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# Nursing Knowledge and Attitudes Toward Trans* and Gender-Nonconforming Patients

Christine Humphrey
christine.humphrey@otterbein.edu

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Christine Humphrey MSN, MBA, RN

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DNP Final Scholarly Project Committee:

Sue Butz, DNP, RN, CCRN
Advisor's Name and Credentials

Jackie Haverkamp, DNP, RN, CNP, NHA
2nd Reader's Name and Credentials

Linda Stoverock, DNP, RN, NEA-BC
Community Member's Name and Credentials

## Executive Summary

This project aims to impact nursing knowledge and attitudes toward trans* and gender-nonconforming patients. The term transgender, synonymous with the term trans*, is utilized by individuals whose gender and designated sex at birth differ from one another, compared to cisgender persons whose gender and assigned sex are aligned (Erickson-Schroth, 2014).

The trans* population remains underserved. Nurses conscious and unconscious biases impede the advancement of knowledge and attitudes needed to promote best outcomes for trans* patients. Trans* patients have many of the same healthcare concerns as cisgender individuals. However, unique needs for this population arise from compounded issues of prejudice and bias (Stroumsa, 2014). Nursing staff must be confident and competent in their abilities to care for trans* patients. Improved cultural competence is one component that is impactful and essential to the improvement of nursing knowledge and attitudes (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). Utilizing the *Lesbian, Gay, Bisexual, and Transgender Healthcare (LGBT Healthcare) Scale* and *Lesbian, Gay, Bisexual, and Transgender Knowledge (LGBT Knowledge) Questionnaire,* this DNP project revealed the participant sample presented with positive knowledge and attitudes at baseline before reviewing the education module. Results of the knowledge questionnaire exhibited a statistically significant increase from the pre to posttest, while attitudes remained unchanged. Information gained, promotes culturally sensitive care for the trans* and gender-nonconforming population and will be disseminated to the greater population at a large mid-western pediatric hospital. In fact, future implications of this project include: improved retention and greater satisfaction for both staff and patients.

# Nursing Knowledge and Attitudes Toward Trans* and Gender-Nonconforming Patients

## Introduction

Standards of care for transgender and gender-nonconforming individuals were initially published by the World Professional Association for Transgender Health (WPATH) in 1980 (Shumer, Nokoff, & Spack, 2016). However, this population remains misunderstood and ill served. The term transgender, synonymous with the term trans*, is utilized by individuals whose gender and designated sex at birth differ from one another, compared to cisgender persons whose gender and assigned sex are aligned (Erickson-Schroth, 2014). Transmen are individuals who were assigned female sex designation at birth and identify as male; transwomen are individuals who were assigned male sex designation at birth and identify as female.

In recent years, gender clinics have noted an increase in the number of gender-nonconforming youth. Between 0.3% and 5% of individuals in the United States (US) identify as trans* (Hyderi, Angel, Madison, Perry, & Hagshenas, 2016). Trans* female prevalence rates range from 1:7,000 to 1:20,000 while trans* males range from 1:33,000 to 1:50,000 (Janicka & Forcier, 2016). When healthcare providers have an insufficient knowledge base, this already marginalized group suffers from inadequate care.

## Significance of Problem to Nursing

Nurses interact with trans* patients in a variety of settings. Inpatient or outpatient, medical or surgical, this patient population is represented and deserves appropriate care. Trans* patients have the same healthcare concerns as cisgender individuals. Unique needs for this population arise from compounded issues of prejudice and bias (Stroumsa, 2014). Nursing staff must be confident and competent in their abilities to care for trans* patients.

Improved cultural competence is one component that is impactful and essential to the improvement of nursing knowledge and attitudes (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). Cultural competence encompasses awareness of personal beliefs, biases, and attitudes, knowledge and understanding of various cultural groups, and the ability to ensure culturally sensitive assessments and interventions (Boroughs et al., 2015).

## Clinical Needs Assessment

The nursing profession has attempted to address health disparities (Redfern & Sinclair, 2014). Healthy People 2020 identified the need to improve health and well-being of the trans* community as a goal (Redfern & Sinclair, 2014; US Department of Health and Human Services, 2017).

An inquiry regarding strengths, weaknesses, opportunities, threats (SWOT) analysis was completed via informal discussions with clinical nursing staff at a large mid-western pediatric clinic setting. The analysis identified the need for further education to better serve the growing trans* population. Nursing staff identified a personal lack of knowledge regarding these patients. Redfern and Sinclair (2014) suggest that enhanced communication skills, knowledge and attitudes will be required to meet trans* healthcare needs. Nurses must increase awareness and receptivity toward this population (Redfern & Sinclair, 2014). Providers with insufficient knowledge of this already ostracized group, contribute to continued inadequate care.

## Problem Statement

The trans* population remains underserved. Nurses' conscious and unconscious biases impede the advancement of knowledge and attitudes needed to promote best outcomes for trans* patients.

## Literature Review

The trans* population is becoming more visible in society today. WPATH was founded in 1979, publishing their first standards of care for trans* and gender-nonconforming individuals in 1980 (Shumer et al., 2016). The American Psychiatric Association (APA) originally coined the phrase gender identity disorder (GID) in 1980 and updated terminology to gender dysphoria (GD) in 2012 (Strousma, 2014). Historically, trans* was referred to as a disorder needing treatment; in 2013 the APA changed gender affirming treatment to a valid focus and removed the label "mental disorder" from transgender (Schuster, Reisner, & Onorato, 2016).

In 2016, Hyderi et al. identified child and adolescent criteria for a GD diagnosis (GD). At the young age of two years children are able to label themselves as boy or girl and at four to five years of age gender becomes part of a child's identity (Shumer et al., 2016). Janicka and Forcier (2016) then identified that ages 10 to 14 years old is a crucial period for gender identification. Children and adolescents require support in times of growth and influence (Janicka & Forcier, 2016). Healthcare providers must be attuned to the formation of gender identity as early as toddlerhood and remain mindful of these milestones in the continued development of gender identity.

Trans* individuals experience the need for a wide variety of care. Trans* people are already underserved and more likely to stay "closeted" because of anxiety about disclosure of their trans* status (Roberts et al., 2014). Healthcare needs present an additional caveat. Some trans* individuals simply need access to primary care, while others seek in depth care to assist in their gender transition. Studies have focused on problems related to barriers and high risk behaviors of these individuals, however limited research has been conducted regarding delivery of primary

care for these youth (Snyder, Burack, & Petrova, 2017). Assessment of primary care should be considered to find ways to best meet the needs of trans* youth.

Furthermore, there are additional factors to consider when a person is using gender-affirming hormone therapy. Gender-affirming therapies are ones that aid trans* individuals in modifying their bodies to more closely match the preferred gender identity (Erickson-Schroth, 2014). Not only does the trans* person need effective primary care, he or she also needs effective hormone therapy monitoring. Table 1 provides an analysis of twenty-eight articles found in the literature. Three identified trends are related to barriers, risks, and knowledge gaps.

**Barriers**

The literature identifies a number of barriers encountered by trans* individuals. Table 2 is a synthesis table which identifies major barriers to care and frequency in which they are found in the reviewed articles. Sanchez, Sanchez, and Danoff (2009) performed a qualitative study with 101 male-to-female transgender individuals in which barriers and high risk behaviors were identified. 32% identified lack of a knowledgeable provider, 30% lack of access to a transgender friendly provider, 29% cost, 28% access to a specialist, 18% location, 13% language (Sanchez et al., 2009). In 2010, the National Transgender Discrimination Survey Report on Health and Health Care surveyed 6,000 trans* individuals and found 19% have been refused care related to gender identity (Shumer et al., 2016). Additionally, 27% of trans* individuals were refused care by providers and 70% stated one or more experiences of inappropriate actions by unknowledgeable healthcare providers (Redfern & Sinclair, 2014).

Stigma and bias are two additional barriers to care for trans* and gender-nonconforming people (Bishop, 2015). Bishop (2015) ascertains that these obstacles place the trans* population at greater risk for tobacco, alcohol and substance abuse, in addition to suicide attempts and other

significant stressors. Bradford, Reisner, Honnold, and Xavier (2013) completed a study with 350 self-identified trans* adults over 18 years of age. Survey results from the study shows significant barriers which related to discrimination and unknowledgeable healthcare providers. 41% of trans* individuals reported discrimination related to geography, gender, low socioeconomic status, racial and ethnic minority, lack of health insurance, transition indicators, history of violence, needed but unattainable healthcare, substance abuse or interpersonal factors (Bradford et al., 2013). The participants also indicated 15% are uncomfortable with discussing trans* needs with their provider and astoundingly, 20% educate their primary care providers regarding transgender specific care (Bradford et al., 2013).

**Increased Risk**

Because of these identified barriers trans* individuals are at a higher risk of adverse outcomes than their cisgender counterparts. Table 3 is a synthesis table listing the identified risks that are encountered by this population and the frequency. Trans* individuals have a two to three-fold increased likelihood of depression, anxiety, suicidal ideation and attempt, self-harm and need for mental health treatment (Reisner et al., 2015). Colizzi, Costa, and Todarello (2015) noted in their study, patients with GD suffered from mental health conditions including 30% dissociative disorder, 46% major depressive disorder, 21% suicide attempts, and 46% childhood trauma. Trans* and gender-nonconforming people have increased risk of HIV, sexual violence, discrimination, lack of healthcare access, and adverse health outcomes (Sedlak & Boyd, 2016). Reisner et al. (2016) identified a gap in the inability of surveys to correctly identify trans* individuals in items, as all gender identity options were not present. There are likely additional disparities. However, currently, compilation of a complete list is impossible because “gender identity” is a demographic component often missing from surveys.

Some trans* people use hormones to affect their voice, hair growth and other areas of development. While hormones can be life-affirming, trans* individuals, like anyone taking hormones, need to be monitored for risks and side effects. Sanchez et al. (2009) found that 70% of trans* patients are on hormones and 23% receive the hormones from a source other than a healthcare provider. Nontraditional sources may be sought out due to fear of having to disclose information to the healthcare provider, inability to locate a provider, or decreased likelihood of having insurance. Hormone medication and needles received from nontraditional sources engages trans* individuals in high risk behaviors (Sanchez et al., 2009).

**Knowledge Gap: Healthcare Providers**

Table 4 is a synthesis table identifying a range of strategies and education topics used in academia. Trans* individuals lack access to knowledgeable providers (Hicks, Schafersman, Schmotzer, Spencer, & Tyler-Simonson, 2014). Hicks et al. (2014) identify a correlation between healthcare provider attitudes and willingness of trans* patients to access care. It appears as if providers are open minded and nonjudgmental, trans* individuals have a much higher likelihood of seeking care. Additional barriers to accessing care are fear of violence, discrimination, isolation and suboptimal care (Hicks et al., 2014).

Murray and McCrone (2015) conducted a literature review of twenty-nine articles which revealed one glaring barrier: lack of trust. Nurses and healthcare providers are among the most trusted professions, yet trust remains a potential problem. Congruence between the "truster" expectation and the "trustee" behavior is the foundation of a trusting relationship (Murray & McCrone, 2015). When there is alignment between the patient's expectations and the provider's behaviors, the trusting relationship builds. Trust was proven to increase with the length of time spent with the patient, consistent provider presence, and increased visits with the healthcare team

(Murray & McCrone, 2015). In contrast, Murray and McCrone (2015) found that failed promises and commitments led to diminished trust from the trans* individual to provider.

Poteat, German, and Kerrigan (2013) also found trust to be an issue in their study of fifty-five transmen and transwomen and twelve medical providers. Blaming, shaming, othering, and discriminating are four categories of issues all of which lead to stigmatization toward trans* people (Poteat et al., 2013). Stewart and O'Reilly (2017) performed a systematic review of articles regarding nurse and midwife knowledge, beliefs and attitudes toward lesbian, gay, bisexual, transgender, queer (LGBTQ) patients. Stark themes were identified including heteronormativity, queerphobia, "rainbow of attitudes", learning diversity which led to problems due to a lack of knowledge (Stewart & O'Reilly, 2017). Heteronormativity refers to "the assumption that heterosexuality is the norm" (Erickson-Schroth, 2014, p. 615). Additionally, queerphobia is defined as "a term for prejudice against LGBTQ people" (Stewart & O'Reilly, 2017, p. 68). "Rainbow of attitudes" refers to a wide range of attitudes, beliefs and knowledge. Lastly, learning diversity refers to both proactive and insufficient education and skills (Stewart & O'Reilly, 2017).

Barriers, when compounded by prejudices, can lead to a lack of timely, culturally competent, medically appropriate and respectful care for this patient population. Healthcare providers who fail to provide comprehensive trans* care are in direct ethical conflict with their own professional standards (Strousma, 2014). In addition to identification of knowledge, attitudes and barriers by healthcare providers, assessment of healthcare administration, nursing schools and medical schools have begun to be investigated as well. Klotzbaugh and Spencer (2014) completed a qualitative study of three hundred and forty three Magnet hospital Chief Nursing Officers (CNOs). The authors identified a correlation between religious individuals and more

prominent homonegative attitudes which indicates "a continuum of discrimination against LGBT people" (Klotzbaugh & Spencer, 2014, p. 481). Religion is not defined within the study. Participants self-reported religiosity of very, somewhat or not at all religious. Additionally, the less homonegative attitudes felt by CNOs, the greater personal LGBT advocacy (Klotzbaugh & Spencer, 2014).

