disagree and non-White respondents were more likely to agree that racial discrimination is a contemporary problem (Item 18).

Table 7 details the significant differences in responses between White and non-White groups on the attitudes scale. Statistical significance was determined by confirming a p-value less than 0.05. Further, descriptive statistics, including frequencies of responses (from strongly disagree to strongly agree), were analyzed for each of these statistically significant items. Tables 8 and 9 show these frequencies for each identified item that was statistically significant. Table 8 highlights the frequency of participant responses for Item 6, which had a p-value of $p=0.039$. Similarly, Table 9 shows the frequency of participant responses for Item 18, which had a p-value of $p=0.049$.

Table 7

Items with Significant Differences Between Races on the Attitude Scale

Item	Question	Race	Mean	*P-Value
6	Discriminatory practices still exist in the workplace because they have been institutionalized.	W	2.47	0.039
		N	3.21	
18	Racial discrimination is a contemporary problem.	W	3.32	0.049
		N	4.00	

Note. W = White; N = non-White.

* $p < 0.05$.

Table 8

Item 6: Frequency of Survey Responses Sorted by Race

Response	Gender	Frequency	%
1 Strongly Disagree	W	1	2.90
	N	0	0.00
2 Disagree	W	9	26.50
	N	1	7.70
3 Neutral	W	5	14.70
	N	2	15.40
4 Agree	W	16	47.10
	N	6	46.20
5 Strongly Agree	W	3	8.80
	N	4	30.80

Note. W = White; N = non-White.

*p < 0.05.

Table 9

Item 18: Frequency of Survey Responses Sorted by Race

Response	Gender	Frequency	%
1 Strongly Disagree	W	5	13.90
	N	2	14.30
2 Disagree	W	17	47.20
	N	2	14.30
3 Neutral	W	7	19.40
	N	3	21.40
4 Agree	W	6	16.70
	N	5	35.70
5 Strongly Agree	W	1	2.80
	N	2	14.3

Note. W = White; N = non-White.

*p < 0.05.

White males and marginalized members. For this comparison group, WM were placed in a group to be compared with MM, or those who identified with at least one historically marginalized group (e.g., women, racial or ethnic minorities). A complete set of results is shown in Appendix H, Table H1 and all attitude scale survey items are presented in Table 1. Both groups agreed that diversity at the executive level enhances the workplace (Item 1) and that it is important to have female leaders at work (Item 15). Furthermore, both WM and MM disagreed that women and racial or ethnic minorities are given preferential treatment in their workplaces (Items 11 and 13). The two groups also disagreed that attention on diversity has a negative impact on the workplace (Item 9).

Table 10 details the significant differences in responses between WM and MM on the attitudes scale. Statistical significance was determined by confirming a p-value less than 0.05. Table 10 shows that MM were more likely to agree or strongly agree that attention on diversity has a positive impact in the workplace (Item 8); further, WM were more likely to disagree or strongly disagree that men are given preferential treatment in the workplace (Item 12). Table 10 also includes the p-value for Item 6 ($p=0.083$), which was close to being statistically significant. The responses for this item showed that WM were more likely to disagree or strongly disagree that discrimination is institutionalized.

Descriptive statistics, including frequencies of responses (from strongly disagree to strongly agree), were analyzed for each of these statistically significant items. Tables 11 and 12 show these frequencies for each identified item that was statistically significant. Table 11 details the participant responses, separated by WM and MM, for Item 8, which had a p-value of $p=0.032$. Similarly, Table 12 shows the participant responses for Item 12, which had a p-value of $p=0.000$.

Table 10

Items with Significant Differences Between White Males and Marginalized Members on the Attitude Scale

Item	Q	Marginalization Status	Mean	P-Value
6 ⁺	Discriminatory practices still exist in the workplace because they have been institutionalized.	WM MM	2.15 2.78	0.083
8	Attention on diversity in the workplace has a positive impact on the workplace community.	WM MM	3.62 4.20	0.032
12	Male executives are given preferential treatment in my workplace.	WM MM	1.62 2.59	0.000

Note. WM = White male; MM = marginalized member.

*Lies just outside of the confidence interval of 95%.

*p < 0.05.

Table 11

Item 8: Frequency of Survey Responses Sorted by Marginalization Status

Response	Gender	Frequency	%
1	WM	0	0.00
Strongly Disagree	MM	1	2.20
2	WM	1	7.70
Disagree	MM	1	2.20
3	WM	4	30.80
Neutral	MM	10	22.20
4	WM	7	53.80
Agree	MM	15	33.30
5	WM	1	7.70
Strongly Agree	MM	18	40.00

Note. WM = White male; MM = marginalized member.

*p < 0.05.

Table 12

Item 12: Frequency of Survey Responses Sorted by Marginalization Status

Response	Gender	Frequency	%
1 Strongly Disagree	WM	6	46.20
	MM	7	15.60
2 Disagree	WM	6	46.20
	MM	18	40.00
3 Neutral	WM	1	7.70
	MM	11	24.40
4 Agree	WM	0	0.00
	MM	8	17.80
5 Strongly Agree	WM	0	0.00
	MM	1	2.20

Note. WM = White male; MM = marginalized member.

* $p < 0.05$.

Support Scale

Men and women. As shown in Table 13, the support scale included Items 2 through 5, 10, 19, and 22 through 28. Appendix F, Table F2 shows that there were almost no significant differences between men and women on the support scale and that most of the responses averaged between neutral (3) and agree (4). Women and men agreed that their workplaces make efforts to ensure a welcoming environment for all (Item 10); both groups disagreed, however, that they see routine conversations about diversity in their department (Item 19).

Table 14 shows that males were slightly more likely to agree that the workplace meets the professional needs of women (Item 27). The p -value for this item was $p=0.098$, so it did not fall within the 95% confidence interval, but it was close enough to be

important for further discussion in Chapter 5. Table 15 shows the different gender-based frequencies of responses on this item.

Table 13

Support Scale Items

Item
2. Hiring a more diverse group of executives is a priority in my workplace.
3. The institutional mission of my workplace includes an explicit statement about its commitment to diversity.
4. Diversity is considered in executive-level hiring decisions in my workplace.
5. The promotion of gender equity among executives is a priority in my workplace.
10.. Efforts are made to ensure my workplace is welcoming of people from all backgrounds.
19. Discussions about diversity in my department occur routinely.
^a 21. Accrediting bodies affecting my workplace state that diversity is a priority.
22. Increasing the participation of people from different backgrounds is a priority in my department.
23. My workplace sets a high priority on diversity.
24. My workplace supports the professional needs of racial and ethnic minority staff members.
25. My peers at work are receptive to diversity issues.
26. My peers at work support the use of strategic hiring to promote diversity.
27. My workplace supports the professional needs of women.
28. Communication about diversity exists in my workplace. (ranking)

Table 14

Items with Significant Differences Between Genders on the Support Scale

Item	Question	Gender	Mean	*P-Value
27 ⁺	My workplace supports the professional needs of women.	M	4.00	0.098
		F	3.52	

Note. M = male; F = female.

⁺Lies just outside of the confidence interval of 95%.

*p < 0.05.

Table 15

Item 27⁺: Frequency of Survey Responses Sorted by Gender

Response	Gender	Frequency	%
1 Strongly Disagree	M	0	0.00
	F	1	3.70
2 Disagree	M	1	4.35
	F	6	22.22
3 Neutral	M	5	21.74
	F	3	11.11
4 Agree	M	10	43.48
	F	12	44.44
5 Strongly Agree	M	7	30.43
	F	5	18.52

Note. M = male; F = female.

⁺Lies just outside of the confidence interval of 95%.

*p < 0.05.

White and non-white. Like the trend seen between men and women in the gender comparison group, many of the support scale items averaged between neutral (3) and agree (4), as shown in Appendix G, Table G2. Both White and non-White respondents agreed that efforts are made to ensure a welcoming workplace environment

(Item 10). Further, both groups disagreed that discussions regarding diversity occur routinely in their departments (Item 19). Many of the other items, for example those asking whether peers support diversity or diverse populations (Items 25 and 26), averaged between neutral (3) and agree (4).

Table 16 shows that White and non-White responses differed slightly on only one support scale item: White respondents were slightly more likely to agree that their peers at work are receptive to diversity (Item 25). The p-value for the item was $p=0.067$, which was not within the 95% confidence interval, but it was very close.

Table 16

Items with Significant Differences Between Race on the Support Scale

Item	Question	Race	Mean	P-Value
25 ⁺	My peers at work are receptive to diversity issues.	W N	4.16 3.50	0.067

Note. W = White; N = non-White.

⁺Lies just outside of the confidence interval of 95%.

* $p < 0.05$.

White males and marginalized members. A complete data set for the differences between WM and MM is shown in Appendix H, Table H2, and the support scale survey items are in Table 13. Like the other comparison groups, both WM and MM agreed that their workplaces are welcoming to people of all backgrounds (Item 10). In accordance with previously noted trends, the responses averaged between neutral (3) and agree (4) when asked if peers support the promotion of diversity (Item 25), if diversity is a workplace priority (Item 23), and if communication about diversity occurs regularly (Item 19).

The responses for Item 27 regarding whether the workplace supports the professional needs of women were significantly different between WM and MM, with WM more strongly agreeing that the workplace is supportive of women's needs, shown in Table 17. Statistical significance was determined by confirming a p-value less than 0.05. Further, descriptive statistics, including frequencies of responses (from strongly disagree to strongly agree), were analyzed for Item 27. Table 18 details the participant responses, separated by WM and MM, for Item 27, which had a p-value of $p=0.048$.

Table 17

Items with Significant Differences Between White Males and Marginalized Members on the Support Scale

Item	Question	Marginalization Status	Mean	P-Value
27	My workplace supports the professional needs of women.	WM	4.23	0.048
		MM	3.55	

Note. WM = White male; MM = marginalized member.

* $p < 0.05$.

Table 18

*Item 27: Frequency of Survey Responses Sorted by
Marginalization Status*

Response	Gender	Frequency	%
1 Strongly Disagree	WM	0	0.00
	MM	1	2.70
2 Disagree	WM	0	0.00
	MM	7	18.90
3 Neutral	WM	2	15.40
	MM	6	16.20
4 Agree	WM	6	46.20
	MM	16	43.20
5 Strongly Agree	WM	5	38.50
	MM	7	18.90

Note. WM = White male; MM = marginalized member.

*p < 0.05.

V. DISCUSSION

The purpose of this investigation was to examine health administrator attitudes towards and support of diversity on the basis of gender, race, and marginalization status. Using a quantitative approach, empirical survey data was collected from health administrators and analyzed using an independent t-test in SPSSStatistics, an analytical statistics software package. This investigation sought to examine the following research questions:

Q₁: To what extent do different genders, races, and marginalization statuses impact health administrator attitudes towards diversity in the workplace?

Q₂: To what extent do healthcare workplaces support diversity in practice as perceived by administrators of different genders, races, and marginalization statuses?

Further, the hypotheses were that:

H₁: Membership to different gender, racial, and marginalized groups will impact health administrator attitudes towards diversity in the healthcare workplace; members of different gender, racial, and marginalized groups will adopt different attitudes towards diversity in the workplace.

H₂: Members of different gender, racial, and marginalized groups perceive that healthcare workplaces are supporting diversity in practice on a marginal level; members of different gender, racial, and marginalized groups will not adopt different perceptions of workplace support of diversity.

Attitudes

Towards the impact of diversity. The results indicated that people across all six comparison groups (male and female, White and non-White, WM and MM) agreed that having diversity at the executive level enhances the workplace. Responses, however, varied significantly regarding the impact of focusing on diversity initiatives. Interestingly, 81% of female respondents, compared to only 56% of males, agreed or strongly agreed that diversity had a positive impact on the work community, as shown in Table 3. Furthermore, Table 12 shows that 73% of MM, compared to 61% of WM, agreed that diversity positively impacted the work community.

These results indicated that, while all respondents agreed that diversity at the executive level enhances the workplace, perceptions of the impact of diversity initiatives on the workplace were more complex. This result was consistent with the findings of a previous study in psychology, which demonstrated women to be more likely to have more positive perceptions of diverse work-groups than men (Nakui et al., 2011).

One of the distinguishing factors of the present research was its use of unidimensional and intersectional group comparisons. Though the present data showed that women more strongly agreed than men that diversity positively impacts the workplace, the data also indicated that MM, which included but were not limited to women, showed a significantly stronger appreciation than WM for the positive impacts of focusing on diversity. This has not been shown before in any known research in health administration.

Towards institutionalized discrimination. There were also significant differences in the perceptions of institutionalized discrimination between White

respondents and non-White respondents (similarly, the differences between WM and MM were very close to being statistically significant). Table 8 shows that while 61% of White participants disagreed or strongly disagreed that institutionalized discrimination exists, only 30% of non-White participants disagreed or strongly disagreed. Similarly, Table 9 shows that when asked if racial discrimination is a contemporary problem, 77% of non-White respondents agreed or strongly agreed (only 8% disagreed or strongly disagreed) whereas 56% of White respondents agreed or strongly agreed (30% disagreed or strongly disagreed).

Some Americans may think that discrimination is a thing of the past, perhaps without considering that the effects of archaic practices of discrimination might linger, embedded and intertwined within the power structures that shape society, or that newer and more nuanced forms of discrimination might have replaced those more overt forms of discrimination. Feminist standpoint theory (FST) has informed this research that power structures are complex and that some are embedded within troubling histories; in this way, FST has provided context with which to analyze the responses of participants.

In the United States, discrimination has been institutionalized, meaning it has permeated via often-invisible channels through social and power structures and through policy and legislation. Racially-charged institutionalized discrimination has existed in a number of different ways: through the demographics of executive level healthcare positions, White and Black patients receiving different quality of health care when controlling for income, inner-city and poorer neighborhoods remaining heavily occupied by people of color, and incarceration rates among various races (Barkan, 2013; Hauser, 2014). Institutionalized discrimination has not stopped there – it also has occurred against

women, non-binary and gender non-conforming individuals, and Muslim citizens, among others.

In this research, 61% of White participants denied the existence of institutionalized discrimination despite substantial anecdotal and experiential evidence suggesting otherwise. What does this mean? Do some self-identified White individuals just not see it because it is not part of their experiences? Or, are some self-identified White people willfully blind to institutionalized discrimination? Can the same be said of the 30% of non-White respondents that disagreed or strongly disagreed that such discrimination exists?

A poll done by the New York Times (2015) complemented the results regarding institutionalized discrimination found in this study. This poll found that, when asked if there had been real progress in diminishing the existence of discrimination, 75% of White people in this poll responded that there had been real progress and 56% of Black people in the poll responded that there had been real progress (New York Times, 2015). Further, White people were also more likely to respond that they believed that everyone in society had an equal chance to get ahead (New York Times, 2015). Another study showed that White people tended to perceive racial discrimination as a historical phenomenon and were more likely to report anti-White discrimination as bigger modern problem than institutionalized racial discrimination against Black people (Fletcher, 2014). These results highlighted the disparities in American perceptions of equality and discrimination.

Towards gender-based preferential treatment. Perhaps one of the most interesting responses on the attitude scale resulted from respondents evaluating the statement that male executives are given preferential treatment in the workplace. On this

item, 72% of men disagreed or strongly disagreed (with only 4% in agreement) while 58% of women disagreed or strongly disagreed (with around 25% in agreement), as shown in Table 5. Similarly, while more than half of MM also disagreed with this item, the data in Table 12 show that a resounding 93% of WM disagreed or strongly disagreed that male executives are given preferential treatment. These data indicated that men, especially White men, tended to react strongly against the idea that males were given preferential treatment in the workplace, whereas other groups were more receptive to this idea.

Simply the nature of the demographics in the field of healthcare indicates that men are likely given some kind of preferential treatment, whether it is deliberate or not. Women hold fewer than 20% of hospital CEO positions and even fewer board seats (Hauser, 2014). While female participation in the workplace has increased since the twentieth century, these numbers are not close to being representative of the population, especially when three-quarters of the entire health workforce is female (Hauser, 2014). Not only that, but more than 50% of female employees in healthcare have reported being sexually harassed while at work (Lockwood, 2015). While men do experience sexual harassment and assault and have begun reporting instances more in recent years, evidence suggests that men still have these experiences less than women (Lockwood, 2015).

These examples may not directly implicate preferential treatment of men in the workplace, but they do so indirectly. The healthcare workplace is a relatively safe space for men – they are heavily represented at the top tiers of health hierarchies, have substantial decision-making power, and often do not have to consider the possibility that they might be harassed or assaulted while at work. Women, on the other hand, are more

heavily represented in caregiving roles that are afforded significantly less decision-making power and, in many cases, are forced to consider possibilities and avoid scenarios in which they might be harassed or assaulted while at work. These experiences suggest that the workplace is not always a safe space for women. This disparity – one of the workplace being a place of relative safety for men and a space of vulnerability for women – shows just one way that men are shown preferential treatment.

Towards non-binary individuals. While the concept of a non-binary gender spectrum is not new, it has recently emerged as a topic of interest and discussion in the United States. Prejudices surrounding homosexuality and transgenderism have surfaced. One item on the attitude scale asked about the importance of representation of non-binary executive leaders, and though it was not statistically significant with an alpha level of 0.05, the difference between genders was very close to being statistically significant ($p=0.052$) and thus worth discussing. On this item, the data presented in Table 6 show that about 36% of women agreed that it is important for non-binary people to be represented at the executive level compared to 20% of men (and 30% of all respondents); further, 12% of women disagreed on this item and 44% of men disagreed.

The attitudes reflected in the responses to this item were somewhat troubling in a few ways. First, fewer than one-third of respondents thought that it is important for non-binary people to serve as leaders in their workplace. Further, almost half of the male respondents did not think that such representation is important. These findings potentially highlight a prejudice against, or perhaps simply a misunderstanding of, non-binary individuals, which may be more prevalent in males.

These findings were not surprising and were consistent with other research on the topic. Gender non-conformity and transgenderism have not been well understood by the general public, and widespread transphobia has been well documented (Weiner and Zinner, 2014). Transgender individuals have been significantly more likely to be victims of harassment, sexual assault, or interpersonal violence (Grant et al., 2011). One study highlighted the negative perceptions people maintain of both same-sex as well as transgender individuals in the realm of parenting (Weiner and Zinner, 2014).

In healthcare, a field that by social construct has been endowed with the power of ascribing an individual's sex (rather than understanding an individual's gender), the power of the fears, phobias, and misunderstandings associated with non-binary individuals should not be underestimated. A study showed that 50% of transgender individuals had to teach their own physicians about transgender healthcare; further, 19% of transgender individuals reported being denied access to care altogether (Grant et al., 2011). These statistics have shown that healthcare has had an institutionalized bias against gender-non-conformity, and this has been evidenced further by the meager support for non-binary representation offered by the respondents of the survey.

Support

Across the three comparison profiles (gender, race, and marginalization status), the data showed very few differences in responses on the support scale. Overall, people tended to agree that their workplaces made efforts to welcome people of all backgrounds. However, different workplaces tended to offer different levels of support for diversity. Some people, for example, responded that their workplaces engaged in frequent discussions about diversity, while others expressed that their workplaces did not. Some

administrators' peers appeared to be receptive to diversity and others' did not. The data on the support scale were generally inconclusive as to whether or not healthcare workplaces are supporting diversity in practice.

Of women and racial or ethnic minorities. The most significant difference in responses regarding support of women and racial or ethnic minorities occurred between WM and MM. For example, 0% of WM disagreed or strongly disagreed and an overwhelming 84.7% agreed or strongly agreed that the workplace supported the professional needs of women, as shown in Table 18. By comparison, 21.6% of MM disagreed or strongly disagreed and 61.2% agreed or strongly agreed with the same statement.

These results were fascinating, especially when compared with the difference in responses between men and women. On this same item, about 4% of men disagreed and almost 74% agreed, compared to about 26% of women that disagreed and 63% that agreed, which is shown in Table 15. The results indicated that over half of every comparison group agreed that the professional needs of women have been met. However, there were some relatively extreme differences in the extent of disagreement among parties. In both of the above comparison groups, fewer than 5% of men disagreed that women's professional needs have been met. Comparatively, about a quarter of women and MM indicated disagreement.

Looking at these questions through the lens of FST, White men are not socially situated to fully appreciate the extent to which women's needs are being met. Conversely, women, who *are* socially situated, more readily recognize this shortcoming. However, the data indicated that men felt strongly that women's needs are being met. The men that

indicated support for this statement thereby revealed their incomplete knowledge set and reminded that the male-over-female power hierarchy is still thoroughly entrenched. In other words, these men who agreed that women's needs were being met spoke on behalf of their female counterparts at work without really understanding the full experience. This phenomenon bears resemblance to the poll question that showed the White people tended to believe everyone has equal opportunities in society (Fletcher, 2014); perhaps the men in the study believed that both women and men have had equal opportunities and needs at work and therefore assumed, if they felt that their needs as men were being met, that women's needs were being met, too.

Perhaps, though, these results highlighted some kind of implicit bias, a term that refers to unconscious attitudes or perceptions (Hall et al., 2015). Implicit biases are deeply embedded in human psychology in a place that operates beyond cognitive awareness (Hall et al., 2015; Staats, 2016). Therefore, because implicit biases often have gone unnoticed by their human hosts, they can be challenging to harness and address (Hall et al., 2015). One study indicated that implicit biases can "create invisible barriers to opportunity and achievement" for underserved or underrepresented populations (Staats, 2016, p.33). Another study found that health care providers often harbor implicit biases and perceptions towards their patients based on race; this study recommended that health care personnel address these complex invisible prejudices because they could be a contributing factor to the racial health disparities that persist (Hall et al., 2015). In the case of the survey conducted for this thesis, perhaps the male participants showed implicit bias when they agreed that women's professional needs were met.

It was fascinating that men, including White men, seemed to be so polarized toward agreement on the issue of women's professional needs. How can men feel so strongly about an issue that primarily impacts women? Furthermore, how can men feel so sure that women's needs are being met when women themselves do not fully concur? Because women's experiences likely differ with respect to the workplace meeting their professional needs, it is not particularly surprising that women's answers landed in different places here. It is, however, surprising to see such strong contention from men.

Clearly, some women agreed that their professional needs have been met by their workplaces. At least a quarter of women, however, disagreed. Why might such a significant proportion of women disagree that their professional needs are being met? One reason why women might feel this way could be because of policies regarding parental leave. The Family and Medical Leave Act (FMLA) of 1993 has provided both women and men up to 12 weeks of unpaid leave to care for a child, care for a personal illness, or tend to an ill family member (Pesonen, 2015). While it has been important that the federal government has a provision for leave, the arrangements provided have still been somewhat meager considering the prevalent make-or-break role policy plays in women accessing higher-level management positions (Christiansen et al., 2016).