**Knowledge Gap: Academia**

Schools of medicine and nursing have also been identified in the literature as arenas for growth in trans* education. *Table 4* is a synthesis table identifying a range of strategies and education topics used in academia. In one study, one hundred and twenty two baccalaureate, master's, and registered nurse (RN)-to-baccalaureate nursing students at a public university were surveyed in reference to their knowledge and comfort in caring for trans* patients (Carabez, Pelligrini, Mankovitz, Eliason, & Dariotis, 2015). A 92% response rate revealed 5% of students felt discomfort with using preferred pronouns and 13% believe that gender identity and sexual orientation does not matter to the patients they serve. The study also identified 62% of students had the needed knowledge to work with LGBT patients, however 85% reported they were prepared from real life experiences not nursing education (Carabez et al., 2015). In addition, a survey of one hundred and eleven nursing programs in Texas was completed (Walsh & Hendrickson, 2015). With a 19% response rate, 47.6% of instructors broadly address trans*, 71% only spend, on average, 1.63 hours on the topic and no one teaches the WPATH standards. Walsh and Hendrickson (2015) identified "broadly addressing" as inclusion of gender identity and terminology within the education.

Medical schools mirror some of the challenges presented by nursing schools as well as contributing different barriers. In review of an emergency medicine residency program, Moll et

al. (2014) identified that 26% present LGBT lecture, 33% incorporate into didactic curriculum, and on average 45 minutes were spent on this topic within the last year. Perceived barriers were also identified by the directors of the residency program. Barriers included a lack of perceived need, lack of interested faculty, funding, and time (Moll et al., 2014).

Lastly, the literature has identified key components for successful and appropriate care for the trans* population. Cultural competence is one element in which healthcare staff are able to identify personal biases, understand various cultures and apply skills to sensitively assess patients (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; Wolf et al., 2016). Fish (2010) also recognized the importance of valuing diversity, effective communication, involvement of LGBT identified individuals in care decisions, provider knowledge of resources, and the impact of discrimination on patients. Knowledgeable involvement by both the trans* person and knowledgeable healthcare provider are imperative to effectively provide care and promote best outcomes.

## Theoretical Framework

An appropriate theoretical framework must be identified to guide formation and implementation of the author's project. Leininger's Cultural Care Diversity and Universality: Theory of Nursing (1988) presents a holistic approach to conceptualizing the missing link in culturally sensitive care. The trans* population is no exception to the need for culturally sensitive care. Leininger defines theory "as sets of interrelated knowledge with meanings and experiences that describe, explain, predict or account for some phenomenon through an open, creative, and naturalistic discovery process" (Leinenger, 1988, p. 154). This is an imperative definition because it describes the essence of inclusion. Her theory supports an emphasis on

"people truths", which promotes a greater understanding of culturally appropriate care within diverse communities (Leinenger, 1988).

The Sunrise model is used to illustrate the multifaceted dimensions of the theory. Utilization of this model can be toward an individual or group (Leinenger, 1988). The model urges nurses to assess many components that shape a person's culture. Technological, religious, philosophical, kinship, social, values, political, legal, economic and educational factors are a few of the considerations included in the Sunrise model (Leinenger, 1988). Reflection on each of these dimensions helps to give the nurse greater insight into the culture of a trans* patient. Greater understanding will help the nurse-patient relationship and guide appropriately sensitive decision-making. Insight gained from the Sunrise model aids the nurse in providing culturally sensitive care the way the patient anticipates receiving said care (Leinenger, 1988).

The idea of transcultural care promotes an innovative way for nurses to care for patients from a variety of backgrounds and various perspectives regarding care. Individuals are born and live entire lives with their own culture and beliefs. However in certain circumstances these persons may find themselves dependent on healthcare providers (Leinenger, 1988). Leinenger (1988) explains that these situations are the epitome of why the cultural care theory is imperative for nurses: "to provide quality care to clients of diverse cultures that is congruent, satisfying, and beneficial to them" (p. 155). Nurses caring for people from the trans* community must connect in ways that provider-patient thoughts and goals for care are congruent. An understanding of culture, world views, and social structures is necessary for the conceptualization of care diversities and universalities (Leinenger, 1988).

## Project Purpose

The purpose of this project is to improve nurses' knowledge and attitudes toward the trans* population with an aim to decrease inadequacies in care. At the outset of this project, the following PICOT question was developed. In nurses, how does (x) intervention compared to no intervention affect knowledge and attitudes toward transgender and gender-nonconforming patients. Objectives will be met via implementation of a self-paced powerpoint education module administered to nursing clinical leaders of the medical specialty clinics at a large mid-western pediatric hospital. Measureable goals will be identified and conveyed to the participants. Objectives include:

1. Define terminology related to transgender and gender-nonconforming individuals to enhance competency in providing care to trans* and gender-nonconforming patients.
2. Discuss health disparities present with transgender and gender-nonconforming persons to improve knowledge of specific healthcare needs.
3. Identify effective communication techniques and phrases to provide care in a sensitive and appropriate manner.

## Financial Implication

Implications of this project may be impactful to both nursing staff and patients. The increase of nursing knowledge regarding terminology, disparities and communication techniques surrounding the trans* and gender-nonconforming population has the potential to improve nurse retention and nurse satisfaction. Turnover may be decreased if nursing staff are given the needed information to gain a greater understanding of this population. Kiel (2012) explicates that a new nurse can cost anywhere from $20,000 to $50,000. This dollar amount includes the recruitment, hiring and orientation phases (Kiel, 2012). Allocating time during the hiring and orientation

processes, to appropriately educate on the trans* population, can have a positive financial impact. Setting clear expectations and distributing knowledge may aid in retention of nursing staff. This may also increase nurse satisfaction because staff are more adequately prepared to work with this population. If the institution is able to retain the employee through engagement and transparency, the allotted amount of education has a positive return on investment (ROI).

Additionally, patient satisfaction may increase. A patient's healthcare perspective is based largely on their trusting relationship with nurses (Rutherford, 2014). If the patient has increased satisfaction and trust with the nursing staff he or she may be more likely to enter into healthcare earlier and receive more preventative treatment. Early entry to healthcare can have a positive financial impact to the organization. Rutherford (2014) explains that patient-nurse trusting relationship is intangible and difficult to measure, however a positive relationship has been correlated with increased patient satisfaction.

## Method

This project was mixed methods approach. Data was collected using REDCap and included both qualitative and quantitative information. Pre and posttests were collected surrounding the learning module. The tests maintained anonymity while measuring knowledge and attitudes of the registered nurse (RN) participants, as well as collecting demographic information. The author worked with a statistician for data analysis.

### Target Population and Sample

The target population for this project includes outpatient nursing clinical leaders working in pediatric medical specialty clinics. The sample will include 16 nurses, with a goal of 15% response rate. Inclusion criteria will be nursing clinical leaders employed at the author's institution, working in the medical specialty clinic outpatient setting. Length of employment and

time in the nursing profession will be captured, but not identified as inclusion criteria. This targeted sample deviated from the original proposal. After much contemplation the author decided that a more focused sample would be advantageous. The initial proposal suggested a target group of about 140 nurses. However, the author's intentions are for this education to be impactful to the target audience. For this to be possible the project was focused on clinical leaders of the medical specialty clinics to identify areas of growth and obtain feedback before expanding education.

The author worked with the Chief Nursing Officer (CNO) of a large mid-western pediatric hospital, to reach RNs via email and set up face-to-face meetings with program managers. Email communication included background and purpose of the study, anonymity, benefit of participation, and incentive. The author submitted and received a grant to fund participant incentive. The Student Research Fund (SRF) at Otterbein University awarded the author the sum of $200 toward gift cards for study participants.

## Outcome Analysis Plan

### Instruments

The author finalized the tools to be used for this project. REDCap was used for data collection. The *Lesbian, Gay, Bisexual, and Transgender Healthcare (LGBT Healthcare) Scale* and *Lesbian, Gay, Bisexual, and Transgender Knowledge (LGBT Knowledge) Questionnaire* were the tools used for assessment. Strong and Folse (2015) tested the validity and reliability of these instruments before implementing within their study regarding nursing students' knowledge, attitudes, and cultural competence for LGBT patients. Appendix B indicates the author's reception of permission to use these tools and modify as needed. The implemented *LGBT*

*Healthcare Scale* is shown in Appendix C and the *LGBT Knowledge Questionnaire* in Appendix D.

**Data Collection**

Data will be collected anonymously via REDCap. The author collected demographic data including gender identity, age in years, and years in nursing. In addition, data was collected to measure impact of the education module on the nurses' knowledge and attitudes using a tool that previously measured nursing student's knowledge and attitudes (Strong & Folse, 2015). Data will then be used for improving the learning module for future projects.

**Analysis Tools**

This project was analyzed using a paired sample *t* test, as well as descriptive statistics to analyze demographic data. The *t* test will be able to assess the pre and posttests of the participants to identify if responses were improved or related to chance.

**Success Definition**

Success of this project will be defined by increasing the knowledge base of nurse participants and achieving the goal response rate of 15%. Identification of additional barriers and biases, as well as how nurses respond to the education will also be measures of success.

**Limitations and Barriers**

Limitations and barriers included time, individual bias, educational interest, and generalizability. Time is a commonly presented barrier because there are already many strains placed on nurses in a given day. In addition to the daily requirements placed on nurses, this project has a constricted timeframe imposed by the author's program. The project was proposed, implemented and analyzed in a short window of time.

Individual bias and educational interest are components internalized within the individual participants. An individual may be averse to participating in the project because of a personal bias toward the population and a lack of open-mindedness to learning additional information. The author hoped that nurses from the medical specialty clinics would participate in this project with a willingness to learn and work as a change champions for their colleagues. Results of the study identified 14 individuals completed the pretest and only 13 completed the posttest. Lastly, generalizability was considered. The results within this study sample may not be representative of RNs in all areas.

**Facilitators**

There are a couple key facilitators for this project. One will be electronic reminders and the other incentives. Nurses have such busy lives both at work and home, that reminders may help improve the response rate. Reinforcement of the purpose and importance of involvement may help give the participants the "why" behind the project and therefore improve participation. Incentives will be the second large facilitator of the project. The ability to entice participants may likely improve the response rate. Innate competitiveness and a willingness to be vulnerable and learn will improve the likelihood of success for this project. Some of the participants work in trans* health and that may be motivation for them to learn more. Further, support from leadership, including the CNO, may likely facilitate participation along with possible incentives.

**Timeline**

| | |
|---|---|
| July 2017 | Initial start with project organization and proposal presentation. |
| August 2017 | Work with advisor and committee members for program coordination. |
| September - October 2017 | Work with advisor to finalize project. IRB approved. |
| November 2017 | Send recruitment emails to potential participants and meet with program managers. |

| | |
|---|---|
| | Begin project implementation. |
| December 2017 | Continue implementation and data collection. |
| January – March 2018 | Complete data analysis and synthesis; thank sample participants and distribute gift cards. |
| April 2018 | Presentation to faculty and committee members. |

**Budget**

| | |
|---|---|
| Participant Incentive: gift card for completion of pre/posttest and education module | $200 |
| REDCap | $0 |
| PowerPoint | $0 |
| Author's Time | $0 |

The budget for this project was marginal. The author applied for and received a grant of $200 to cover the cost of participant incentive. No printed materials were provided. The pretest, posttest, and educational module were sent electronically via email. Reminder communication was also distributed via REDCap to participants. The nurses were given time during their allotted shift to complete the tests and module.

The author's time included recruitment emails and meetings with managers to promote the project and its importance. Once the pre and posttest data was collected, the author partnered with the statistician to analyze results and determine statistical significance.

## Analysis and Outcome Evaluation

### Sample Characteristics

Statistics were analyzed using SPSS. The identified sample included 16 clinical leaders within the medical specialty clinics. 14 of the 16 individuals completed the project. Important to note, is that only 13 completed the posttest for Table 5, the *LGBT Healthcare Scale*, and Table 6, the *LGBT Knowledge Questionnaire*. The demographic items accounted for within the REDCap survey are listed in Appendix E. 100% of participants identified as female. Furthermore, 100% identified that she has had interactions with LGBT patients and has a personal relationship with

at least one LGBT individual. Years in nursing ranged from 6 to 43 with an average 20.54 years and a standard deviation (SD) of 12.91. The age of the sample ranged from 32 to 65 years with an average of 46.77 and a SD of 10.90. A generational analysis was attempted, however was inconclusive because of the small sample size and median split at age 47. Additionally, a t-test was performed which identified that there were not differences in knowledge and attitudes in relation to the participant's age.

**Data Analysis**

Each of the three previously stated objectives were addressed in the education module. The powerpoint, exhibited in Appendix G, included definitions of terminology related to transgender and gender-nonconforming individuals, discussion of health disparities, and identification of effective communication techniques and phrases. The overarching goal of this project was not only to improve knowledge and attitudes; it was also to identify specific knowledge gaps for future educational interventions related to the target population.

Table 5 presents results of the 17-item *LGBT Healthcare* scale which was assessed pre and post educational intervention to measure attitudes toward this population. For each item the scale was 1-6 and ranged from strongly agree to strongly disagree. The author slightly altered the scale from its original use which was 1-5 and identified a neutral option. Analysis of this scale identified that at baseline the sample participants already identified more positively toward the target population. One of the outlier items addressed attitudes toward identifying bisexuality and homosexuality as natural expressions of male and female sexuality. The pretest scores for both items identified 35.6% somewhat to strongly disagreed, whereas the posttest score moved slightly more negative to 46.2% disagreement.