There is a wealth of evidence suggesting that the FMLA, as compared to other models of parental leave in Europe, has not offered enough support to families or done enough to promote men's participation in caregiving (Escobedo and Wall, 2014; Avendano et al., 2015; Pesonen, 2015). A study on parental leave in Southern Europe showed that leave policies in countries like Greece, Spain, Portugal, and Italy offer from four to 36 months of paid leave for new mothers and fathers, with special incentives for

couples who gender-share parental duties (Escobedo and Wall, 2014). These more generous parental leave programs have been shown to have significant benefits for both men and women. Studies on depression, for example, have found that comprehensive European models of parental leave have produced a reduction in depression rates in older women and that women who had 12 weeks or fewer of maternity leave were more likely to have elevated levels of depression (Chatterji and Markowitz, 2012; Avendano et al., 2015).

Attitudes Towards and Support of Diversity: Answers?

Through a survey of health administrators, this study sought to explore the following research questions:

*Q₁: To what extent do different genders, races, and marginalization statuses impact health administrator **attitudes** towards diversity in the workplace?*

*Q₂: To what extent do healthcare workplaces **support** diversity in practice as perceived by administrators of different genders, races, and marginalization statuses?*

The findings presented in this thesis addressed the research questions and hypotheses in the following ways:

1. Race, gender, and marginalization status impacted health administrators' attitudes towards diversity in the workplace. While people across the three variables (race, gender, and marginalization status) appeared to have a generally positive broad-level perception of diversity, their attitudes differed with respect to the positive impacts of diversity initiatives on the work community and to the presence of institutionalized discrimination. Negative attitudes towards non-binary individuals and gender-non-conformity have

persisted, but more research is warranted to confirm this. These findings supported the hypothesis that membership to different gender, racial, and marginalized groups would impact health administrator attitudes towards diversity in the healthcare workplace; in some cases, members of different gender, racial, and marginalized groups did adopt different attitudes towards diversity in the workplace.

2. Health administrators agreed that their workplaces were generally welcoming of people of all backgrounds. From there, the findings on the most of the support scale items were decisively split regarding general workplace practices of diversity, like regular discussions, diversity as a departmental priority, and the consideration of diversity in hiring processes and decisions. These findings neither supporter nor refuted the hypothesis that members of different gender, racial, and marginalized groups would perceive that healthcare workplaces were supporting diversity in practice on a marginal level.

Recommendations

In the modern era, one in which humans have developed amazing technologies promoting travel and communication across long distances, diversity is no longer an option. Businesses no longer have the choice to diversify their workforces; they simply must. Healthcare has long been an industry that is slow, sometimes indignant, in adapting to the changing world. It is time for healthcare to catch up.

The invisible forces shaping power structures in health administration have persisted. The results of this investigation revealed this subtlety through negative attitudes towards gender non-conformity, White denial of the existence of institutionalized discrimination, and the fact that men in health administration so strongly

agreed that women's professional needs have been met. These power structures have not been oppressive in the same brazen ways that have occurred throughout history; rather, they are nuanced, complex, and intertwined with what is perceived as normality.

Feminist standpoint theory (FST) serves as a way to combat these repressive power structures – this is *not* to say that there should be no power structure in health administration. In fact, there must be some kind of power structure and system of leadership in order for the health industry to progress. FST, however, has great potential to act as a kind of attitude adjustment for the industry that changes the way questions are asked and problems are solved.

One way to do this is to employ more feminist leaders in the healthcare field. That is not to say that these leaders do not already exist in healthcare; on the contrary, they likely can be found in healthcare, but they are also probably a minority. Feminist leadership is a politically and socially situated style of leadership that is fundamentally rooted in empowerment; it has no gender, racial or ethnic identity, or sexual orientation. Further, feminist leadership understands, acknowledges, and seeks to deconstruct the power structures of the past that remain so intricately intertwined with what are perceived as norms today. This process produces a leader that is socially aware, tolerant, and accepting of others, resulting in happier employees and a more welcoming work environment.

An important point about feminist leadership is that it is not necessarily synonymous with gaining more female leaders in the field, although attracting more women to executive-level roles should also be a priority. Not only is greater female participation in leadership better for diversity and for representing the community, but

evidence suggests that it is good for business too (Christiansen et al., 2016). A study of 2 million businesses in Europe showed that firms that had more women in leadership positions tended to bring in more assets and in some cases those assets were increased by 3 to 8% by the addition of just one more woman to an executive-level management team or board (Christiansen et al., 2016).

The process of thinking like a feminist leader starts with the recognition that not all experiences are the same and that no single experience can represent the objective experiences of all. This mindset is critical. It encourages a person or group to think of themselves relationally and contextually rather than independently of others. If a leader begins to consider how their experiences might differ from those around them, that leader might be more likely to ask important questions and uncover differences about the experiences of others. This thinking provides valuable insight for leaders instead of simply assuming that everyone has the same knowledge and experiences.

Consider this example about sidewalks that demonstrates how harmful ethnocentric thinking can be and how discrimination is institutionalized. Inner city and poor neighborhoods have often had poor sidewalk infrastructures (Badger, 2016). These communities have tended to be comprised of people of color and also have tended to have very high rates of preventable health problems like obesity (Badger, 2016; Kelly et al., 2007). Up until somewhat recently, sidewalks and development of green spaces in these communities have not been considered as a solution to combating these health problems.

This example shows that, in solving certain problems and in facing certain circumstances, it takes an insider, someone from the community, to ask critical questions

and to point out viable, sustainable solutions. A physician who, for example, instructs an obese child who lives in a poor inner city community to get more physical exercise by going outside play may not realize that the child may not have access to the infrastructure which would allow him or her simply to go outside and play. It is important for health leaders, including physicians and nurses, to maintain an awareness of and sensitivity to situations in which they may not have all the answers – FST provides this recognition and mindset.

In addition to developing standpoints and changing attitudes through FST and feminist leadership, there is one final recommendation for improving attitudes towards and support of diversity in healthcare. About half of the respondents to my survey indicated that they do not engage in any kind of diversity-related professional development. This must change. It is in the nature of humans to fear and resist change, and it is in the nature of American culture to draw rigid lines around “us” and “them.” These factors interact as a barrier to inclusion in health leadership. Health leaders must be open-minded and ready to accept the challenge of creating a more welcoming and inclusive industry.

In addition to transforming the mindset of the health leader, health organizations that do not already have a model for diversity and inclusion must adopt one. Evidence suggests that management programs which have focused on inclusion result in higher numbers of racial or ethnic minority members, more organizational commitment from employees, and a better overall reputation (Gonzalez, 2014; Finkelstein et al., 2011; Grivastava & Kleiner, 2015). Therefore, adopting a diversity program at the management level has major benefits for employees as well as the company overall.

The implementation of such programs, however, is key and must be handled with care. Diversity initiatives are not all the same, and not all strategies for such programs work effectively (Gonzalez, 2014). This means that it is important for health organizations to use an evidence-based strategy. Fortunately, there are plenty of resources, like the Institute for Diversity in Health Management (IDHM), which is affiliated with the American Hospital Association, that encourage and facilitate inclusion programs for health administrators (IDHM, 2015).

Future Directions

Overall, this research provides more questions than it does answers. In the future, these research questions should be explored through more qualitative methods like ethnography or participant interviews. While the self-reported data collected in this study have been valuable, a research methodology like ethnography will allow an expert researcher to better analyze and deconstruct invisible power structures, implicit bias, and institutionalized discrimination within health organizations.

More research should also be done in the realm of gender non-conformity and transgenderism in healthcare administration. The field seems overwhelmingly conservative in its views of sexuality and gender, but more research should be done to determine if this is actually the case. Of all the groups the survey included in its questioning, those who identify as non-binary seem to be the most misunderstood and potentially the most underrepresented at the executive level. This lack of knowledge about, awareness of, and representation of gender-non-conformity is certainly seen in federal civil rights and policy issues, so it is no surprise that it may exist, too, in healthcare.

More research should also be done on further intersectional variables – for example, what do attitudes towards diversity in health administration look like across different religions, sexual orientations, and geographic regions? How do such attitudes influence policy and trickle down to the patient? There are many additional factors, variables, and unanswered questions yet to be explored in this area.

APPENDIX SECTION

- A. Survey Materials
- B. Elimination Codes
- C. Modification Codes
- D. Survey Items
- E. Correspondence
- F. Survey Results: Males and Females
- G. Survey Results: Whites and Non-Whites
- H. Survey Results: White Males and Marginalized Members
- I. SPSS Statistics Analysis of Equal/Unequal Variance
- J. Research Proposal

APPENDIX A: SURVEY MATERIALS

Survey of Health Managers

Welcome!

This survey was designed by Jenna Parro, a graduate student in health administration. The first section is demographic data, followed by five questions that ask you to respond to statements on a scale from "strongly disagree" to "strongly agree." Please answer each question as accurately as possible. Your identity will remain anonymous, and your responses will be confidential. This survey should take about 10 minutes.

Thank you for being a part of this research!

Next

Demographic Data

1. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Other (please specify)

2. Please describe your race/ethnicity.

3. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

4. Which of the following describes your job role within your organization?

- ☐ Entry-level management
- ☐ Mid-level management
- ☐ Executive-level management
- ☐ Member of the board

5. How long have you served in your current job role?

- ☐ 0-5 years
- ☐ 5-10 years
- ☐ 10-15 years
- ☐ 15+ years

6. How long have you worked in the healthcare industry?

- ☐ 0-5 years
- ☐ 5-10 years
- ☐ 10-15 years
- ☐ 15+ years

Prev

Next

7. Please respond to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
Having more diversity at the executive level enhances my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hiring a more diverse group of executives is a priority in my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The institutional mission of my workplace includes an explicit statement about its commitment to diversity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diversity is considered in executive-level hiring decisions in my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The promotion of gender equity among executives is a priority in my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discriminatory practices still exist in the workplace because they have been institutionalized.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The leadership of my workplace is representative of the racial and ethnic diversity of the United States.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attention on diversity has a positive impact on the workplace community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attention on diversity has a negative impact on the workplace community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Efforts are made to ensure my workplace is welcoming of people from all backgrounds.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Female executives are given preferential treatment in my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Male executives are given preferential treatment in my workplace.

☐☐☐☐☐

Racial and ethnic minority executives are given preferential treatment in my workplace.

☐☐☐☐☐

I am sensitive to the existence of institutionalized discrimination.

☐☐☐☐☐

It is important that female executives serve as leaders in my workplace.

☐☐☐☐☐

It is important that non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') executives serve as leaders in my workplace.

☐☐☐☐☐

Prev

Next

8. Please respond to each statement.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Gender discrimination is a contemporary problem.

☐☐☐☐☐

With 1 being "a big problem" and 10 being "not a problem," please rank the gravity of this problem on a scale of 1-10.

Racial discrimination is a contemporary problem.

☐☐☐☐☐

With 1 being "a big problem" and 10 being "not a problem," please rank the gravity of this problem on a scale of 1-10.

Prev

Next

9. Please respond to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Discussions about diversity in my department occur routinely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I regularly participate in professional development activities related to diversity in my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accrediting bodies affecting my workplace state that diversity is a priority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increasing the participation of people from different backgrounds is a priority in my department.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Prev

Next

10. Please respond to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
My workplace sets a high priority on diversity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My workplace supports the professional needs of racial and ethnic minority staff members.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My peers at work are receptive to diversity issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My peers at work support the use of strategic hiring to promote diversity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My workplace supports the professional needs of women.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communication about diversity exists in my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

With 1 being "not at all" and 10 being "frequently," please rate how often this communication occurs on a scale from 1-10.