When asked about assuming feelings of disgust toward individuals from the LGBT community, 100% individuals disagreed with exhibiting those feelings. Additionally, from pre to posttest a number of the items increased in positivity. The pretest identified 14.2% of participants feel that a person whose sex does not match their gender identity is wrong. The posttest resulted in 100% disagreement with the above statement. 21.4% slightly to strongly disagreed to feeling competent to provide nursing care to the LGBT population in the pretest, as opposed to the posttest which identified 100% of participants felt competent. Lastly, in the pretest 7.1% slightly disagreed to feeling confident in talking to a LGBT patient in a sensitive and appropriate manner. The posttest showed 100% felt some sense of agreement in their ability to talk sensitively to this population. Table 7 shows the results of a *t*-test for the *LGBT Healthcare* scale. The significance level was 0.91. Statistical significance was not reached in regard to participant attitudes.

Table 6 exhibits results from the 15-item *LGBT Knowledge* scale, which was also assessed pre and post educational intervention. Each item was scored as 1 for true and 0 for false or "don't know". The scale was slightly altered from original use because there were only true or false options. The author identified the need for the "don't know" option to deter participants from guessing the response if the answer was unknown. Table 6 displays the participant number and percent of correct answers. 5 of the pretest items were scored correct by 100% of the participants; however the posttest showed 0 items scored correctly 100% of participants. On the posttest 13 of the items were correctly answered by 92.9% of the participants.

Table 8 shows the results of a *t*-test completed for the *LGBT Knowledge* scale. The significance level was 0.016. A statistically significant increase was achieved from the pre to posttest regarding participant knowledge level.

## Conclusion and Recommendations

Based on the outcomes that were measured and analyzed, the author was able to conclude that knowledge and attitudes of the target sample were primarily positive prior to the intervention. However, the minute instances that attitudes moved slightly more negative, by one survey participant, the author speculates that this change may be due to an increase in discussion resulting from the education module. The wording of different test items may have been a factor as well. Certain negative words of phrases such as “disgusting”, “just plain wrong” or “cry for help” could be thought to trigger a more negative reaction, as opposed to positively worded items.

The author realizes that attitudes of participants may not change and may be related to religious beliefs and upbringing. Nonetheless additional knowledge and discussion attributes success to this project. Verbal comments from participants included “I had to make sure I read the question and answered is correctly for my feelings. It was like taking nursing boards” and “The survey made me really have to think about if I assume heteronormativity and I think I do”. This dialogue signifies the importance of identifying personal feelings while maintaining positive patient relationships.

This pilot study was able to provide insight and perform a deep dive into future focus areas for education on providing culturally sensitive care to the trans* community. As next steps, the author speculates possible outcomes of surveying additional individuals outside medical specialty clinics, as well as outside the nursing profession. Nursing school provides a foundation and importance of caring for the individual. Other areas such as unit coordinators, registration, respiratory therapy, social work and other disciplines may have a variety of training backgrounds that differ significantly from nursing. The environment in which a health care professional

operates may also meaningfully impact his or her interactions with the patient population. For instance a clinic who cares specifically for trans* and gender-nonconforming patients may be more attune to specific health needs; conversely individuals working in an emergency department who do not have as much exposure may identify the need for additional training. Regardless of discipline or work location the education implemented in this study can be translated across areas and individuals.

Results of this study also indicate that dissemination of information is imperative. Discussion of project findings and the educational intervention will be presented at Nursing Grand Rounds at the author's organization. Additionally, the information and results will be published within an internal institutional wide publication sent to all staff and faculty. Future goals include implementation of education for all new staff during hospital wide orientation, education for residents and physicians, and recurring annual trainings. Education on the trans* population is one that should continue. As with many healthcare topics and trends, this area is one that is continually updating and changing. It is imperative to identify staff champions who are engaged and vested in the organization and population to serve as channels for future education.

## Summary

Knowledge and attitudes attribute to the patient-provider relationship. This includes the connection between patients and nurses. Providing culturally sensitive care to the marginalized trans* and gender-nonconforming population may aid in addressing the multitude of comorbidities presented. Nurses must be aware of their attitudes and educated on how to appropriately interact with this patient population. Many barriers and increased risks for these individuals are identified within the literature. Utilization of Leininger's theoretical framework provides a basis for the importance of holistic medicine and caring for people individually. Pre

and posttests are used as effective methods of assessment of interventions. This includes ongoing education about continually changing populations such as trans* and gender-nonconforming persons. Culturally sensitive care is at the foundation of nursing care and must be achieved to provide best patient outcomes.

Table 1

*Literature Evaluation*

| Citation | Conceptual Framework<br>==========<br>Design Method<br>==========<br>Level of Evidence | Sample/Setting | Variables<br>Independent (interventions)<br>Dependent (outcome desired) | Outcomes Measurement<br>==========<br>Data Analysis | Findings<br>==========<br>Quality of Evidence: worth to practice |
|---|---|---|---|---|---|
| Bishop, 2015 | n/a<br>Expert opinion<br>VII | Pharmacists | Education on transgender issues | Trans*->increase risk tobacco/alcohol/substance abuse, suicide attempts, significant stressors;<br>Barriers: stigma, bias;<br>Access to Primary care imperative to ensure safety of hormone tx;<br>Use of preferred name vs legal name | Trans* pts at high risk for adverse outcomes;<br>Preferred name use important to pt<br>HCP awareness of barriers and trans* considerations imperative; improve awareness among pharmacists |
| Boroughs, Bedoya, O'Cleirigh, & Safren, 2015 | n/a<br>Expert opinion<br>VII | LGBT population | Recommendation of minimal standards for ideal training in cultural competence for psychologists | Cultural competence-awareness of own biases, knowledge/understanding of cultural groups, skills/tools to culturally sensitively assess;<br>Open-mindedness and self awareness;<br>Out of classroom experiences w/ LGBT individuals;<br>Recommendations applic to nursing: cultural competence, LGBT-specific theory r/t identity formation, minority stress, current lit, familiarity w/ societal context, appropriate assessment | Recommendations applicable across disciplines<br>Supports need for cultural awareness |

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| Bradford, Reisner, Honnold, & Xavier, 2013 | n/a<br>Quantitative study<br>VI | 350 self-identified over 18 yrs trans* individuals in Virginia | Survey online/paper | 41% reported discrimination- geographic, gender, low socioeconomic status, racial/ethnic minority, lack of health insurance, transition indicators, hx of violence, needed but unattainable healthcare (hormone therapy or mental health), substance abuse, interpersonal factors;<br>27% healthcare discrimination; 15% uncomfortable discussing trans* needs w/ provider; 20% educate their PCPs r/t trans* care<br>SAS statistical software version 9.2 | Barriers – discrimination, unknowledgeable HCP<br>Supports need for improved HCP education on trans* healthcare needs |
| Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015 | n/a<br>Qualitative<br>VI | 122 baccalaureate, master's, RN-to-baccalaureate nursing students; urban public university in US | Readings, 2-hr LGBT presentation, scripted interview assignment; pre/post student survey | 112/122 (92% response rate);<br>5% uncomfortable w/ preferred pronoun, 70% comfortable;<br>13% gender identity & sexual orientation does not matter to the pts they serve, 28% matters a lot;<br>62% have knowledge to work w/ LGBT pts;<br>85% nursing ed did not prepare them, knowledge acquired from real life experiences;<br>74% reported assignment made students aware of unconscious biases | LGBT language, knowledge, skills are lacking in formal nursing education<br>Supports need for improved formal education on LGBT community |
| Colizzi, Costa, & Todarello, 2015 | n/a<br>Quantitative study<br>VI | 118 pts w/ gender dysphoria @ Gender Identity Unit of Bari University Psychiatric Dept | Self-reported scale & Interview w/ 132 items investigating dissociative symptoms, conditions, psychopharmalogical tx, hx suicide attempts & child trauma | 29.6% dissociative disorder;<br>45.8% major depressive disorder;<br>21.2% suicide attempts;<br>45.8% childhood trauma<br>STATA 10 | Pts w/ gender dysphoria are at increased risk of mental health conditions<br>Increase awareness to HCP |
| Fish, 2010 | n/a<br>Expert Opinion<br>VII | Nursing profession in UK | Health equity promotion | 1997: New Labour Gov't ->social inclusion key concept in policy;<br>Key pts: value diversity, effective communication, LGBT right to be involved in care decisions/consult w/ family of choice, knowledge of local & national resources, research needed to ID LGBT healthcare needs & impact of multiple discrimination | Healthcare professionals need awareness of LGBT needs and concerns<br>Supports need for increased awareness of LGBT specific care and |

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| | | | | | differences from cisgender |
| Hicks, Schafersman, Schmotzer, Spencer, & Tyler-Simonson, 2014 | n/a<br>Expert opinion<br>VII | Transgender clients; University Health Clinic | Education | Evolving trans* pop->struggles r/t lack of nursing ed;<br>General lack of resources & lack of knowledgeable faculty & staff;<br>HCP attitudes affect willingness of trans* to access care;<br>Nurses need familiarity: current research/guidelines, care needs-health promotion, health prevention, chronic medication monitoring, adverse effects monitoring, surveillance screening;<br>Barriers: fear of violence, discrimination, isolation, suboptimal care;<br>Sensitive questioning & use of appropriate terms | Uneasiness by HCP while caring for trans* pts at university clinic;<br>Barriers exist<br>Supports need for cultural competence training;<br>Increase knowledge of current lit |
| Hyderi, Angel, Madison, Perry, & Hagshenas, 2016 | n/a<br>Expert opinion<br>VII | Transgender patients; Family physicians | n/a | 0.3-0.5% US pop ID's trans*;<br>Child & adolescent criteria for GD diagnosis;<br>Complex transition process;<br>Testosterone not contraceptive | HCP help trans* pts become "authentic selves"<br>HCP knowledge imperative to help trans* pts be informed and aid in diagnosis |
| Janicka & Forcier, 2016 | n/a<br>Expert opinion<br>VII | Transgender youth | n/a | Prevalence: 1:7k -1:20k trans* females, 1:33k-1:50k trans* males;<br>Increase in gender nonconforming youth;<br>Age 10-14yrs =crucial period for gender identification;<br>Support, well-timed interventions help decrease poor outcomes;<br>Supportive fam ->less depression, higher self-esteem & satisfaction, lower perceived burden;<br>HCP promote parental support | Parents struggles may mirror youth's;<br>Need more youth support<br>Supports need for adolescent trans* clinics and support system; improve HCP knowledge on support for parents as well as youth |
| Klotzbaugh & Spencer, 2014) | Health Belief Model<br>Quantitative<br>VI | 343 Magnet CNOs | Survey- Modern Homonegativity Scale; assess attitudes and comfort level to advocate for LGBT pop | 115 responses (33.5%);<br>Religious->high MHS score (mean, 62.12, 95% CI, 63.08-73.16)<br>Not religious->low MHS score(mean, 58.42, 95% CI, P=.005)<br>Higher MHS score=greater homonegativity;<br>Professional: Mean SD attitude score 64.1=moderate homonegativity; Mean SD self-efficacy score 3.29=slightly more than moderate advocacy;<br>Personal: Mean SD self-efficacy score3.53 = moderate advocacy; | CNOs less homonegative attitudes-> greater personal LGBT advocacy<br>Supports the need for sensitivity training and awareness of unconscious bias |

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| | | | | Mean SD attitude score 64.13 moderate homonegativity<br>Statistical Package for Social Sciences (SPSS) 20.0; ANOVA; independent sample *t* test | |
| Lim, Brown, & Jones, 2013 | n/a<br>Expert opinion<br>VII | Nursing students | Education on LGBT | 2012 - TJC added accreditation criteria r/t communication, cultural competence, patient-family-centered care for LGBT recipients;<br>Surveys lack ID for gender identify->difficulty gathering data;<br>Healthy People 2020 – ID'd significant health disparities: 2-3x likely to attempt suicide, homelessness, less preventative tx, higher risk HIV/victimization/mental health issues, obesity, no insurance, isolation, tobacco/alcohol/drug use;<br>Study showed US/Canada undergrad medical education ~5hrs ed;<br>Strategies incorporate LGBT ed – simulation, case studies, care plans, course development, independent study | Nursing/medical students lack exposure to LGBT pop in curriculum<br>Supports need for improved inclusive curriculum; students are the future nurses to take care of growing LGBT pop |
| Moll, Krieger, Moreno-Walton, Lee, Slaven, James, & ... Heron, 2014 | n/a<br>Qualitative/Descriptive<br>VI | Emergency medicine residency program directors – from listserv | 12-item descriptive survey- actual/desired hrs of LGBT instruction, perceived barriers | 124/160 responses- 78%;<br>26% presented LGBT lecture;<br>33% incorporate topics in didactic curriculum;<br>0-8hrs, average 45 mins w/in past year;<br>Support for 0-10hrs, average 2.2hrs;<br>Perceived barriers: 59% lack of need, 23% lack interested faculty, 6% funding, 34% time, 10% other (not previously thought of need)<br>Statistical Analysis System (SAS 9.2) | LGBT mindset re: education among medical faculty ranges;<br>Minority faculty currently teach LGBT information<br>Need for more focus on LGBT education to HCP |
| Murray & McCrone, 2015 | n/a<br>Literature Review<br>V | 29 articles | Search CINAHL, MEDLINE, PsycARTICLES; 1998-2013;<br>Search terms: trust w/ concept, practitioner, provider, physician, | Trust only discussed once broken;<br>Trust = failed promises, failed commitments;<br>Congruence btwn truster expectation & trustee behaviors = trusting rltnshp;<br>+ trust r/t length of time, same provider, increased visits with healthcare team<br>Methodological assessment tools; independent review | Lack of trust = delayed/no care;<br>Barriers: conflicting info btwn HCP, controlling HCP<br>Supports HCP need increased education to promote trusting relationships with trans* pts |

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| | | | developing, creating, engendering, promoting, establishing. | | |
| Nicol, Chapman, Watkins, Young, & Shields, 2013 | n/a<br>Descriptive comparative study<br>V | 646 HCP in pediatric tertiary setting in Australia | Cross-sectional survey to describe knowledge, skills, beliefs toward LGBT parents seeking care for their children | (+) interaction w/ HCP increase likelihood of seeking care for children;<br>212/646 (32.8% response rate);<br>25% nurses answered 90% knowledge questions correctly;<br>Negative attitudes from frequent religious service attendees;<br>14% nurses answered 50/60 on Gay Affirmative Practice (GAP)= gay affirming beliefs;<br>Negative correlation btwn attitude & knowledge scores=increased knowledge associated w/ positive attitudes<br>SPSS version 19; chi squared test | HCP with positive knowledge and attitudes-> increase chance of LGBT parents seeking healthcare for their children<br>Supports equitable care, family-centered care policies and guidelines; need for affirmative health and innovative education methods |
| Poteat, German, & Kerrigan, 2013 | Grounded theory<br>Qualitative<br>VI | Purposive sampling; 55 transgender (>18yrs; 25 transmen, 30 transwomen) people and 12 medical providers | Interview- r/t stigma, discrimination and healthcare interactions btwn transgender and HCP | Providers aware of trans* difficulties – believe this leads to mental health and behavioral health issues;<br>Trans* - aware providers may have negative attitudes; distrust in HCP<br>Uncertainty – common theme;<br>Quotes r/t blaming, shaming, othering, discriminating<br>Audio recording of interviews; Altas.ti version 6.2 | Stigma -> inequality and attribute to health disparities for transgender patients<br>Supports that further education is needed to decrease stigma and discrimination against transgender pts |

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| Redfern & Sinclair, 2014 | n/a<br>Literature Review/expert opinion<br>V; VII | 82 included in review | Criteria: original research, review articles, editorials; English; 1995-2013.<br>Search terms: transgender, transsexual health, barriers, disparities, attitudes, cultural competency, physician-patient relationship, health needs assessment | Prevalence 1:2900 to 1:100,000 for male-to-female; 1:8300 to 1:400,000 female-to-male; comparable to prevalence of blindness & epilepsy in US;<br>2010 survey-27% were refused treatment; 70% at least 1 experience HCP refused to touch, used harsh language, blamed pt for health status;<br>2011 National Transgender Discrimination Survey – 15%/6450 trans* household incomes under 10k/yr; general pop 4%;<br>Delay care- 28% discrimination, 48% economic reasons<br>8% physicians regularly discuss gender identify w/ pts | Disparities in care- refusal by physician, social stigma<br>Delayed care -> mental hygiene issues (depression, alcohol/substance abuse, anxiety, suicidal tendencies), STI's r/t high risk behaviors, medical conditions from iatrogenic effects of hormone therapy<br>Proves need for further education for HCP; increased cultural competence may lead to decrease cost r/t trans* seeking healthcare |
| Reisner, Poteat, Keatley, Cabral, Mothopeng, Dunham, & ... Baral, 2016 | n/a<br>Systematic Lit Review<br>V | 116 studies; 30 countries | Criteria: 2008-2014, peer-reviewed, PubMed, Embase, OVID, PsycINFO, Web of Science, ProQuest;<br>Search terms: transgender, associated terms w/ health, social factors | 6 data points ID'd:<br>mental health(303/918; most studied; 32% mood disorders; 17% non-suicidal self-injury; 15% anxiety disorders), sexual/reproductive health(219/918; 75% STI/HIV prevalence)<br>substance abuse (193/918; 18% alcohol; 13% marijuana; 8% illicit drug use; 7% tobacco)<br>violence/victimization(105/918; 76% prevalence data only; 44% mean prevalence; 34% sexual; 17% physical; 7% psychological/emotional; 4% verbal; 38% not specified)<br>stigma/discrimination(93/918; 54% healthcare specific r/t care denial & postponement of care r/t stigma)<br>general health (68/918; least research; 77% unadjusted prevalence)<br>Gap: lack of identification of trans* individuals on survey items | Importance of gender affirmation;<br>Lack consistent definitions;<br>More research needed r/t gen health<br>Supports need for greater inclusion of trans* identification on surveys and consistent definitions |
| Reisner, Vetters, Leclerc, Zaslow, Wolfrum, Shumer, & Mimiaga, 2015 | n/a<br>Cohort Study - Retrospective<br>IV | 180 trans* pts, 12-29yrs, 2002-2011, Boston-based community health center; 106 female-to-male, 74 male-to-female | EMR review; Mental health outcomes | Trans* : 2-3 fold increase r/t depression, anxiety, suicidal ideation/attempt, self-harm, mental health treatment (IP/OP)<br>SAS version 9.3 statistical software; conditional regression model | Trans* @ higher risk of adverse outcomes vs cisgender pts<br>Support improved knowledge for HCP to offer appropriate svcs for trans* |

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| Sanchez, Sanchez, & Danoff, 2009 | n/a<br>Qualitative<br>VI | 101 male-to-female transgender; 3 community health centers in NYC | Survey | 77% have insurance (57% Medicaid; 43% private); barriers- 32% lack of knowledgeable provider, 30% access to trans*-friendly provider, 29% cost, 28% access to specialist, 18% location, 13% language; hormones- 70% on hormones (23% receive from source outside of physician, i.e. friend or street vender), 66% use needles to administer<br>Likert scale; SPSS version 16 and SAS version 9.1.3 | Lack of health insurance – if on hormones received med & needles from nontraditional sources = high risk behaviors<br>Barriers to care: lack of knowledgeable provider, access, location, language, cost, living expenses<br>Supports increased education for healthcare providers on trans* patients |
| Schuster, Reisner, & Onorato, 2016 | n/a<br>Expert Opinion<br>VII | Transgender pts | n/a | Obama vs North Carolina r/t public school legal obligation allow transgender students use of RR aligned w/ gender identity;<br>Trans* delay RR use ->UTI, kidney infection, stool impaction, hemorrhoids;<br>Harassment r/t RR use -> mental health problems (depressive symptoms, anxiety, stress), physical assault,<br>2015: 375 Fortune 500 comp. prohibit gender discrimination, up from 15 in 2002;<br>2008-2009 US National Transgender Discrimination Survey: 28% trans* adults exp harassment in med setting, 19% were refused care, 28% postponed care, *50% had to teach clinician about trans* care;*<br>2013 American Psychiatric Association – gender affirming tx are valid focus; transgender is NOT mental disorder | RR use is 1 discussion area;<br>Surveys continue to identify need for improved healthcare competency and inclusion<br>Supports need for sensitivity and competence training for HCP; suggests need for training outside healthcare arena as well |
| Shumer, Nokoff, & Spack 2016 | n/a<br>Expert opinion<br>VII | Child & adolescents w/ gender dysphoria | n/a | 1980 – WPATH(formed in 1979) published Standards of Care;<br>2009 – Endo Society issued clinical practice guidelines r/t hormone suppression;<br>HCP education vs pt expectation = struggles;<br>1952 – 1st published case of trans* female in US;<br>2 yrs label self boy/girl; 4-5 yrs understand gender is part of identity;<br>41% adults attempted suicide;<br>Primary medical goal: prevent development of unwanted biological sex characteristics, promote development of desired characteristics of affirmed gender;<br>National Transgender Discrimination Survey Report on Health and | Use appropriate terminology r/t gender ID;<br>Advocate for pts<br>Supports need for HCP education and implementation of education programs for hospital staff and students |

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| | | | | Health Care 2010: 6k trans* surveyed, 19% have been refused care r/t gender identity;<br>Suggestion: multidisciplinary programs include training/education for staff/students, advocate for changes to forms and EMR, promote research, assist w/ transition to adult care | |
| Sedlak & Boyd, 2016 | n/a<br>Expert Opinion<br>VII | Transgender Individuals (TI) | Strategies & policies to eliminate healthcare disparities | Trans* increased risk: HIV, sexual violence, discrimination, healthcare access, adverse health outcomes;<br>Need EBP grounded education: healthcare professionals, medical staff, administrators (i.e. clinical experiences in school & didactic learning);<br>Need increase awareness of barriers-> better access | Inequities in care resolved w/ educated healthcare professionals<br>Supports need for further educated healthcare professionals and administrators |
| Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012 | Grounded Theory<br>Qualitative<br>V | 13 physicians from Ontario, Canada | Interviews – perceived barriers when caring for trans* pts | Physician barriers- resource access, knowledge deficit, ethics of transition care, diagnose vs pathologising trans* pts, health system determinants<br>"feel completely out-at-sea…trying to find physicians" to help with surgical transition<br>Lack of training and exposure identified – not added bc so much other to learn | Physicians perceive many barriers to trans* care – mirrors patient perspective<br>Supports need for improved knowledge and support systems to breakdown physician barriers |
| Snyder, Burack, & Petrova, 2017 | | | | | |
| Stewart & O'Reilly, 2017 | Wakefield's Framework<br>Systematic Review<br>V | 24 articles- nurse & midwife knowledge, beliefs, attitudes r/t LGBTQ pts | Databases: CINAHL, MEDLINE, PubMed, InterNurse;<br>Criteria: 2006-2015, 7 countries | Themes: heteronormativity across healthcare, queerphobia, rainbow of attitudes (affirmation & advocacy, tx everyone equal, intrusion & judgement), learning diversity (proactive & appropriate education, insufficient education & skills);<br>Heteronormativity & lack of education ->issues | Barriers: lack of educated nurses/midwives<br>Supports need for further education in school and continued prof dev |
| Strousma, 2014 | n/a<br>Expert opinion<br>VII | Transgender individuals in US | Federal policies | Gender nonconformity – 1920's;<br>Gender identity disorder (GID) in American Psychiatric Association – 1980;<br>Change GID ->gender dysphoria – 2012;<br>0.3% ID trans* in US;<br>Trans* needs compounded by prejudices: barriers to access/timely | Long hx of trans*;<br>Barriers->trans* high risk population<br>Supports need for further HCP training on sensitivity and cultural competence |

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| | | | | care, cultural competence, medically appropriate/respectful care, care refusal;<br>Barriers->risk for violence, suicide, STIs;<br>HCP failure to provide comprehensive trans* care = ethical contradiction;<br>2008 LGBT taskforce survey: 1st largescale national trans* survey – 19% denied care, 28% verbal harassment, 28% postponed care r/t discrimination, 33% postponed preventative care, 19% no insurance | |
| Vance, Deutsch, Rosenthal, & Buckelew, 2017 | n/a<br>Descriptive<br>VI | 20 medical pediatric trainees' & students | 6 interactive online education modules r/t psychosocial & medical issues facing transgender youth; observational experience | Stat sig. improvement r/t knowledge/awareness;<br>Likert scale 5 = satisfied;<br>4.5+-.7 quality of curriculum;<br>4.4+-.7 quality of modules;<br>4.5+-.8 observational experience;<br>13/20 increased median score to knowledgeable/aware from not;<br>Improved self-perceived knowledge<br>IBM SPSS Statistics version 23 software | Modules: gender construct, gender hs, psychosocial hx, physical exam, assessment and psychosocial plan, medical plan => improved knowledge<br>Supports modules as effective education method; may be transferrable to nursing |
| Walsh & Hendrickson, 2015 | n/a<br>Qualitative<br>VI | 111 nursing programs, Texas | 12-question, web based survey; Nov2013-Jan 2014 | 21/111 (18.9% response rate);<br>Address trans* content: 47.6% broadly address trans*; 57.1%teach gender identity; 28.5%teach diff btwn transvestite, transgender, transsexual;<br>Clinical care: 14.29%teach r/t gender-reassigned pt; 15% believe student knows a referral source; 5.3% believe students know med-surg therapy options; 1 responded did not "know what my students know";<br>NONE teach WPATH standards;<br>Psychosocial care: 40% think students know where to find trans* resources, 33.3% teach gender dysphoria diagnosis, 23.8% teach psychosocial support techniques;<br>Classroom hours w/ LGBT ed: 71.4% (15/21) average 1.63 hrs, 4/15 spend 0 hrs; 0/15 spend >4 hrs;<br>"would need to be part of the NCLEX-RN blueprint and included in textbooks" | Academia may be naive to the trans* pop;<br>Standard time not spent for nursing students to learn r/t trans*<br>Supports the need for further education to academia to make the case for increased ed r/t trans* |

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| Wolf, Adams, Dayton, Verster, Joe, Romero, & ... Keatley, 2016 | n/a<br>Expert opinion<br>VII | Transgender individuals | Tools for assessment of trans* healthcare needs | Focus: community empowerment;<br>Gender affirming care-clinical and cultural competency;<br>Advocacy for trans* in global HIV national strategic plans | Need trans* competent svcs and staff<br>Supports need for education regarding trans* HIV prevention |