Prev

Next

11. Please respond to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Mentoring female colleagues in upper-level management roles is a significant part of my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mentoring racial or ethnic minority colleagues in upper-level management roles is a significant part of my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mentoring non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') colleagues in upper-level management roles is a significant part of my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assist in the recruitment of prospective female executives to my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assist in the recruitment of prospective racial or ethnic minority executives to my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assist in the recruitment of prospective non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') executives to my workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At work, I collaborate with people who are a different race or ethnicity than I am.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Prev

Next

Survey Complete.

Thank you for participating in this research!

Prev

Done

APPENDIX B: ELIMINATION CODES

Table B1

Elimination Code Legend

Code	Criteria for Elimination
1	Poor adaptability to healthcare
2	Little relevance to research questions
3	Duplicate question

Table B2

Survey Items & Their Assigned Elimination Codes

Item	Elimination Code
Hiring a more diverse faculty should be a priority at my university.	
A more diverse faculty would enhance my university.	
Hiring a more diverse staff should be a priority at my university.	3
Creating a diverse campus environment should be a priority at my university.	3
Recruiting a more diverse student body should be a priority at my university.	1
A diverse student body enhances the educational experience of all students.	1
The institutional mission of my university should include an explicit statement about its commitment to diversity.	
Diversity should be a factor considered in student admissions to my university.	
The promotion of gender equity among faculty should be a priority at my university.	
Discriminatory practices still exist in American higher education because they have been institutionalized.	
The leadership of my university should be representative of the racial and ethnic diversity of the United States.	
Gender discrimination is a major contemporary problem.	
Improving access to higher education for racial and ethnic minorities is important to compensate for the historical legacy of discrimination.	2

Table B2 (cont.)

Racial discrimination is a major contemporary problem.	
Too much attention on diversity can divide the campus community.	
Diversity is relevant to the future professional lives of my students.	1
Efforts should be made to ensure my university is welcoming of people from all backgrounds.	
Regardless of students' background characteristic, everyone in the US should have an equal opportunity to attend college.	1
Female faculty members are given preferential treatment at my university.	
Racial and ethnic minority faculty members are given preferential treatment at my university.	
I am sensitive to the existence of institutionalized racism.	
It is important that female faculty members serve as leaders in my university and field.	
The university's goal to achieve greater diversity on this campus is a responsibility shared equally by all faculty members.	1
Racial and ethnic diversity is represented in the curriculum of my courses.	1
There are frequent discussions about diversity in the classes I teach.	
I strive to expand students' knowledge of racial and ethnic minority groups.	1
I explore questions related to gender in my research.	1
Women are represented in the curriculum of my courses.	1
Diversity is irrelevant to my research interests.	1
Diversity is a central component of my research agenda.	1
Issues of diversity are unrelated to the content of my courses.	1
I regularly participate in professional development activities related to diversity on campus.	
I am familiar with resources to assist in revising my curriculum so it is more inclusive of diverse perspectives.	1
My faculty colleagues routinely consider issues of race, ethnicity, and gender in their work.	1
Accrediting bodies in my field state that diversity is a priority.	
Increasing the participation of people from diverse backgrounds is a priority in my field.	

Table B2 (cont.)

I serve on committees that promote racial and ethnic diversity at my university.	1
My university sets a high priority on diversity.	
My university supports the professional needs of racial and ethnic minority faculty members.	
Faculty members of different races and ethnicities are treated unfairly at my university.	1
My faculty peers are receptive to diversity issues.	1
There is a lot of rhetoric about diversity at my university, but not enough action.	1
Faculty members from other countries are treated unfairly at my university.	1
My faculty colleagues are ambivalent about the importance of diversity.	1
My university supports the professional needs of faculty members from other countries.	1
My university upholds respect for the expression of diverse perspectives.	
There is a great deal of racial tension on this campus.	1
My university supports the professional needs of female faculty members.	1
Faculty members in my department support the use of strategic hiring to promote diversity.	
Female faculty members are treated unfairly at my university.	
Mentoring female students in research is an important part of my work.	
Mentoring racial or ethnic minority students in research is an important part of my work.	
Mentoring international students in research is an important part of my work.	1, 2
I assist in the recruitment of prospective female students to my academic program.	
I assist in the recruitment of prospective students from racial and ethnic minority backgrounds to my academic program.	
I collaborate on research with people who are a different race or ethnicity than I am.	

Note. Adapted with permission from “ACES: The Development of a Valid Instrument to Assess Faculty Support of Diversity Goals in the United States,” by J. Ng, W. Skrupski, B. Frey, L. Wolf-Wendel, 2013, *Research and Practice in Assessment*, 8, 29-41. Copyright 2013 by RPA Journal.

APPENDIX C: MODIFICATION CODES

Table C1

Modification Code Legend

Code	Reason for modification
1	Relevance to healthcare
2	Reflect present state of workplace practice
3	Reflect additional demographics
4	Reduce bias in wording
5	Add a ranking scale

Table C2

Survey Items & Their Assigned Modification Codes

Item	Modification Code
Hiring a more diverse faculty should be a priority at my university.	1, 2
A more diverse faculty would enhance my university.	1, 2
The institutional mission of my university should include an explicit statement about its commitment to diversity.	1, 2
Diversity should be a factor considered in student admissions to my university.	1, 2
The promotion of gender equity among faculty should be a priority at my university.	1, 2
Discriminatory practices still exist in American higher education because they have been institutionalized.	1
The leadership of my university should be representative of the racial and ethnic diversity of the United States.	1, 2
Gender discrimination is a major contemporary problem.	1, 4, 5
Racial discrimination is a major contemporary problem.	1, 4, 5
Too much attention on diversity can divide the campus community.	1, 3, 4
Efforts should be made to ensure my university is welcoming of people from all backgrounds.	1, 2

Table C2 (cont.)

Female faculty members are given preferential treatment at my university.	1, 3
Racial and ethnic minority faculty members are given preferential treatment at my university.	1, 3
I am sensitive to the existence of institutionalized racism.	1, 4
It is important that female faculty members serve as leaders in my university and field.	1
There are frequent discussions about diversity in the classes I teach.	1
I regularly participate in professional development activities related to diversity on campus.	1
Accrediting bodies in my field state that diversity is a priority.	1
Increasing the participation of people from diverse backgrounds is a priority in my field.	1
My university sets a high priority on diversity.	1
My university supports the professional needs of racial and ethnic minority faculty members.	1
My faculty peers are receptive to diversity issues.	1
There is a lot of rhetoric about diversity at my university, but not enough action.	1, 4, 5
My university supports the professional needs of female faculty members.	1
Faculty members in my department support the use of strategic hiring to promote diversity.	1
Mentoring female students in research is an important part of my work.	1, 3
Mentoring racial or ethnic minority students in research is an important part of my work.	1, 3
I assist in the recruitment of prospective female students to my academic program.	1, 3
I assist in the recruitment of prospective students from racial and ethnic minority backgrounds to my academic program.	1, 3
I collaborate on research with people who are a different race or ethnicity than I am.	1

Note. Adapted with permission from “ACES: The Development of a Valid Instrument to Assess Faculty Support of Diversity Goals in the United States,” by J. Ng, W. Skorupski, B. Frey, L. Wolf-Wendel, 2013, *Research and Practice in Assessment*, 8, 29-41. Copyright 2013 by RPA Journal.

APPENDIX D: SURVEY ITEMS

Table D1

Attitude Scale Survey Items and Research Question Addressed

Item	RQ
1. Having more diversity at the executive level enhances my workplace.	1
6. Discriminatory practices still exist in the workplace because they have been institutionalized.	1
7. The leadership of my workplace is representative of the racial and ethnic diversity of the United States.	1
8. Attention on diversity in the workplace has a positive impact on the workplace community.	1
9. Attention on diversity in the workplace has a negative impact on the workplace community.	1
11. Female executives are given preferential treatment in my workplace.	1
12. Male executives are given preferential treatment in my workplace.	1
13. Racial and ethnic minority executives are given preferential treatment in my workplace.	1
14. I am sensitive to the existence of institutionalized discrimination.	1
15. It is important that female executives serve as leaders in my workplace.	1
16. It is important that non-binary (individuals not defined by traditional notions of gender like ‘male’ or ‘female’) executives serve as leaders in my workplace.	1
17. Gender discrimination is a contemporary problem. (ranking)	1
18. Racial discrimination is a contemporary problem. (ranking)	1

Note. RQ = research question. Adapted with permission from “ACES: The Development of a Valid Instrument to Assess Faculty Support of Diversity Goals in the United States,” by J. Ng, W. Skorupski, B. Frey, L. Wolf-Wendel, 2013, *Research and Practice in Assessment*, 8, 29-41. Copyright 2013 by RPA Journal.

Table D2

^a*Engagement Scale Survey Items and Research Question Addressed*

Item	RQ
^a 20. I regularly participate in professional development activities related to diversity in my workplace.	n/a
^a 29. Mentoring female colleagues in upper-level management roles is a significant part of my work.	n/a
^a 30. Mentoring racial or ethnic minority colleagues in upper-level management roles is a significant part of my work.	n/a
^a 31. Mentoring non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') colleagues in upper-level management roles is a significant part of my work.	n/a
^a 32. I assist in the recruitment of prospective female executives to my workplace.	n/a
^a 33. I assist in the recruitment of prospective racial or ethnic minority executives to my workplace.	n/a
^a 34. I assist in the recruitment of prospective non-binary (individuals not defined by traditional notions of gender like 'male' or 'female') executives to my workplace.	n/a
^a 35. At work, I collaborate with people who are a different race or ethnicity than I am.	n/a

Note. RQ = research question; n/a = not applicable. Adapted with permission from “ACES: The Development of a Valid Instrument to Assess Faculty Support of Diversity Goals in the United States,” by J. Ng, W. Skorupski, B. Frey, L. Wolf-Wendel, 2013, *Research and Practice in Assessment*, 8, 29-41. Copyright 2013 by RPA Journal.

^aRemoved from analysis.

Table D3

Support Scale Survey Items and Research Question Addressed

Item	RQ
2. Hiring a more diverse group of executives is a priority in my workplace.	2
3. The institutional mission of my workplace includes an explicit statement about its commitment to diversity.	2
4. Diversity is considered in executive-level hiring decisions in my workplace.	2
5. The promotion of gender equity among executives is a priority in my workplace.	2
10.. Efforts are made to ensure my workplace is welcoming of people from all backgrounds.	2
19. Discussions about diversity in my department occur routinely.	2
^a 21. Accrediting bodies affecting my workplace state that diversity is a priority.	2
22. Increasing the participation of people from different backgrounds is a priority in my department.	2
23. My workplace sets a high priority on diversity.	2
24. My workplace supports the professional needs of racial and ethnic minority staff members.	2
25. My peers at work are receptive to diversity issues.	2
26. My peers at work support the use of strategic hiring to promote diversity.	2
27. My workplace supports the professional needs of women.	2
28. Communication about diversity exists in my workplace. (ranking)	2

Note. RQ = research question. Adapted with permission from “ACES: The Development of a Valid Instrument to Assess Faculty Support of Diversity Goals in the United States,” by J. Ng, W. Skorupski, B. Frey, L. Wolf-Wendel, 2013, *Research and Practice in Assessment*, 8, 29-41. Copyright 2013 by RPA Journal.

^aRemoved from analysis.