Table 2

*Synthesis Table: Barriers to Care*

| Studies | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Barriers to Care** | | | | | | | | | | | |
| Bias | X | | | | | | | | | | |
| Blaming | | | | | X | X | | | | | |
| Cost | | | | | | | | X | | | |
| Discrimination | | X | X | | X | X | X | | | | X |
| Fear/hx of violence | | X | X | | | | X | | | | |
| Harrassment | | | | | | | | | X | | X |
| Isolation | | | X | | | | | | | | |
| Lack of insurance | | X | | | | | | | | | X |
| Lack of trans* friendly provider | | | | | | | | X | | | |
| Lack of trust | | | | X | X | | | | | | |
| Language | | | | | | | | X | | | |
| Location | | | | | | | | X | | | |
| Refused care by provider | | | | | | X | | | X | | X |
| Shaming | | | | | X | | | | | | |
| Stigma | X | | | | | | X | | | | |
| Suboptimal care | | | X | | | | | | | | |
| Timely care | | | | | | | | | | | X |
| Unattainable care (hormones, mental health) | | X | | | | | | | | | |
| Unknowledgable provider | | X | | | | | | X | X | X | X |
| Victimization | | | | | | | X | | | | |

Legend: 1 = Biship, 2015; 2 = Bradford, Reisner, Honnold, & Xavier, 2013; 3 = Hicks, Schafersman, Schmotzer, Spencer, & Tyler-Simonson, 2014; 4 = Murray & McCrone, 2015; 5 = Poteat, German &, Kerrington, 2013; 6 =Redfern & Sinclair, 2014; 7 = Reisner et al., 2016; 8 = Sanchez, Sanchez, & Danoff, 2009; 9 = Schuster, Reisner, Onorato, 2016; 10 = Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012; 11 = Strousma, 2014
X = presence of the intervention

Table 3

*Synthesis Table: Increased Risk*

| **Studies** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |
|---|---|---|---|---|---|---|---|---|
| **Increased Risk for:** | | | | | | | | |
| Adverse health outcomes | | | | | | | | **X** |
| Delayed restroom use | | | | | | | **X** | |
| Delayed preventative treatment/HCP refused treatment | | | **X** | **X** | **X** | | **X** | |
| Discrimination/stigma | | | | | **X** | | | **X** |
| Harassment | | | | | | | **X** | |
| HIV | | | **X** | | | | | **X** |
| Homeless | | | **X** | | | | | |
| Isolation | | | **X** | | | | | |
| Lack of healthcare access | | | | | | | | **X** |
| Mental health issues (anxiety, depression, major depressive disorder, dissociative disorder, etc) | | **X** | **X** | | **X** | **X** | | |
| Obesity | | | **X** | | | | | |
| Self-harm | | | | | | **X** | | |
| Sexual violence | | | | | | | | **X** |
| Significant stressors | **X** | | | | | | | |
| Suicide attempts | **X** | **X** | **X** | | | **X** | | |
| Tobacco/alcohol/ substance abuse | **X** | | **X** | | **X** | | | |
| Trauma | | **X** | | | **X** | | | |
| Victimization | | | **X** | | **X** | | | |

1 = Bishop, 2015; 2 = Colizzi, Costa, & Todarello, 2015; 3 = Lim, Brown, & Jones, 2013; 4 = Redfern & Sinclair, 2014; 5 = Reisner et al., 2016; 6 = Reisner et al., 2015; 7 = Schuster, Reisner, & Onorato, 2016; 8 = Sedlak & Boyd, 2016; 9 = Stewart & O'Reilly, 2017
X = presence of the intervention

Table 4

*Synthesis Table: Education Strategies/Topics*

| **Studies** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Education Strategies/Topics** | | | | | | | | | | | |
| Case studies | | | | | | **X** | | | | | |
| Cultural competence | | **X** | | | | **X** | | | | | |
| Current literature/theory | | **X** | | **X** | | | | **X** | **X** | | |
| Didactic curriculum | | | | | | | **X** | | | | |
| Increase time spent | | | | | | | **X** | | | | **X** |
| Lecture | | | | | | | **X** | | | | |
| Online modules | | | | | | | | | | **X** | |
| Outside experiences | | **X** | | | | **X** | | | | **X** | |
| Parental support | | | | | **X** | | | | | | |
| Preferred name, pronoun | **X** | | **X** | **X** | | | | | | | |
| Sensitive questioning | | | | **X** | | | | | | | |
| Simulation | | | | | | **X** | | | | | |

1 = Bishop, 2015; 2 = Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; 3 = Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; 4 = Hicks, Schafersman, Schmotzer, Spencer, & Tyler-Simonson, 2014; 5 = Janicka & Forcier, 2016; 6 = Lim, Jones, Brown, 2013; 7 = Moll et al., 2014; 8 = Shumer, Nokoff, & Spack, 2016; 9 = Sedlak & Boyd, 2016; 10 = Vance, Deutsch., Rosenthal, & Buckelew, 2017; 11 = Walsh & Hendrickson, 2015

X = presence of the intervention

Table 5

*Results Pretest ($T^1$) – Posttest ($T^2$) Scores of Participants (N=14) on the LGBT Healthcare Attitude Scale*

| **Item** | **Survey** | **Strongly Agree n(%)** | **Agree n(%)** | **Somewhat Agree n(%)** | **Somewhat Disagree n(%)** | **Disagree n(%)** | **Strongly Disagree n(%)** |
|---|---|---|---|---|---|---|---|
| Sex between two men is just plain wrong. | $T^1$ | 2(14.3) | 1(7.1) | 1(7.1) | 2(14.3) | 6(42.9) | 2(14.3) |
| | $T^2$ | 2(15.2) | 1(7.7) | 0(0) | 2(15.4) | 5(38.5) | 3(23.1) |
| I think male homosexuals (gays) are disgusting. | $T^1$ | 0(0) | 0(0) | 0(0) | 0(0) | 5(35.7) | 9(64.3) |
| | $T^2$ | 0(0) | 0(0) | 0(0) | 2(15.4) | 4(30.8) | 7(53.8) |
| Male homosexuality is a natural expression of sexuality in men. | $T^1$ | 2(14.3) | 1(7.1) | 6(42.9) | 1(7.1) | 1(7.1) | 3(21.4) |
| | $T^2$ | 0(0) | 4(30.8) | 3(23.1) | 2(15.4) | 1(7.7) | 3(23.1) |
| Sex between two women is just plain wrong. | $T^1$ | 2(14.3) | 1(7.1) | 1(7.1) | 1(7.1) | 7(50.0) | 2(14.3) |
| | $T^2$ | 2(15.4) | 0(0) | 1(7.7) | 3(23.1) | 4(30.8) | 3(23.1) |
| I think female homosexuals (lesbians) are disgusting. | $T^1$ | 0(0) | 0(0) | 0(0) | 1(7.1) | 5(35.7) | 8(57.1) |
| | $T^2$ | 0(0) | 0(0) | 0(0) | 2(15.4) | 4(30.8) | 7(53.8) |
| Female homosexuality is a natural expression of sexuality in women. | $T^1$ | 1(7.1) | 2(14.3) | 5(35.7) | 2(14.3) | 1(7.1) | 3(21.4) |
| | $T^2$ | 0(0) | 4(30.8) | 3(23.1) | 2(15.4) | 1(7.7) | 3(23.1) |
| Having sex with both males and females is just plain wrong. | $T^1$ | 2(14.3) | 1(7.1) | 3(21.4) | 0(0) | 6(42.9) | 2(14.3) |
| | $T^2$ | 2(15.4) | 3(23.1) | 0(0) | 1(7.7) | 4(30.8) | 3(23.1) |

| Item | Survey | Strongly Agree n(%) | Agree n(%) | Somewhat Agree n(%) | Somewhat Disagree n(%) | Disagree n(%) | Strongly Disagree n(%) |
|---|---|---|---|---|---|---|---|
| I think bisexuals are disgusting. | T[1] | 0(0) | 0(0) | 0(0) | 0(0) | 7(50.0) | 7(50.0) |
| | T[2] | 0(0) | 0(0) | 0(0) | 4(30.8) | 3(23.1) | 6(46.2) |
| Bisexuality is a natural expression of sexuality in males and females. | T[1] | 2(14.3) | 2(14.3) | 5(35.7) | 0(0) | 3(21.4) | 2(14.3) |
| | T[2] | 0(0) | 4(30.8) | 3(23.1) | 2(15.4) | 1(7.7) | 3(23.1) |
| A person who feels that their sex (male or female) does not match their gender identity (masculine or feminine) is just plain wrong. | T[1] | 0(0) | 1(7.1) | 1(7.1) | 1(7.1) | 5(35.7) | 6(42.9) |
| | T[2] | 0(0) | 0(0) | 0(0) | 2(15.4) | 7(53.8) | 4(30.8) |
| I think transgender people are disgusting. | T[1] | 0(0) | 0(0) | 0(0) | 0(0) | 5(35.7) | 9(64.3) |
| | T[2] | 0(0) | 0(0) | 0(0) | 2(15.4) | 4(30.8) | 7(53.8) |
| Being transgender is a natural expression of gender identity in men and women. | T[1] | 1(7.1) | 2(14.3) | 4(28.6) | 3(21.4) | 2(14.3) | 2(14.3) |
| | T[2] | 0(0) | 4(30.8) | 4(30.8) | 0(0) | 1(7.7) | 4(30.8) |
| I would prefer not to provide nursing care for LGBT patients. | T[1] | 0(0) | 0(0) | 0(0) | 0(0) | 2(14.3) | 12(85.7) |
| | T[2] | 0(0) | 0(0) | 0(0) | 0(0) | 2(15.4) | 11(84.6) |
| I would refuse to care for an LGBT patient if I were aware they identify as LGBT. | T[1] | 0(0) | 0(0) | 0(0) | 0(0) | 2(14.3) | 12(85.7) |
| | T[2] | 0(0) | 0(0) | 0(0) | 0(0) | 2(15.4) | 11(84.6) |

| Item | Survey | Strongly Agree n(%) | Agree n(%) | Somewhat Agree n(%) | Somewhat Disagree n(%) | Disagree n(%) | Strongly Disagree n(%) |
|---|---|---|---|---|---|---|---|
| I feel competent to provide nursing care for LGBT patients. | $T^1$ | 0(0) | 5(35.7) | 6(42.9) | 2(14.3) | 0(0) | 1(7.1) |
| | $T^2$ | 0(0) | 8(61.5) | 5(38.5) | 0(0) | 0(0) | 0(0) |
| LGBT patients do not have any specific health needs. | $T^1$ | 1(7.1) | 0(0) | 1(7.1) | 2(14.3) | 6(42.9) | 4(28.6) |
| | $T^2$ | 0(0) | 0(0) | 1(7.7) | 1(7.7) | 4(30.8) | 7(53.8) |
| I feel I would be able to talk with a patient who identifies as LGBT in a sensitive and appropriate manner. | $T^1$ | 0(0) | 7(50.0) | 6(42.9) | 1(7.1) | 0(0) | 0(0) |
| | $T^2$ | 0(0) | 8(61.5) | 5(38.5) | 0(0) | 0(0) | 0(0) |

*Note.* Only 13 participants completed $T^2$.

Table 6

*Results Pretest-Posttest Scores of Participants (N=14) on the LGBT Knowledge Scale*

| **Item** | **Pretest n(%)** | **Posttest n(%)** |
|---|---|---|
| Sex and gender have the same meaning. | 13(92.9) | 13(100) |
| Most homosexuals want to be members of the opposite sex. | 12(85.7) | 13(100) |
| Homosexual men always act and dress in a feminine way. | 14(100) | 13(100) |
| Homosexual men are more likely to be victims of violent crime than the general public. | 13(92.9) | 13(100) |
| Homosexuals may experience some or all of the six phases of "coming out". | 10(71.4) | 13(100) |
| It is important to conduct a suicide assessment when working with LGBT patients. | 13(92.9) | 13(100) |
| Bisexuals will eventually "come out" as homosexuals. | 11(78.6) | 13(100) |
| Bisexual behavior is often just a cry for help. | 11(78.6) | 12(92.3) |
| In order to be considered transgender, a person must have undergone a sexual reassignment surgery. | 13(92.9) | 13(100) |
| Transgender women (male to female) are always attracted to people with male genitals. | 12(85.7) | 13(100) |
| A transgender person should be addressed using pronouns of the preferred gender rather than biological sex. | 14(100) | 13(100) |
| Homosexual women always dress and act in a masculine way. | 14(100) | 13(100) |
| LGBT patients do not seek medical treatment as early as heterosexuals because of fear of discrimination. | 12(85.7) | 12(92.3) |
| Most health care providers automatically make the assumption that their patient is heterosexual if they have not specifically addressed orientation. | 14(100) | 13 (100) |
| LGBT patients may present with signs of depression due to lack of social acceptance. | 14(100) | 13(100) |

*Note.* Scale: 0 – 100 points. Only 13 participants completed the posttest.

Table 7

*Participant (N=14) T-Test Results From Pretest-Posttest LGBT Healthcare Attitude Scale*

| **M(SD) Pretest** | **M(SD) Posttest** | ***t*** | **Significance (2-Tailed)** |
|---|---|---|---|
| 75.85(7.17) | 75.69(7.53) | 0.12 | 0.91 |

Table 8

*Participant (N=14) T-Test Results From Pretest-Posttest LGBT Knowledge Scale*

| **M(SD) Pretest** | **M(SD) Posttest** | ***t*** | **Significance (2-Tailed)** |
|---|---|---|---|
| 13.62(1.71) | 14.85(0.38) | -2.79 | 0.016 |

# Appendix A

INSTITUTIONAL REVIEW BOARD
RESEARCH INVOLVING HUMAN SUBJECTS
OTTERBEIN UNIVERSITY

X Original Review
____ Continuing Review
____ Five-Year Review
____ Amendment

ACTION OF THE INSTITUTIONAL REVIEW BOARD

With regard to the employment of human subjects in the proposed research:

**HS # 17/18-08**
**Butz & Humphrey: Nursing knowledge and attitudes toward trans* …**

THE INSTITUTIONAL REVIEW BOARD HAS TAKEN THE FOLLOWING ACTION:

____ Approved
✓ Approved with Stipulations*
____ Deferred
____ Disapproved
____ Waiver of Written Consent Granted

*Stipulations stated by the IRB have been met by the investigator and, therefore, the protocol is APPROVED.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the principal investigator leave the college, signed consent forms are to be transferred to the Institutional Review Board for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the IRB, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date: 14 September 2017 Signed: Meredith C Jacy
Chairperson

OC HS Form AF

* In your consent language, please include "By starting this survey, I consent to participate in this research and I affirm that I am at least 18 years old."

Appendix B

8/13/2017
Kristy Strong
1438 West Flournoy Street
Chicago, IL 60607

I, the principle investigator, give permission for Christine Humphrey to use and modify as necessary the educational module and tools that were used in the study:

Strong K., Folse V.(2015). Assessing Undergraduate Nursing Students' Knowledge, Attitudes, and Cultural Competence in Caring for Lesbian, Gay, Bisexual, and Transgender Patients. *J Nurs Educ.* 54(1) 45-49. doi: 10.3928/01484834-20141224-07

The tools used include the modified ATLG scale, the LGBT Healthcare scale, and the LGBT Knowledge questionnaire. The educational module includes one Powerpoint presentation.

Please include an acknowledgement of the source of the material used in the references of your study.

Thank you,

Kristy Strong, BSN, RN

Appendix C

## LGBT Healthcare Scale

| | Strongly Agree | Agree | Somewhat Agree | Somewhat Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|---|
| Sex between two men is just plain wrong. | ○ | ○ | ○ | ○ | ○ | ○ |
| I think male homosexuals (gays) are disgusting. | ○ | ○ | ○ | ○ | ○ | ○ |
| Male homosexuality is a natural expression of sexuality in men. | ○ | ○ | ○ | ○ | ○ | ○ |
| Sex between two women is just plain wrong. | ○ | ○ | ○ | ○ | ○ | ○ |
| I think female homosexuals (lesbians) are disgusting. | ○ | ○ | ○ | ○ | ○ | ○ |
| Female homosexuality is a natural expression of sexuality in women. | ○ | ○ | ○ | ○ | ○ | ○ |
| Having sex with both males and females is just plain wrong. | ○ | ○ | ○ | ○ | ○ | ○ |
| I think bisexuals are disgusting. | ○ | ○ | ○ | ○ | ○ | ○ |
| Bisexuality is a natural expression of sexuality in males and females. | ○ | ○ | ○ | ○ | ○ | ○ |
| A person who feels that their sex (male or female) does not match their gender identity (masculine or feminine) is just plain wrong. | ○ | ○ | ○ | ○ | ○ | ○ |
| I think transgender people are disgusting. | ○ | ○ | ○ | ○ | ○ | ○ |
| Being transgender is a natural expression of gender identity in men and women. | ○ | ○ | ○ | ○ | ○ | ○ |
| I would prefer not to provide nursing care for LGBT patients. | ○ | ○ | ○ | ○ | ○ | ○ |
| I would refuse to care for an LGBT patient if I were aware they identify as LGBT. | ○ | ○ | ○ | ○ | ○ | ○ |

*Confidential*



| | | | | | | |
|---|---|---|---|---|---|---|
| I feel competent to provide nursing care for LGBT patients. | O | O | O | O | O | O |
| LGBT patients do not have any specific health needs. | O | O | O | O | O | O |
| I feel I would be able to talk with a patient who identifies as LGBT in a sensitive and appropriate manner. | O | O | O | O | O | O |

Appendix D

## LGBT Knowledge Questionnaire

| | True | False | Don't Know |
|---|---|---|---|
| Sex and gender have the same meaning. | ○ | ○ | ○ |
| Most homosexuals want to be members of the opposite sex. | ○ | ○ | ○ |
| Homosexual men always act and dress in a feminine way. | ○ | ○ | ○ |
| Homosexual men are more likely to be victims of violent crime than the general public. | ○ | ○ | ○ |
| Homosexuals may experience some or all of the six phases of "coming out". | ○ | ○ | ○ |
| It is important to conduct a suicide assessment when working with LGBT patients. | ○ | ○ | ○ |
| Bisexuals will eventually "come out" as homosexuals. | ○ | ○ | ○ |
| Bisexual behavior is often just a cry for attention. | ○ | ○ | ○ |
| In order to be considered transgender, a person must have undergone a sexual reassignment surgery. | ○ | ○ | ○ |
| Transgender women (male to female) are always attracted to people with male genitals. | ○ | ○ | ○ |
| A transgender person should be addressed using pronouns of the preferred gender rather than biological sex. | ○ | ○ | ○ |
| Homosexual women always dress and act in a masculine way. | ○ | ○ | ○ |
| LGBT patients do not seek medical treatment as early as heterosexuals because of fear of discrimination. | ○ | ○ | ○ |

| | | | |
|---|---|---|---|
| Most health care providers automatically make the assumption that their patient is heterosexual if they have not specifically addressed sexual orientation. | ○ | ○ | ○ |
| LGBT patients may present with signs of depression due to lack of social acceptance. | ○ | ○ | ○ |

Appendix E

## Demographics

What is your gender?

○ Male ○ Female ○ Transgender/non-binary/third gender

Age in years

_____

Years as a nurse

_____

Have you ever interacted with a transgender patient?

○ Yes ○ No

Do you personally know anyone who identifies lesbian, gay, bisexual or transgender?

○ Yes ○ No

Appendix F

**Consent**

The Department of Nursing at Otterbein University supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty. As a participant you have the right to decline to respond to any question for any reason. By participating in the survey, I consent to participate in this study and affirm that I am over 18 years old.

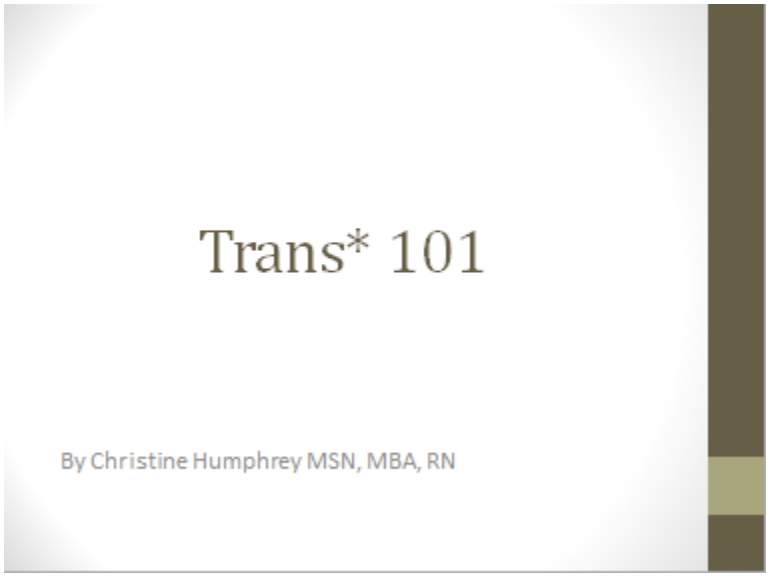
We are interested in studying the effects of education on nurses' knowledge and attitudes toward the transgender and gender-nonconforming population. You will be participating in completing a pre and post survey and completing a self-paced 30 minute education module. It is estimated that this will take no more than 45 minutes of your time. Although it is not likely, there is a chance that you might feel slightly uncomfortable with some of the questions and parts of the education module.

Your participation is solicited although strictly voluntary. We assure you that your name will not be associated in any way with the study findings.

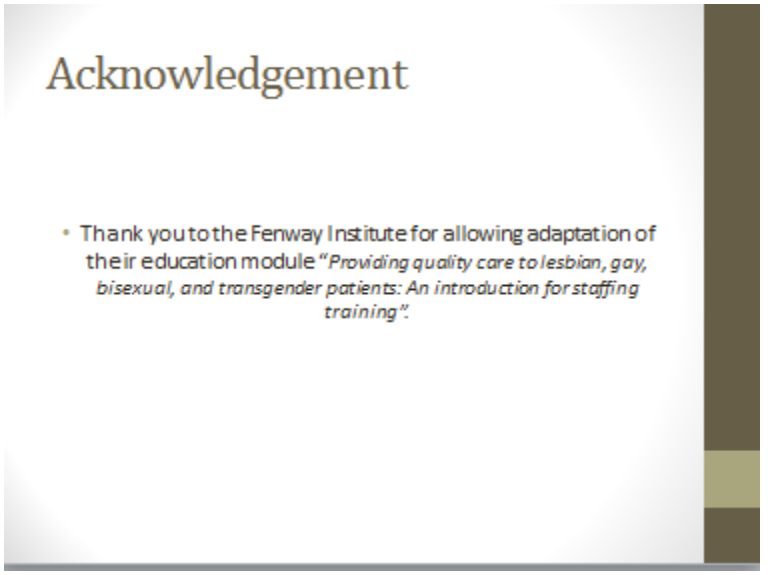
If you would like additional information concerning this study before or after it is complete, please feel free to contact me by phone or mail.

Sincerely,
Sue Butz, DNP, RN, CCRN Principal Investigator
Christine Humphrey
1 South Grove St.
Westerville, OH 43081
614-397-3544

Appendix G



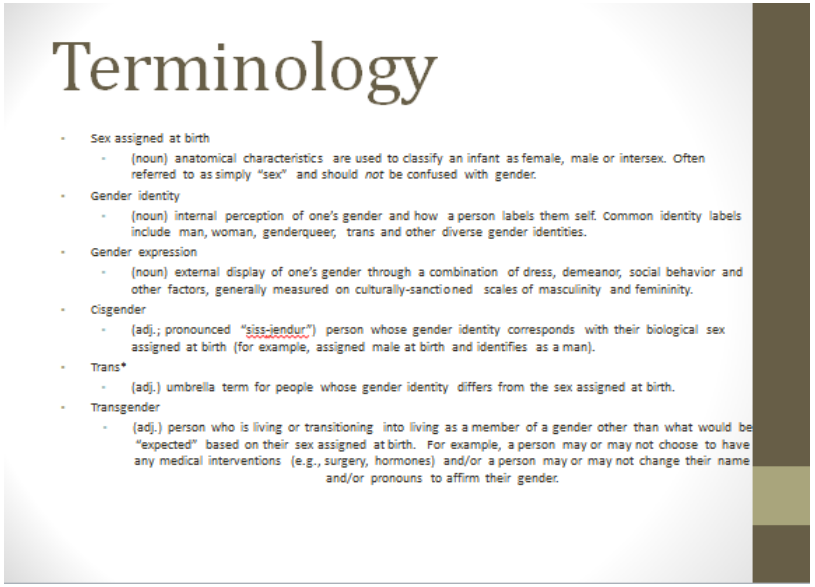

Welcome to the learning module: Trans* 101. In this module, you will learn ways to provide affirming and inclusive health care for transgender and gender-nonconforming patients.




No notes


Objectives
Define terminology related to transgender and gender non-confirming individuals.
Discuss health disparities present with transgender and gender non-conforming persons.
Identify effective communication techniques and phrases.

No notes




**This is not an exhaustive list of terms, for purposes of the talk to clarify what the terms mean**

**Sex assigned at birth** (noun) is the determination of an infant's sex at birth. Typically, anatomical characteristics are used to classify an infant as female or male or intersex. Often referred to as simply "sex" and should not be confused with gender. Often "biological sex" is seen as a binary but as there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics. It is more accurate to view sex as a spectrum, which is more inclusive of intersex people and trans-identified people.

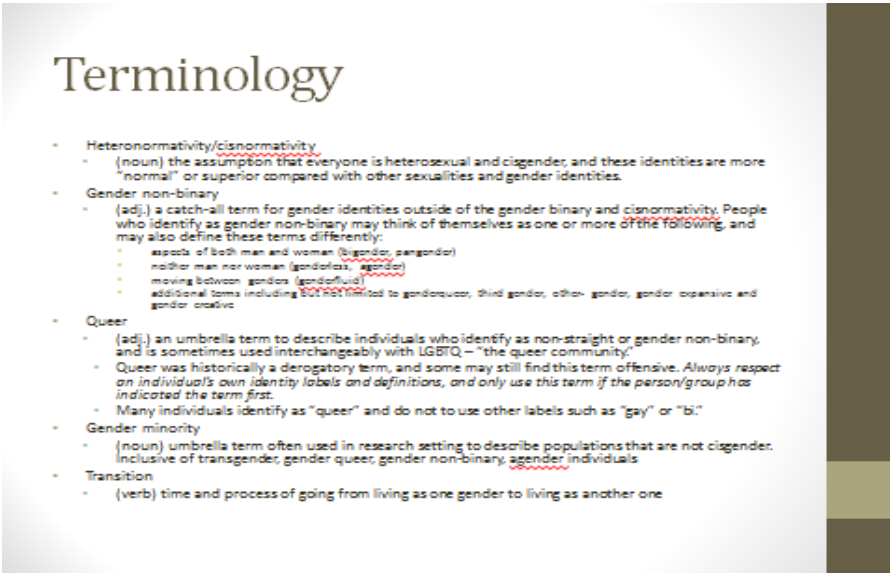
**Gender identity** (noun) is the internal perception of one's gender, and how a person labels themselves. Common identity labels include man, woman, genderqueer, trans and other diverse gender identities. Gender is not to be confused with sex assigned at birth or "biological sex."