APPENDIX E: CORRESPONDENCE

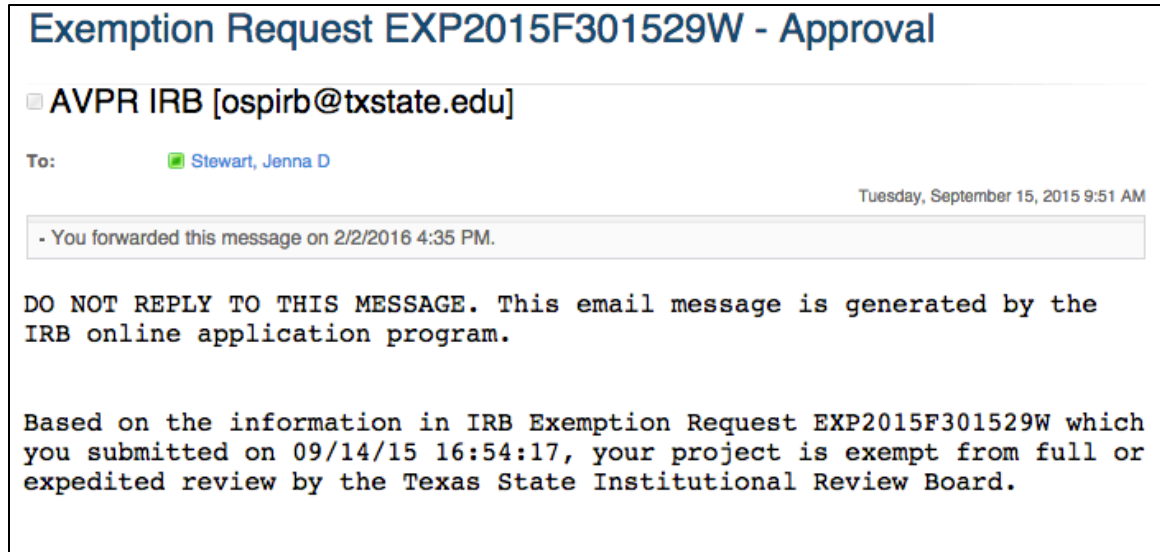


Figure E1. IRB exemption letter. This letter shows an email received indicating that this project is exempt from full or expedited IRB review.

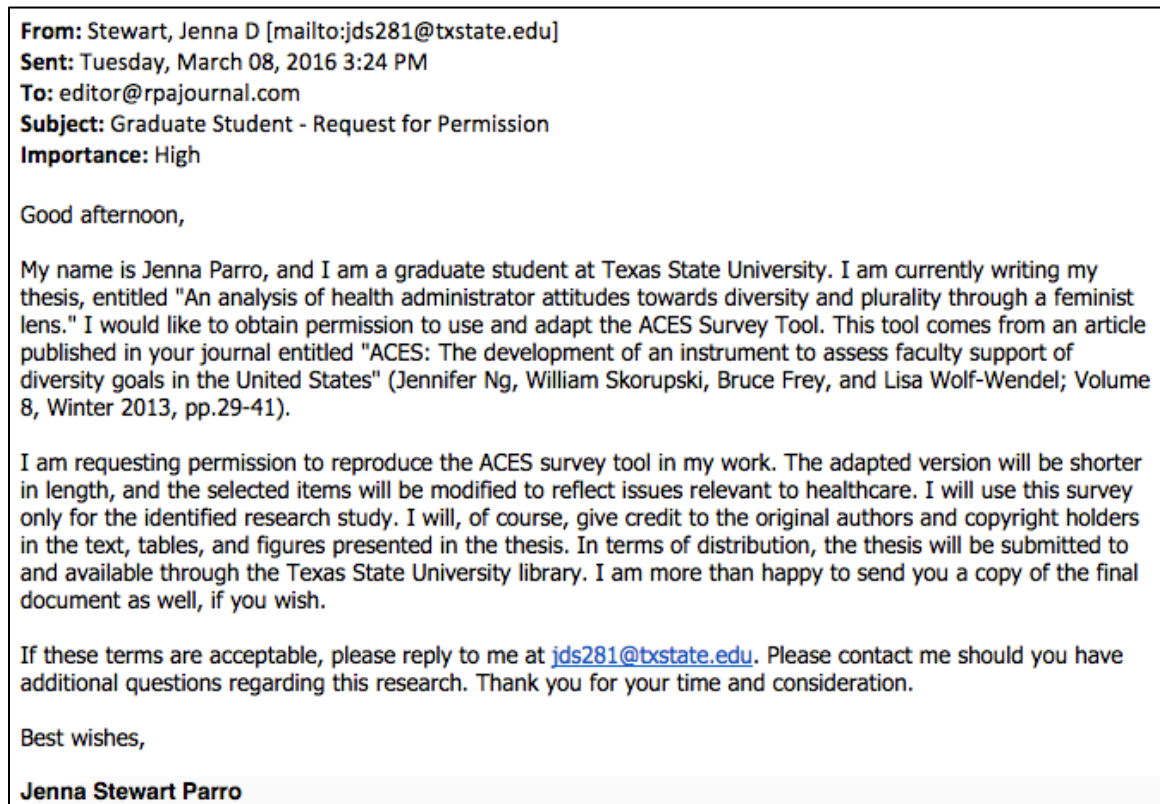


Figure E2. Request for permission. This is a request for permission to use and adapt the ACES tool, as per permission and copyright instructions on the RPA journal website.

From: Busby, Katie K [kbusby@tulane.edu]
Sent: Wednesday, March 09, 2016 12:58 PM
To: Stewart, Jenna D; editor@rpajournal.com
Subject: RE: Graduate Student - Request for Permission

Dear Jenna,

As Editor of *Research & Practice in Assessment* I approve your request to adapt the survey indicated below and advance the scholarship in this field. Thank you for your attention to appropriate citations where needed.

I wish you the best of luck with your thesis and hope that you will consider RPA as a publication for your own research in the future.

Kindest Regards,
Katie

Katie Busby, Ph.D.
Assistant Provost for Assessment and Institutional Research
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Editor, *Research & Practice in Assessment*
<http://www.rpajournal.com/>

Figure E3. Written permission to use and adapt the ACES tool. This presents written permission to use and adapt the ACES survey tool in my own research.

Wednesday, February 03, 2016 7:46 AM

Greetings!

My name is Jenna Parro, and I am a graduate student in health administration. I am conducting a survey of health managers for my graduate thesis. Because you are a health manager, I am inviting you to participate in this research study by completing the attached survey.

This survey will remain open until February 10, 2016 and should take about 10 minutes to complete. In order to ensure that all information will remain confidential, no identifying or sensitive information will be collected. If you choose to participate in this research, please answer each question as honestly and completely as possible. Participation is on a voluntary basis, so you may refuse to participate at any time. Please [click here](#) to start the survey.

Thank you for helping me in this academic endeavor! If you would like a summary copy of this study or if you require additional information, please email me at jenna.parro@gmail.com. Otherwise, thank you for your time and thoughtful responses.

Kindest regards,
Jenna Parro

Figure E4. Cover letter email. This cover letter email accompanied and introduced the survey to a list of 264 individuals from the Texas State University MHA program database of professionals and was also attached to a LinkedIn posting on the Texas State University Health Administration alumni page with a potential audience of 990 individuals.

Wednesday, February 10, 2016 4:31 PM

Good afternoon!

You are receiving this as a follow-up email. Last week, I distributed a survey of health managers for my graduate thesis. The survey link was originally set to close today, February 10, 2016, but that deadline has been extended for those who still want to participate but have not yet done so. The survey will now close on Monday, February 15, 2016. As a reminder, all responses are anonymous and confidential. The link is [here](#).

A very warm 'thank you' to each and every one of you for your help in this academic endeavor.

Best wishes,

Jenna Stewart Parro

Figure E5. Follow-up email. This follow-up email was sent to the same list of 264 individuals from the Texas State University MHA program database of professionals.

APPENDIX F: SURVEY RESULTS BETWEEN MALES & FEMALES

Table F1

Attitude Scale Survey Responses: Gender

Item	Gender	n	Mean	Std. Deviation	P-Value	Significance?
1	M	25	4.20	.957	0.772	No
	F	34	4.26	.751		
6	M	25	2.52	1.327	0.863	No
	F	33	2.58	1.032		
7	M	25	3.00	1.291	0.843	No
	F	32	3.06	1.076		
8*	M	25	3.60	1.041	0.008	Yes
	F	33	4.24	.751		
9*	M	25	2.28	.792	0.025	Yes
	F	33	1.82	.727		
11	M	25	2.12	1.166	0.580	No
	F	33	1.97	.770		
12*	M	25	1.96	.889	0.023	Yes
	F	33	2.58	1.062		
13	M	25	1.88	.781	0.173	No
	F	33	2.21	.992		
14	M	25	3.52	1.229	0.683	No
	F	33	3.64	.929		

Table F1 (cont.)

Item	Gender	n	Mean	Std. Deviation	P-Value	Significance?
15	M	25	3.96	1.020	0.673	No
	F	33	4.06	.788		
16 ⁺	M	25	2.72	1.100	0.052	Close
	F	33	3.24	.902		
17	M	24	3.17	.917	0.208	No
	F	29	3.52	1.056		
17.RANKING	M	19	5.58	1.953	0.853	No
	F	22	5.45	2.262		
18	M	24	3.50	1.063	0.680	No
	F	29	3.38	1.049		
18.RANKING	M	19	5.95	2.571	0.852	No
	F	20	5.80	2.331		

Note: Items designated with an * indicate a statistically significant difference between the means between males and females on the attitude scale. Items designated with a ⁺ indicate that the difference between the means is very close to being statistically significant. Statistical significance assigned if $p < 0.05$. M=male; F=female.

Table F2

Support Scale Survey Responses: Gender

Item	Gender	n	Mean	Std. Deviation	P-Value	Significance?
2	M	25	3.56	1.044	0.902	No
	F	34	3.53	.861		
3	M	25	3.20	1.291	0.194	No
	F	33	3.61	1.059		
4	M	25	3.52	1.046	0.984	No
	F	33	3.52	.755		
10	M	25	4.32	.852	0.365	No
	F	33	4.09	1.011		
19	M	24	2.83	1.167	0.944	No
	F	28	2.86	1.268		
22	M	24	3.00	1.180	0.435	No
	F	28	3.25	1.110		
23	M	23	3.22	1.204	0.733	No
	F	27	3.33	1.177		
24	M	23	3.78	.795	0.985	No
	F	27	3.78	.974		
25	M	23	3.91	.596	0.699	No
	F	27	4.00	.920		

Table F2 (cont.)

Item	Gender	n	Mean	Std. Deviation	P-Value	Significance?
26	M	23	3.13	1.058	0.384	No
	F	27	3.41	1.152		
27 ⁺	M	23	4.00	.853	0.098	Close
	F	27	3.52	1.156		
28	M	23	3.57	1.037	0.930	No
	F	26	3.54	1.067		
28.RANKING	M	17	4.88	2.233	0.860	No
	F	19	4.74	2.621		

Note: Items designated with a ⁺ indicate that the difference between the means is very close to being statistically significant on the support scale. Statistical significance assigned if $p < 0.05$. M=male; F=female.

APPENDIX G: SURVEY RESULTS BETWEEN WHITES & NON-WHITES

Table G1

Attitude Scale Survey Responses: Race

Item	Racial Category	n	Mean	Std. Deviation	P-Value	Significance?
1	W	37	4.27	.804	0.360	No
	N	14	4.50	.760		
6*	W	36	2.47	1.028	0.039	Yes
	N	14	3.21	1.311		
7	W	35	3.14	1.033	0.512	No
	N	14	2.86	1.460		
8	W	36	4.00	.793	0.601	No
	N	14	4.14	1.027		
9	W	36	1.97	.696	0.626	No
	N	14	1.86	.864		
11	W	36	2.03	.971	0.554	No
	N	14	2.21	1.051		
12	W	36	2.28	1.031	0.504	No
	N	14	2.50	1.092		
13	W	36	2.17	1.028	0.209	No
	N	14	1.79	.699		
14	W	36	3.75	.937	0.246	No
	N	14	3.29	1.326		

Table G1 (cont.)