**Gender expression** (noun) is the external display of one's gender through a combination of dress, demeanor, social behavior and other factors, generally measured on culturally-sanctioned scales of masculinity and femininity.

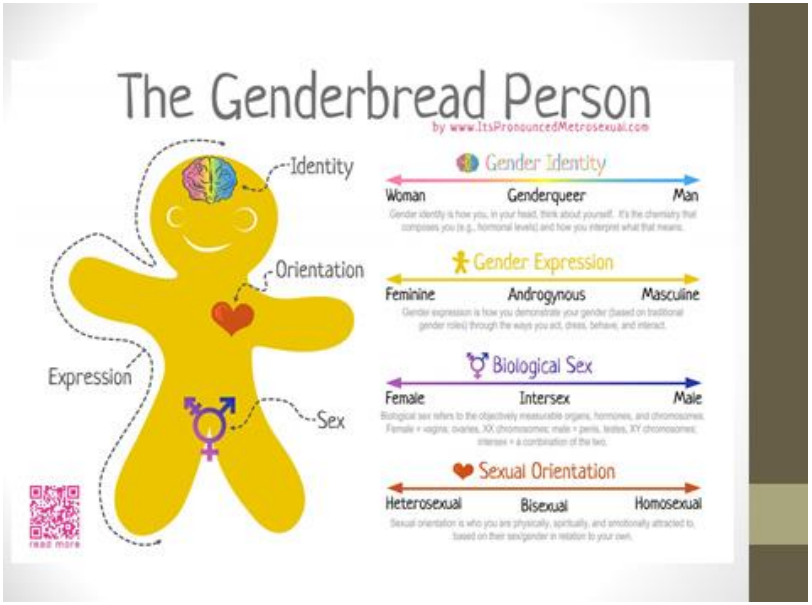
**Cisgender** (adj.; pronounced "siss-jendur") is a person whose gender identity corresponds with their biological sex assigned at birth (for example, assigned male at birth and identifies as a man). This term can be shortened to "cis," which is a Latin prefix that means "on the same side [as]" or "on this side [of]."

**Trans** (adj.) is sometimes considered to be an umbrella term for people whose gender identity differs from the sex they were assigned at birth. Trans people may identify with a particular descriptive term (transgender, genderqueer, FTM/Female to Male, etc.) or identify simply as "trans." Though some non-binary individuals do not consider themselves under the "trans" umbrella and consider the term to be an abbreviation for transgender only. Always follow an individual's self-identified terms.

**Transgender** (adj.) typically indicates a person who is living or transitioning into living as a member of a gender other than what would be "expected" based on their sex assigned at birth. What this means can vary from person to person. For example, a person may or may not choose to have any medical interventions (e.g., surgery, hormones) and/or a person may or may not change their name and/or pronouns to affirm their gender. Transsexual is a relatively outdated clinical term that you may encounter in medical literature used to refer to transgender people who are choosing to pursue medical interventions, but many people in the transgender community find this term offensive.




**Heteronormativity/cisnormativity** (noun) is the assumption, in individuals or in institutions, that everyone is heterosexual and cisgender, and these identities are more "normal" or superior compared with other sexualities and gender identities. This leads to invisibility and stigmatization.
**Gender non-binary** (adj.) is a catch-all term for gender identities outside of the gender binary and cisnormativity. People who identify as gender non-binary may think of themselves as one or more of the following, and may also define these terms differently:
aspects of both man and woman (bigender, pangender)
neither man nor woman (genderless, agender)
moving between genders (genderfluid)
additional terms including but not limited to genderqueer, third gender, other-gender, gender expansive and gender creative
**Queer** (adj.) is generally used as an umbrella term to describe individuals who identify as non-straight or gender non-binary, and is sometimes used interchangeably with LGBTQ – "the queer community."
Queer was historically a derogatory term, and some may still find this term offensive. Always respect an individual's own identity labels and definitions, and only use this term if the person/group has indicated the term first.
Many individuals identify as "queer" and do not to use other labels such as "gay" or "bi." If appropriate, you might ask someone what it means for them so you don't make any assumptions.
**Gender Minority**: Umbrella term often used in research setting to describe populations that are not cisgender. Inclusive of transgender, gender queer, gender non-binary, agender individuals
**Transition**: Time and process of going from living as one gender to living as another one



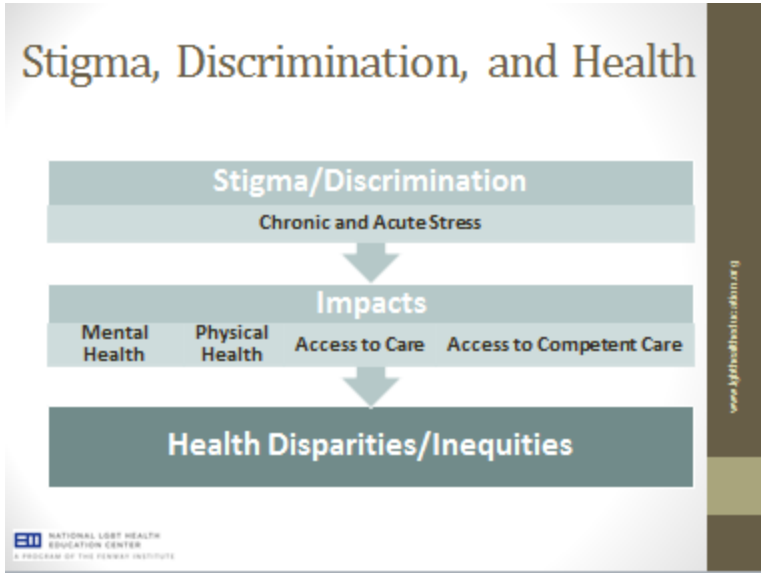

No notes


Transgender and gender non-conforming people are very diverse and live in communities across the United States.

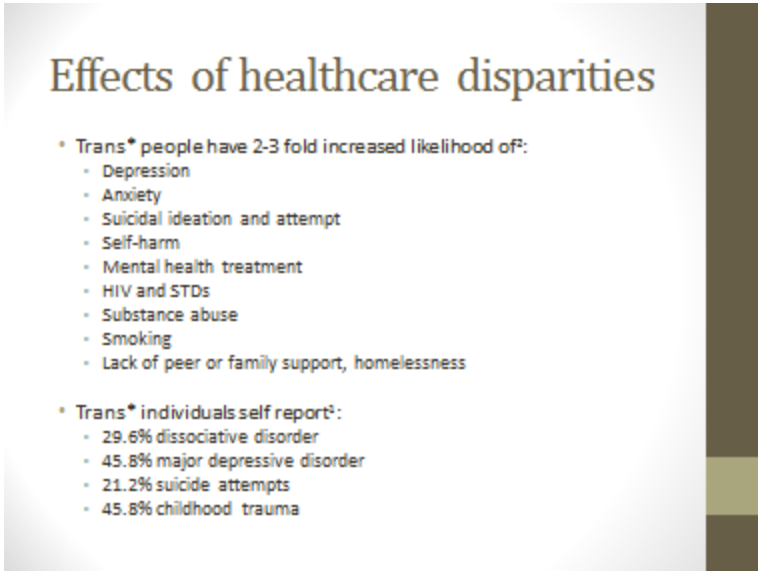

No notes


No notes


Many trans* people have experienced rejection, unfair treatment, bullying and other types of victimization, as well as other forms of discrimination. Daily chronic stigma can then lead to stress, anxiety, depression, and other health disparities.

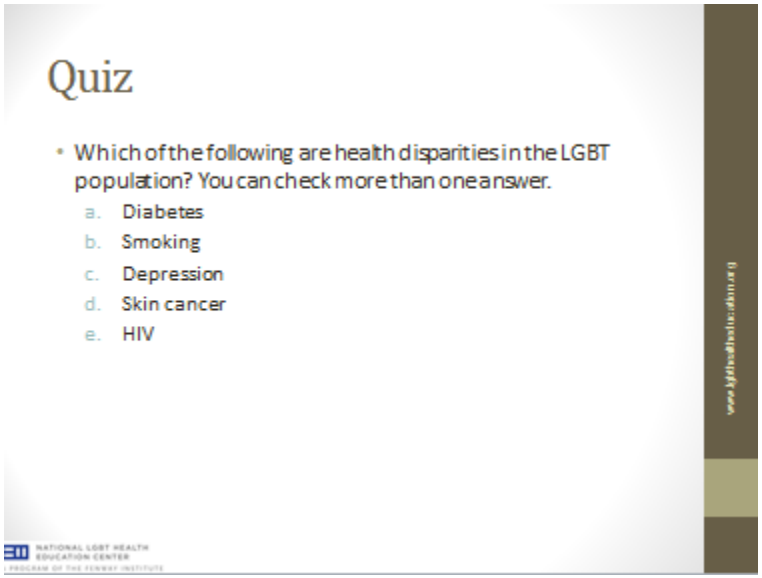



Stigma and discrimination can create a lot of stress and can limit access to care. The daily and acute stress caused by these issues can impact an individual's mental and physical health--so can the lack of access to culturally competent care. When a population, such as LGBT people, experience negative health impacts, we see health disparities in that population.




There is a long history of stigma and discrimination against trans* individuals in health care settings. Gender dysphoria used to be considered a mental health disorder. Even today, some clinicians continue with this mindset. Many trans* people feel unwelcome in health care settings and avoid or delay care in order to avoid uncomfortable or stigmatizing experiences.


Although it is important to study and address LGBT health disparities, it is also important to remember the resiliency and strength of the LGBT community. Despite widespread stigma and discrimination, most LGBT people are physically and emotionally healthy and don't engage in risky behaviors. Resilience can come from the strength of the individual as well as from the strength of the community.




a. This is incorrect. There is no research evidence to suggest that diabetes rates are higher in LGBT populations.

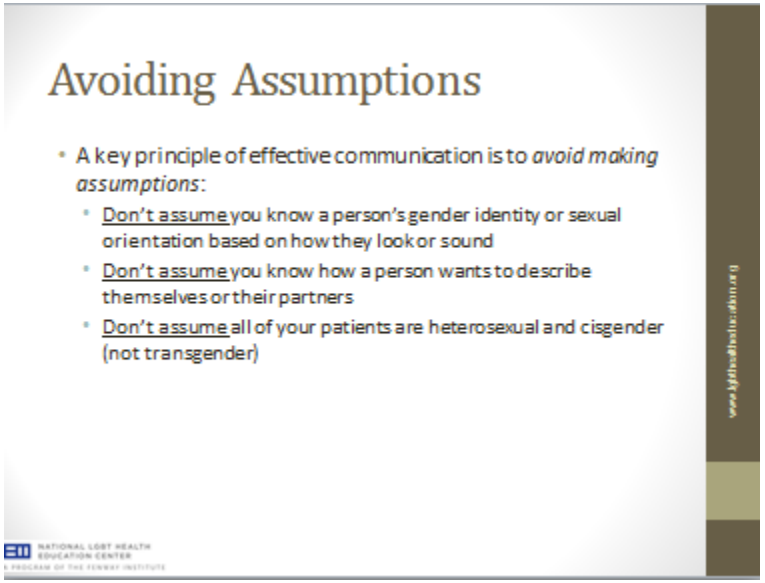
b. This is correct. Smoking rates are much higher among LGBT people compared to non-LGBT people.

c. This is correct. Depression rates are higher among LGBT people compared to non-LGBT people.

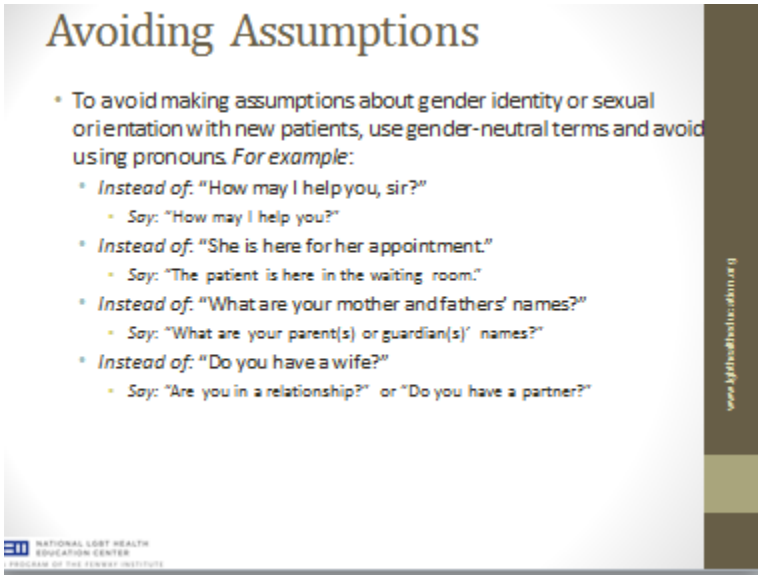
d. This is incorrect. There is no research evidence to suggest that skin cancer rates are higher in LGBT populations.

e. This is correct. HIV rates are much higher among LGBT people (specifically gay and bisexual men, and transgender women) compared to non-LGBT people.