Item	Racial Category	n	Mean	Std. Deviation	P-Value	Significance?
15	W	36	4.00	.862	0.204	No
	N	14	4.36	.929		
16	W	36	2.97	1.000	0.156	No
	N	14	3.43	1.016		
17	W	34	3.32	1.065	0.270	No
	N	13	3.69	.855		
17.RANKING ⁺	W	27	5.85	1.994	0.057	Close
	N	11	4.45	1.968		
18*	W	34	3.32	1.065	0.049	Yes
	N	13	4.00	.913		
18.RANKING	W	25	6.24	2.026	0.227	No
	N	11	5.00	2.966		

Note: Items designated with an * indicate a statistically significant difference between the means between those identifying as White and those identifying as non-White. Items designated with a ⁺ indicate that the difference between the means is very close to being statistically significant. Statistical significance assigned if $p < 0.05$. W=White; N=non-White.

Table G2

Support Scale Survey Responses: Race

Item	Racial Category	n	Mean	Std. Deviation	P-Value	Significance?
2	W	37	3.62	.953	0.272	No
	N	14	3.29	.994		
3	W	36	3.42	1.180	0.828	No
	N	14	3.50	1.286		
4	W	36	3.58	.996	0.446	No
	N	14	3.36	.745		
10	W	36	4.31	.889	0.141	No
	N	14	3.86	1.099		
19	W	33	2.91	1.182	0.731	No
	N	13	2.77	1.363		
22	W	33	3.27	1.039	0.458	No
	N	13	3.00	1.291		
23	W	32	3.47	1.107	0.229	No
	N	12	3.00	1.206		
24	W	32	3.97	.782	0.109	No
	N	12	3.50	1.000		
25 ⁺	W	32	4.16	.574	0.067	Close
	N	12	3.50	1.087		

Table G2 (cont.)

Item	Racial Category	n	Mean	Std. Deviation	P-Value	Significance?
26	W	32	3.38	1.157	0.445	No
	N	12	3.08	.996		
27	W	32	3.84	1.019	0.354	No
	N	12	3.50	1.243		
28	W	31	3.71	.902	0.080	Close
	N	12	3.08	1.311		
RANKING	W	22	5.00	2.430	0.763	No
	N	11	4.73	2.412		

Note: Items designated with a ⁺ indicate that the difference between the means is very close to being statistically significant on the support scale. Statistical significance assigned if $p < 0.05$. W=White; N=non-White.

APPENDIX H: SURVEY RESULTS BETWEEN WHITE MALES & MARGINALIZED MEMBERS

Table H1

Attitude Scale Survey Responses: Marginalization Status

Item	Status	n	Mean	Std. Deviation	P-Value	Significance?
1	WM	13	4.15	.801	0.409	No
	MM	42	4.36	.759		
6 ⁺	WM	13	2.15	1.068	0.083	Close
	MM	41	2.78	1.129		
7	WM	13	3.08	1.256	0.942	No
	MM	40	3.05	1.131		
8*	WM	13	3.62	.768	0.032	Yes
	MM	41	4.20	.843		
9	WM	13	2.15	.689	0.244	No
	MM	41	1.88	.748		
11	WM	13	2.00	1.155	0.813	No
	MM	41	2.07	.905		
12*	WM	13	1.62	.650	0.000	Yes
	MM	41	2.59	1.024		
13	WM	13	1.92	.862	0.506	No
	MM	41	2.12	.954		
14	WM	13	3.92	.954	0.274	No
	MM	41	3.56	1.050		

Table H1 (cont.)

Item	Status	n	Mean	Std. Deviation	P-Value	Significance?
15	WM	13	4.15	.899	0.769	No
	MM	41	4.07	.848		
16	WM	13	2.77	1.166	0.152	No
	MM	41	3.22	.909		
17	WM	13	3.23	1.013	0.411	No
	MM	36	3.50	1.000		
RANKING_B	WM	10	5.90	1.792	0.369	No
	MM	29	5.21	2.161		
18	WM	13	3.46	.967	0.847	No
	MM	36	3.53	1.082		
RANKING_A	WM	10	5.90	2.132	0.831	No
	MM	27	5.70	2.569		

Note: Items designated with an * indicate a statistically significant difference between the means White males and those with identity features other than White male. Items designated with a ⁺ indicate that the difference between the means is very close to being statistically significant. Statistical significance assigned if $p < 0.05$. WM=White male; MM=marginalized member.

Table H2

Support Scale Survey Responses: Marginalization Status

Item	Status	n	Mean	Std. Deviation	P-Value	Significance?
2	WM	13	3.62	1.044	0.762	No
	MM	42	3.52	.917		
3	WM	13	3.00	1.354	0.109	No
	MM	41	3.61	1.115		
4	WM	13	3.62	1.261	0.784	No
	MM	41	3.51	.779		
10	WM	13	4.46	.660	0.234	No
	MM	41	4.10	1.020		
19	WM	13	2.77	1.013	0.687	No
	MM	35	2.91	1.292		
22	WM	13	3.08	1.038	0.672	No
	MM	35	3.23	1.114		
23	WM	13	3.23	1.166	0.725	No
	MM	33	3.36	1.141		
24	WM	13	4.00	.707	0.390	No
	MM	33	3.76	.902		
25	WM	13	4.08	.494	0.593	No
	MM	33	3.94	.864		

Table H2 (cont.)

Item	Status	n	Mean	Std. Deviation	P-Value	Significance?
26	WM	13	3.08	1.115	0.382	No
	MM	33	3.39	1.088		
27*	WM	13	4.23	.725	0.048	Yes
	MM	33	3.55	1.121		
28	WM	13	3.62	.961	0.812	No
	MM	32	3.53	1.107		
RANKING	WM	9	4.44	2.186	0.589	No
	MM	25	4.96	2.508		

Note: Items designated with an * indicate a statistically significant difference between the means White males and those with identity features other than White male. Items designated with a ⁺ indicate that the difference between the means is very close to being statistically significant. Statistical significance assigned if $p < 0.05$. WM=White male; MM=marginalized member.

APPENDIX I: SPSSSTATISTICS ANALYSIS OF EQUAL/UNEQUAL VARIANCE

Table I1

SPSS Statistics Data: Gender

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	If Sig > 0.05, then equal var. assumed Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
NSS	Item1	3.883	.054	-.291	57	.772	-.065	.222	-.510	.381
	Equal variances not assumed			-.280	44.073	.780	-.065	.231	-.530	.400
NSS	Item2	1.955	.168	.123	57	.902	.031	.248	-.467	.528
	Equal variances not assumed			.120	45.700	.905	.031	.256	-.484	.545
NSS	Item3	1.987	.164	-1.316	56	.194	-.406	.309	-1.024	.212
	Equal variances not assumed			-1.280	45.779	.207	-.406	.317	-1.045	.233
NSS	Item4	2.911	.093	.021	56	.984	.005	.236	-.469	.478
	Equal variances not assumed			.020	41.812	.984	.005	.247	-.494	.503

Table II (cont.)

NSS	Item5	Equal variances assumed	.314	.578	1.275	55	.208	.345	.271	-.197	.887
		Equal variances not assumed			1.296	54.244	.200	.345	.266	-.189	.879
NSS	Item6	Equal variances assumed	5.026	.029	-.180	56	.858	-.056	.309	-.676	.564
		Equal variances not assumed			-.174	44.088	.863	-.056	.320	-.701	.590
NSS	Item7	Equal variances assumed	1.524	.222	-.199	55	.843	-.063	.314	-.691	.566
		Equal variances not assumed			-.195	46.506	.846	-.063	.321	-.708	.583
SS	Item8	Equal variances assumed	2.695	.106	-2.732	56	.008	-.642	.235	-1.114	-.171
		Equal variances not assumed			-2.613	41.800	.012	-.642	.246	-1.139	-.146
SS	Item9	Equal variances assumed	.311	.579	2.306	56	.025	.462	.200	.061	.863
		Equal variances not assumed			2.279	49.352	.027	.462	.203	.055	.869
NSS	Item10	Equal variances assumed	.749	.391	.913	56	.365	.229	.251	-.274	.732
		Equal variances not assumed			.935	55.307	.354	.229	.245	-.262	.720

Table I1 (cont.)

NSS	Item11	Equal variances assumed	4.370	.041	.590	56	.557	.150	.255	-.360	.660
		Equal variances not assumed			.559	39.257	.580	.150	.269	-.394	.694
SS	Item12	Equal variances assumed	2.281	.137	-2.343	56	.023	-.616	.263	-1.142	-.089
		Equal variances not assumed			-2.401	55.387	.020	-.616	.256	-1.130	-.102
NSS	Item13	Equal variances assumed	1.774	.188	-1.380	56	.173	-.332	.241	-.814	.150
		Equal variances not assumed			-1.426	55.897	.159	-.332	.233	-.799	.134
NSS	Item14	Equal variances assumed	2.709	.105	-.411	56	.683	-.116	.283	-.684	.451
		Equal variances not assumed			-.395	43.218	.694	-.116	.294	-.710	.477
NSS	Item15	Equal variances assumed	1.816	.183	-.424	56	.673	-.101	.237	-.576	.375
		Equal variances not assumed			-.409	43.894	.684	-.101	.246	-.596	.395
close	Item16	Equal variances assumed	1.531	.221	-1.986	56	.052	-.522	.263	-1.049	.004
		Equal variances not assumed			-1.933	45.786	.059	-.522	.270	-1.067	.022

Table II (cont.)

NSS	Item17	Equal variances assumed	1.702	.198	<u>-1.276</u>	51	<u>.208</u>	-.351	.275	-.902	.201
		Equal variances not assumed			-1.293	50.866	.202	-.351	.271	-.895	.194
NSS	RANKIN G_B	Equal variances assumed	.318	<u>.576</u>	<u>.187</u>	39	<u>.853</u>	.124	.665	-1.222	1.470
		Equal variances not assumed			.189	39.000	.851	.124	.658	-1.207	1.456
NSS	Item18	Equal variances assumed	.030	.862	<u>.414</u>	51	<u>.680</u>	.121	.291	-.464	.705
		Equal variances not assumed			.414	48.915	.681	.121	.292	-.465	.707
NSS	RANKIN G_A	Equal variances assumed	1.190	.282	<u>.188</u>	37	<u>.852</u>	.147	.785	-1.443	1.738
		Equal variances not assumed			.187	36.184	.853	.147	.787	-1.448	1.743
NSS	Item19	Equal variances assumed	.973	.329	<u>-.070</u>	50	<u>.944</u>	-.024	.340	-.707	.659
		Equal variances not assumed			-.070	49.726	.944	-.024	.338	-.703	.655

Table I1 (cont.)

NSS	Item20	Equal variances assumed	1.238	.271	.396	50	.694	.131	.330	-.533	.795
		Equal variances not assumed			.399	49.666	.692	.131	.328	-.529	.791
NSS	Item21	Equal variances assumed	.182	.671	.074	50	.941	.024	.321	-.622	.669
		Equal variances not assumed			.074	47.376	.942	.024	.323	-.627	.674
NSS	Item22	Equal variances assumed	.286	.595	-.787	50	.435	-.250	.318	-.888	.388
		Equal variances not assumed			-.783	47.733	.438	-.250	.319	-.892	.392
NSS	Item23	Equal variances assumed	.003	.956	-.344	48	.733	-.116	.338	-.795	.563
		Equal variances not assumed			-.343	46.377	.733	-.116	.338	-.796	.565
NSS	Item24	Equal variances assumed	1.047	.311	.019	48	.985	.005	.254	-.507	.516
		Equal variances not assumed			.019	47.928	.985	.005	.250	-.498	.508
NSS	Item25	Equal variances assumed	.465	.499	-.389	48	.699	-.087	.224	-.537	.363
		Equal variances not assumed			-.402	45.033	.690	-.087	.216	-.523	.349

Table II (cont.)

NSS	Item26	Equal variances assumed	.242	.625	<u>-879</u>	48	<u>.384</u>	-.277	.315	-.910	.356
		Equal variances not assumed			-886	47.709	.380	-.277	.313	-.906	.352
NSS	Item27	Equal variances assumed	4.903	.032	1.650	48	.105	.481	.292	-.105	1.068
		Equal variances not assumed			<u>1.691</u>	47.110	<u>.098</u>	.481	.285	-.091	1.054
NSS	Item28	Equal variances assumed	.048	.828	<u>.089</u>	47	<u>.930</u>	.027	.301	-.580	.633
		Equal variances not assumed			.089	46.565	.930	.027	.301	-.579	.632
NSS	RANKIN G	Equal variances assumed	.720	.402	<u>.178</u>	34	<u>.860</u>	.146	.817	-1.514	1.805
		Equal variances not assumed			.180	33.929	.858	.146	.809	-1.499	1.790
NSS	Item29	Equal variances assumed	.067	.797	<u>1.622</u>	43	<u>.112</u>	.587	.362	-.143	1.317
		Equal variances not assumed			1.624	43.000	.112	.587	.362	-.142	1.316
NSS	Item30	Equal variances assumed	.267	.608	<u>1.231</u>	43	<u>.225</u>	.457	.371	-.291	1.204
		Equal variances not assumed			1.234	42.917	.224	.457	.370	-.290	1.203

Table II (cont.)

NSS	Item31	Equal variances assumed	.140	.710	.574	43	.569	.166	.289	-.418	.750
		Equal variances not assumed			.573	42.397	.570	.166	.290	-.419	.751
NSS	Item32	Equal variances assumed	.033	.856	1.489	43	.144	.565	.380	-.200	1.331
		Equal variances not assumed			1.489	42.913	.144	.565	.380	-.200	1.331
NSS	Item33	Equal variances assumed	.033	.856	1.489	43	.144	.565	.380	-.200	1.331
		Equal variances not assumed			1.489	42.913	.144	.565	.380	-.200	1.331
NSS	Item34	Equal variances assumed	.211	.648	.676	43	.503	.231	.342	-.459	.921
		Equal variances not assumed			.677	42.864	.502	.231	.341	-.457	.920
NSS	Item35	Equal variances assumed	.537	.468	-.758	43	.453	-.119	.156	-.434	.197
		Equal variances not assumed			-.756	42.137	.454	-.119	.157	-.435	.198

Note. Equal variances assumed if Sig. > 0.05. NSS=no statistical significance; SS=statistical significance.

*p < 0.05.

Table I2

SPSS Statistics Data: Race

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
NSS	Item1	.046	.832	-.924	49	.360	-.230	.249	-.730	.270
	Equal variances not assumed			-.948	24.766	.352	-.230	.242	-.729	.269
NSS	Item2	.006	.940	1.110	49	.272	.336	.303	-.272	.944
	Equal variances not assumed			1.089	22.620	.288	.336	.309	-.303	.975
NSS	Item3	.512	.478	-.219	48	.828	-.083	.381	-.849	.683
	Equal variances not assumed			-.210	22.032	.835	-.083	.396	-.905	.738
NSS	Item4	2.043	.159	.768	48	.446	.226	.295	-.366	.818
	Equal variances not assumed			.872	31.686	.390	.226	.259	-.302	.755

Table I2 (cont.)

NSS	Item5	Equal variances assumed	.692	.410	<u>-.168</u>	47	<u>.867</u>	-.057	.339	-.740	.626
		Equal variances not assumed			-.182	28.553	.857	-.057	.314	-.700	.586
SS	Item6	Equal variances assumed	1.338	.253	<u>-2.119</u>	48	<u>.039</u>	-.742	.350	-1.446	-.038
		Equal variances not assumed			-1.902	19.538	.072	-.742	.390	-1.557	.073
NSS	Item7	Equal variances assumed	5.593	.022	.774	47	.443	.286	.369	-.457	1.028
		Equal variances not assumed			<u>.668</u>	18.445	<u>.512</u>	.286	.428	-.611	1.182
NSS	Item8	Equal variances assumed	3.074	.086	<u>-.526</u>	48	<u>.601</u>	-.143	.272	-.689	.403
		Equal variances not assumed			-.469	19.337	.644	-.143	.305	-.780	.494
NSS	Item9	Equal variances assumed	2.815	.100	<u>.490</u>	48	<u>.626</u>	.115	.235	-.357	.587
		Equal variances not assumed			.445	19.918	.661	.115	.259	-.424	.655

Table I2 (cont.)

Item11	Equal variances assumed	.017	.896	<u>-.596</u>	48	<u>.554</u>	-.187	.313	-.815	.442
	Equal variances not assumed			-.575	22.150	.571	-.187	.324	-.858	.485
Item12	Equal variances assumed	.000	.990	<u>-.673</u>	48	<u>.504</u>	-.222	.330	-.886	.441
	Equal variances not assumed			-.656	22.574	.518	-.222	.339	-.924	.479
Item13	Equal variances assumed	1.482	.229	<u>1.273</u>	48	<u>.209</u>	.381	.299	-.221	.983
	Equal variances not assumed			1.502	34.888	.142	.381	.254	-.134	.896
Item14	Equal variances assumed	4.854	.032	1.395	48	.169	.464	.333	-.205	1.134
	Equal variances not assumed			<u>1.199</u>	18.287	<u>.246</u>	.464	.387	-.348	1.277
Item15	Equal variances assumed	.456	.503	<u>-1.288</u>	48	<u>.204</u>	-.357	.277	-.915	.200
	Equal variances not assumed			-1.245	22.239	.226	-.357	.287	-.952	.237
Item16	Equal variances assumed	.388	.536	<u>-1.443</u>	48	<u>.156</u>	-.456	.316	-1.092	.180
	Equal variances not assumed			-1.432	23.391	.165	-.456	.319	-1.115	.202

Table I2 (cont.)

NSS	Item17	Equal variances assumed	2.190	.146	-1.116	45	.270	-.369	.330	-1.034	.297
		Equal variances not assumed			-1.232	27.014	.229	-.369	.299	-.983	.245
Close	RANKIN G_B	Equal variances assumed	.006	.939	1.966	36	.057	1.397	.711	-.044	2.839
		Equal variances not assumed			1.977	18.849	.063	1.397	.707	-.083	2.877
SS	Item18	Equal variances assumed	3.286	.077	-2.020	45	.049	-.676	.335	-1.351	-.002
		Equal variances not assumed			-2.167	25.257	.040	-.676	.312	-1.319	-.034
NSS	RANKIN G_A	Equal variances assumed	4.243	.047	1.463	34	.153	1.240	.848	-.482	2.962
		Equal variances not assumed			1.263	14.277	.227	1.240	.982	-.862	3.342
NSS	Item19	Equal variances assumed	.377	.542	.346	44	.731	.140	.404	-.675	.954
		Equal variances not assumed			.325	19.519	.749	.140	.431	-.760	1.039

Table I2 (cont.)

NSS	Item20	Equal variances assumed	.087	.769	.623	44	.537	.247	.397	-.553	1.047
		Equal variances not assumed			.632	22.741	.534	.247	.391	-.562	1.056
SS	Item21	Equal variances assumed	.002	.963	-2.140	44	.038	-.800	.374	-1.552	-.047
		Equal variances not assumed			-2.112	21.452	.047	-.800	.379	-1.586	-.013
NSS	Item22	Equal variances assumed	1.209	.278	.748	44	.458	.273	.365	-.462	1.008
		Equal variances not assumed			.680	18.455	.505	.273	.401	-.569	1.114
NSS	Item23	Equal variances assumed	.023	.879	1.222	42	.229	.469	.384	-.306	1.243
		Equal variances not assumed			1.174	18.393	.255	.469	.399	-.369	1.306
NSS	Item24	Equal variances assumed	.667	.419	1.639	42	.109	.469	.286	-.108	1.046
		Equal variances not assumed			1.464	16.322	.162	.469	.320	-.209	1.146
NSS	Item25	Equal variances assumed	6.752	.013	2.607	42	.013	.656	.252	.148	1.164
		Equal variances not assumed			1.990	13.370	.067	.656	.330	-.054	1.367

Table I2 (cont.)

NSS	Item26	Equal variances assumed	.897	.349	.771	42	.445	.292	.378	-.471	1.055
		Equal variances not assumed			.826	22.867	.417	.292	.353	-.439	1.022
NSS	Item27	Equal variances assumed	.955	.334	.938	42	.354	.344	.366	-.396	1.083
		Equal variances not assumed			.856	16.867	.404	.344	.402	-.504	1.192
NSS	Item28	Equal variances assumed	3.592	.065	1.793	41	.080	.626	.349	-.079	1.332
		Equal variances not assumed			1.521	15.207	.149	.626	.412	-.250	1.503
NSS	RANKIN G	Equal variances assumed	.021	.885	1.305	31	.763	.273	.895	-1.553	2.099
		Equal variances not assumed			.305	20.242	.763	.273	.893	-1.588	2.134
NSS	Item29	Equal variances assumed	5.176	.029	1.217	37	.231	.545	.448	-.363	1.454
		Equal variances not assumed			1.430	26.739	.164	.545	.381	-.237	1.328
NSS	Item30	Equal variances assumed	3.231	.080	.676	37	.503	.312	.461	-.623	1.246
		Equal variances not assumed			.766	24.417	.451	.312	.407	-.527	1.151

Table I2 (cont.)

NSS	Item31	Equal variances assumed	.295	.590	-1.033	37	.308	-.367	.355	-1.086	.353
		Equal variances not assumed			-1.075	19.946	.295	-.367	.341	-1.079	.345
NSS	Item32	Equal variances assumed	.961	.333	1.305	37	.200	.591	.453	-.327	1.508
		Equal variances not assumed			1.202	15.735	.247	.591	.492	-.453	1.634
NSS	Item33	Equal variances assumed	1.750	.194	1.016	37	.316	.464	.457	-.461	1.390
		Equal variances not assumed			.898	14.711	.383	.464	.517	-.639	1.568
NSS	Item34	Equal variances assumed	.129	.722	1.137	37	.263	.455	.400	-.356	1.265
		Equal variances not assumed			1.134	18.263	.271	.455	.401	-.387	1.296
NSS	Item35	Equal variances assumed	4.047	.052	.893	37	.378	.169	.189	-.214	.552
		Equal variances not assumed			.751	13.670	.465	.169	.225	-.314	.652

Note. Equal variances assumed if Sig. > 0.05. NSS=no statistical significance; SS=statistical significance.

*p < 0.05.