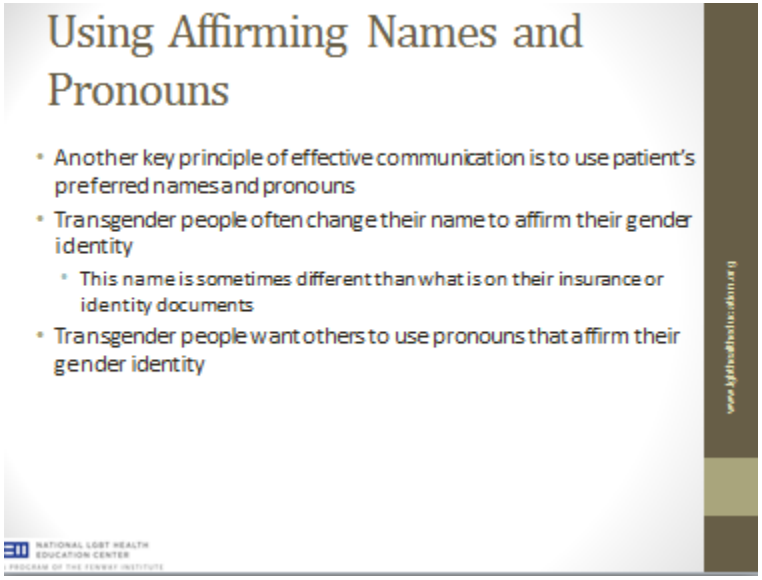

No notes




No notes




When you encounter a new patient, try to steer clear of words that assume a certain gender identity or sexual orientation. For example, avoid using pronouns (e.g., he and she) or words like sir, ma'am, Mrs., Ms., or Mr. This will help you from accidentally insulting the patient. The scripts on this slide provide examples of how to do this. You may need to practice these scripts with friends, family, and colleagues, before it comes naturally.

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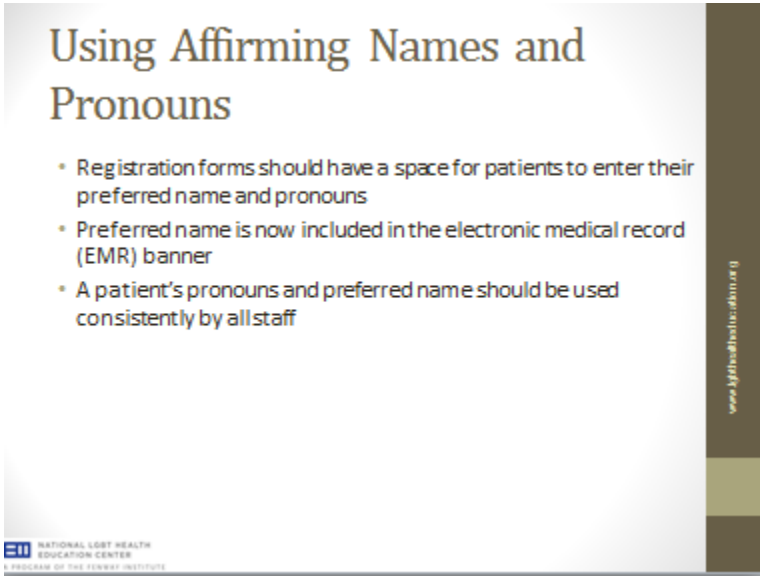
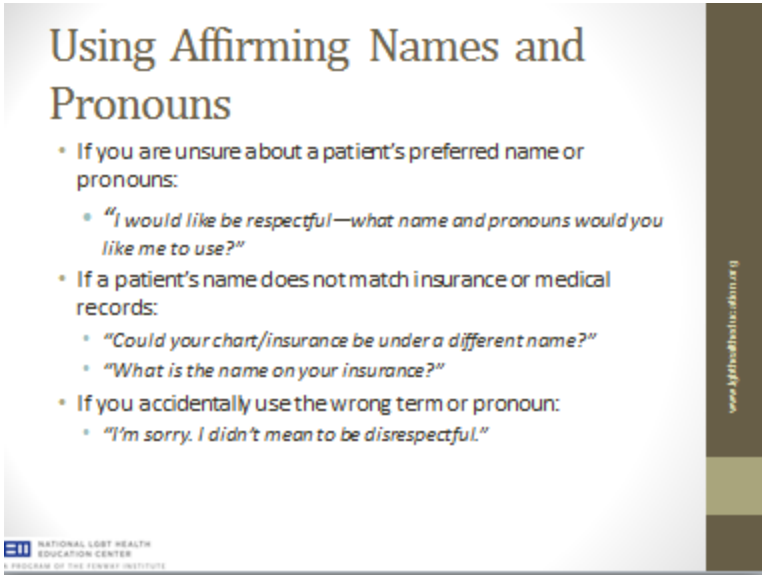


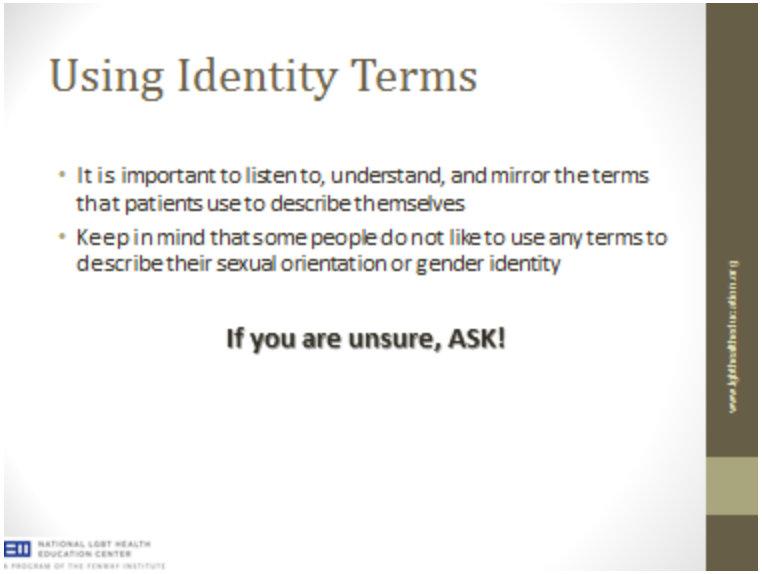

No notes


Some people may use words or pronouns that are unfamiliar. Pronouns such as "zie" or "they" are sometimes used by people who do not want to identify with the gender binary of he/she.
The button on this slide is used by Fenway Health staff members. Other buttons have “he/him/his”, “she/her/hers”, and “Ask me.”




No notes


No notes

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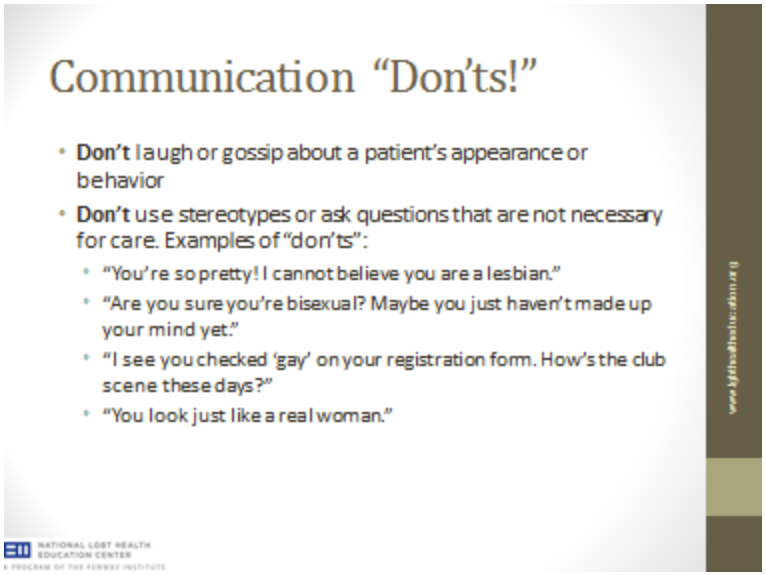
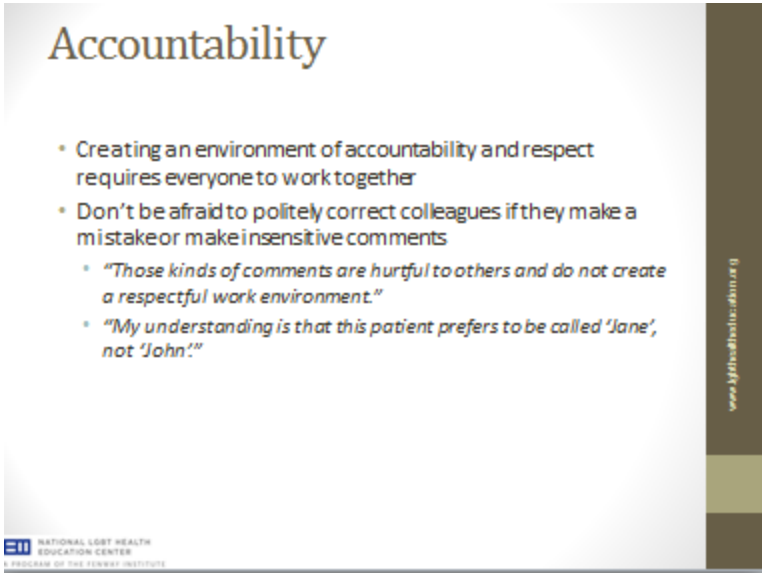
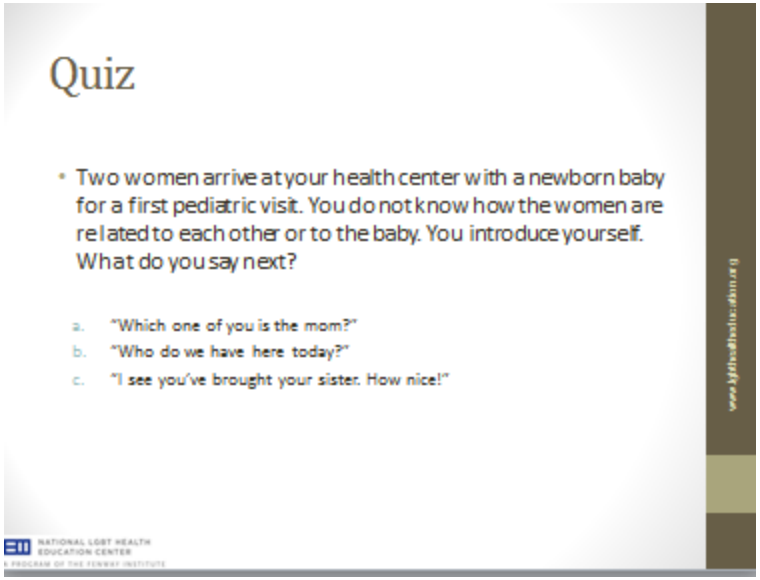



It is easy to fall into stereotypes or ask unnecessary questions when trying to engage your patients and build rapport. Before asking a question, ask yourself: "What do I need to know? How can I ask this in a sensitive way?"



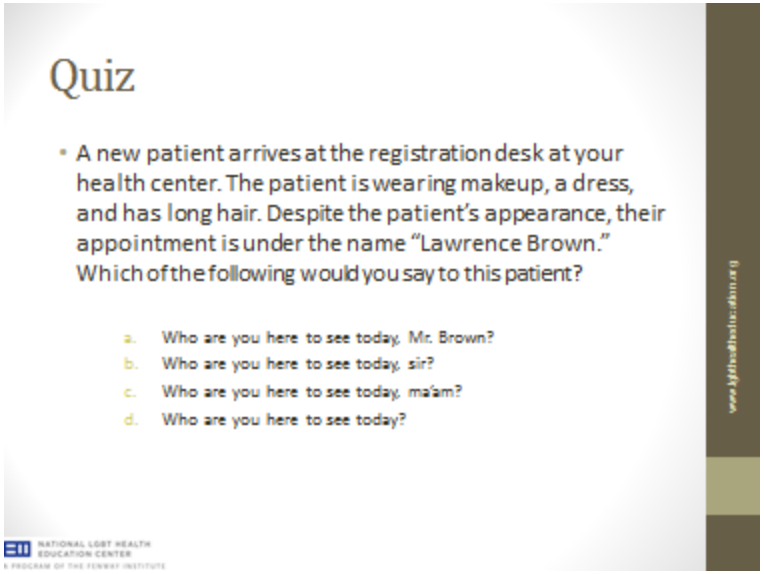

Be each other's wingman.




a. This is incorrect. Both women may be the mother of the child. This answer makes assumptions and could offend the patients. Try again!

b. Correct! This is the best answer because you are keeping the greeting open-ended to give the patients a chance to introduce themselves. Unlike answers a and c, this is a good way to avoid assumptions.

c. This is incorrect. This answer assumes that if you see two women together, they must be sisters or mother and daughter. It is best to ask open-ended questions. Try again!




a. This is incorrect. You should not use gender terms like "Mr." unless you know how the patient likes to be addressed. Try again!

b. This is incorrect. You should not use gender terms like "sir" unless you know how the patient likes to be addressed. Try again!

c. This is incorrect. You should not use gender terms like "ma'am" unless you know how the patient likes to be addressed. Try again!

d. This is the best answer because you are not using any gender terms. The other answers assume you know how the patient wishes to be addressed.

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No notes

## Questions??

This module provided a basic introduction to transgender and gender non-conforming patient's health care and effective communication.

Please contact with any questions or if you would like additional resources:

Christine.Humphrey@nationwidechildrens.org

No notes

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