Table I3

SPSS Statistics Data: Marginalization Status

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
NSS	Item1	.004	.950	Equal variances assumed -833	53	.409	-.203	.244	-.693	.286
	Equal variances not assumed			-.810	19.178	.428	-.203	.251	-.728	.322
NSS	Item2	.373	.544	Equal variances assumed .305	53	.762	.092	.301	-.511	.695
	Equal variances not assumed			.284	18.114	.780	.092	.322	-.585	.768
NSS	Item3	.304	.584	Equal variances assumed -1.631	52	.109	-.610	.374	-1.360	.141
	Equal variances not assumed			-1.473	17.476	.159	-.610	.414	-1.481	.262
NSS	Item4	5.956	.018	Equal variances assumed .355	52	.724	.103	.291	-.480	.686
	Equal variances not assumed			.279	15.011	.784	.103	.370	-.686	.892

Table I3 (cont.)

NSS	Item5	Equal variances assumed	.069	.794	.877	51	.384	.294	.335	-.379	.968
		Equal variances not assumed			.854	19.556	.403	.294	.344	-.425	1.014
close	Item6	Equal variances assumed	.461	.500	-1.765	52	.083	-.627	.355	-1.339	.086
		Equal variances not assumed			-1.817	21.215	.083	-.627	.345	-1.343	.090
NSS	Item7	Equal variances assumed	.008	.931	.073	51	.942	.027	.371	-.718	.771
		Equal variances not assumed			.069	18.762	.946	.027	.392	-.793	.847
NSS	Item8	Equal variances assumed	.327	.570	-2.204	52	.032	-.580	.263	-1.108	-.052
		Equal variances not assumed			-2.315	21.965	.030	-.580	.250	-1.099	-.060
NSS	Item9	Equal variances assumed	.326	.571	1.179	52	.244	.276	.234	-.194	.745
		Equal variances not assumed			1.232	21.746	.231	.276	.224	-.189	.741
NSS	Item10	Equal variances assumed	2.450	.124	1.205	52	.234	.364	.302	-.242	.970
		Equal variances not assumed			1.500	31.603	.144	.364	.243	-.131	.859

Table I3 (cont.)

NSS	Item11	Equal variances assumed	.336	.565	<u>-237</u>	52	<u>.813</u>	-.073	.308	-.692	.545
		Equal variances not assumed			-.209	16.940	.837	-.073	.350	-.812	.666
SS	Item12	Equal variances assumed	4.073	.049	-3.204	52	.002	-.970	.303	-1.577	-.363
		Equal variances not assumed			<u>-4.023</u>	32.293	<u>.000</u>	-.970	.241	-1.461	-.479
NSS	Item13	Equal variances assumed	.498	.483	<u>-669</u>	52	<u>.506</u>	-.199	.297	-.795	.397
		Equal variances not assumed			-.706	22.118	.488	-.199	.282	-.783	.385
NSS	Item14	Equal variances assumed	.737	.395	<u>1.106</u>	52	<u>.274</u>	.362	.327	-.295	1.019
		Equal variances not assumed			1.163	22.012	.257	.362	.311	-.283	1.008
NSS	Item15	Equal variances assumed	.010	.921	<u>.295</u>	52	<u>.769</u>	.081	.274	-.469	.630
		Equal variances not assumed			.286	19.275	.778	.081	.282	-.510	.671

Table I3 (cont.)

NSS	Item16	Equal variances assumed	1.249	.269	-1.452	52	.152	-.450	.310	-1.072	.172
		Equal variances not assumed			-1.275	16.880	.219	-.450	.353	-1.196	.295
NSS	Item17	Equal variances assumed	.000	.986	-.829	47	.411	-.269	.325	-.922	.384
		Equal variances not assumed			-.824	21.043	.419	-.269	.327	-.948	.410
NSS	RANKIN G_B	Equal variances assumed	.127	.723	-.910	37	.369	.693	.762	-.850	2.237
		Equal variances not assumed			.998	18.773	.331	.693	.694	-.761	2.148
NSS	Item18	Equal variances assumed	.289	.593	-.194	47	.847	-.066	.341	-.752	.620
		Equal variances not assumed			-.205	23.635	.839	-.066	.323	-.734	.602
NSS	RANKIN G_A	Equal variances assumed	.248	.622	.215	35	.831	.196	.912	-1.656	2.048
		Equal variances not assumed			.235	19.350	.817	.196	.836	-1.551	1.944
NSS	Item19	Equal variances assumed	4.034	.050	-.365	46	.717	-.145	.398	-.946	.656
		Equal variances not assumed			-.408	27.361	.687	-.145	.356	-.875	.584

Table I3 (cont.)

NSS	Item20	Equal variances assumed	.493	.486	<u>-1.370</u>	46	<u>.713</u>	-.145	.392	-.934	.644
		Equal variances not assumed			-.365	20.938	.719	-.145	.398	-.973	.683
NSS	Item21	Equal variances assumed	.191	.664	<u>-1.847</u>	46	<u>.071</u>	-.679	.368	-1.419	.061
		Equal variances not assumed			-1.871	22.058	.075	-.679	.363	-1.432	.074
NSS	Item22	Equal variances assumed	.193	.663	<u>-.427</u>	46	<u>.672</u>	-.152	.355	-.867	.564
		Equal variances not assumed			-.441	22.979	.663	-.152	.344	-.863	.560
NSS	Item23	Equal variances assumed	.015	.904	<u>-.354</u>	44	<u>.725</u>	-.133	.376	-.890	.624
		Equal variances not assumed			-.350	21.607	.730	-.133	.379	-.921	.655
NSS	Item24	Equal variances assumed	2.200	.145	<u>.867</u>	44	<u>.390</u>	.242	.280	-.321	.806
		Equal variances not assumed			.965	28.015	.343	.242	.251	-.272	.757

Table I3 (cont.)

NSS	Item25	Equal variances assumed	1.407	.242	.538	44	.593	.138	.256	-.378	.653
		Equal variances not assumed			.676	37.797	.503	.138	.203	-.274	.549
NSS	Item26	Equal variances assumed	.017	.896	-.884	44	-.382	-.317	.359	-1.040	.406
		Equal variances not assumed			-.874	21.550	.392	-.317	.363	-1.070	.436
★ SS	Item27	Equal variances assumed	3.985	.052	2.036	44	.048	.685	.337	.007	1.364
		Equal variances not assumed			2.446	33.941	.020	.685	.280	.116	1.255
NSS	Item28	Equal variances assumed	.358	.553	.240	43	.812	.084	.351	-.624	.793
		Equal variances not assumed			.255	25.550	.801	.084	.331	-.596	.764
NSS	RANKIN G	Equal variances assumed	.377	.544	-.545	32	.589	-.516	.945	-2.441	1.410
		Equal variances not assumed			-.583	16.169	.568	-.516	.885	-2.389	1.358
Close	Item29	Equal variances assumed	1.294	.262	2.023	39	.050	.813	.402	.000	1.626
		Equal variances not assumed			1.859	19.345	.078	.813	.437	-.101	1.728

Table I3 (cont.)

NSS	Item30	Equal variances assumed	2.914	.096	1.114	39	.272	.470	.422	-.383	1.323
		Equal variances not assumed			1.005	18.641	.328	.470	.467	-.510	1.449
NSS	Item31	Equal variances assumed	.104	.749	-.613	39	.544	-.203	.332	-.874	.468
		Equal variances not assumed			-.613	23.530	.546	-.203	.332	-.888	.482
NSS	Item32	Equal variances assumed	.070	.792	1.318	39	.195	.549	.417	-.294	1.393
NSS		Equal variances not assumed			1.313	23.275	.202	.549	.418	-.316	1.415
	Item33	Equal variances assumed	.312	.580	1.039	39	.305	.437	.420	-.413	1.287
		Equal variances not assumed			1.066	25.039	.296	.437	.410	-.407	1.280

Table I3 (cont.)

NSS	Item34	Equal variances assumed	.971	.331	.785	39	.437	.291	.371	-.459	1.041
		Equal variances not assumed			.730	19.827	.474	.291	.399	-.542	1.124
SS	Item35	Equal variances assumed	.029	.865	.352	39	.727	-.063	.180	-.427	.300
		Equal variances not assumed			-.362	25.275	.720	-.063	.174	-.422	.296

Note. Equal variances assumed if Sig. > 0.05. NSS=no statistical significance; SS=statistical significance.

*p < 0.05.

APPENDIX J: RESEARCH PROPOSAL

Problem

Standpoint theories, as promulgated by prominent feminist scholars like Sandra Harding and Donna Haraway, emerged in the late twentieth century as a means of exploring the ways in which patriarchy has dominated and influenced the lives of women and other marginalized groups. Although it was born and developed from feminism, standpoint theory (also referred to as feminist standpoint theory) describes the ideas that oppression defines knowledge production and that “all human thought necessarily can only be partial” (Harding, 1995). Standpoint theory recognizes that the knowledge of those at the top of a social hierarchy is produced in a particular social location and is thus incomplete (that is, one’s place in society defines what one can know). Such knowledge disregards knowledge from marked bodies (that is, those characterized as living outside the norm), which is indispensable in describing a more complete and accurate reality.

A meaningful and distinctive facet of standpoint theory is its challenge of the mainstream definition of “objectivity.” The feminist theory version of objectivity, characterized as “strong objectivity” by Harding (1995), emphasizes the “embodied nature of all vision,” implying that there is no one reality or truth (Haraway, 1988).

While feminist standpoint theory and strong objectivity have been explored extensively in science and technology, little has been done to describe what these ideas may have to offer in business relations and leadership roles. Using the structural framework of feminist standpoint theory and its definition of strong objectivity, I aim to develop ideas about the social location of the healthcare administrator and how feminist standpoint theory can develop more socially aware and effective leaders so as to inform

key decisions. In doing so, I also aim to delve into administrator attitudes about workplace plurality and diversity.

Implications

Such a study is important because it provides increased consideration of marginalized groups, which remain underrepresented in healthcare administration. Women, for example, hold 9% of top-level management jobs in healthcare; more frightening, perhaps, is the fact that, of that 9%, only 11.9% are women of color (thus representing just 1% of the total) (Warner, 2014). Using feminist standpoint theory, this study aims to develop a strategy for inclusive, culturally sensitive communication, leadership skills, and decision-making.

Research Questions

- What benefits, if any, would the incorporation of feminist standpoint theory confer on the field of healthcare?
- What characteristics does the typical health administrator have?
- What attitudes do administrators have towards workplace plurality and diversity?
- What obstacles currently prevent feminist standpoint theory from being considered as a useful tool in healthcare?
- How might the incorporation of feminist standpoint theory affect healthcare professionals and sensitive decision-making?

Proposed Methodology

Proposed strategies for data collection and analysis. This study will explore the proposed research questions through a literature review and a survey.

Sources of data. The literature review will feature research from peer-reviewed, academic journals pulled from the Texas State University library. In order to introduce new information to the already-existing literature, I plan to administrate a survey of health administrators in south Texas.

A Sample of Survey Questions

The proposed anonymous survey will be distributed to health administrators in south Texas, including (but not limited to) organizations such as Seton Healthcare, St. David's HealthCare, Baptist Medical Center, Christus Santa Rosa Health System, and Methodist Healthcare. Where appropriate, questionnaire response items will be presented using a Likert scale. A benefit of the Likert scale is the ability to measure the intensity of each response for more accurate reflection.

- Demographic Items
 - Gender
 - Age Group
 - Ethnicity
 - Religious Affiliation
 - Sexual Orientation
 - Career level
- Diversity-Oriented Questions (Likert Scale)
 - Views on gender

Using a Likert scale, these questions will focus on health administrator views on gender, leadership, and the perceived leadership differences between males and females.

- Views on sexuality

Using a Likert scale, these questions will focus on health administrator views on sexual orientation and perceived presence of homosexuality in executive and top-level leadership roles.

- Views of spirituality

Using a Likert scale, these questions will focus on health administrator views on religion, ethnicity, and perceived plurality in the workplace.

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