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A Phenomenological Study of Adults Receiving Gender Affirmation Care at Clinics Specializing in Transgender Healthcare

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Thank you.

Dedication

We dedicate our research study to our participants whose honesty and bravery we appreciate.

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Abstract

Transgender adults encounter obstacles accessing adequate healthcare; additionally, providers face barriers in meeting the unique needs of transgender people. To mitigate barriers, select clinics specialize in transgender healthcare. The purpose of this study is to describe the lived experiences of adults receiving gender affirmation care at clinics specializing in transgender healthcare. We administered a digital questionnaire with open-ended questions and an optional photograph upload representative of participants' experiences, obtaining a purposeful sample of 20 respondents. Steeped in a critical inquiry paradigm while utilizing hermeneutic phenomenology in data analysis, six themes emerged: *Clinic Operational Experiences*, *A Sense of Belonging*, *Participants' Views of Providers*, *Anxiety and Relief*, *Personal Agency*, and *Lens on Duality*. Participants reported satisfaction with the care they received at their specialized clinic, highlighting the importance of inclusive language to avoid misgendering but noting long wait times for initial consultations. Based upon study findings, we recommend healthcare teams utilize chosen names and pronouns, develop collaborative partnerships, create inclusive spaces, and foster holistic care.

Keywords: transgender specialty care, LGBTQ health, gender affirmation care, transgender social determinants of health, hermeneutic phenomenology

Introduction

Transgender clients in the healthcare setting raise the dilemma of whose embodied presence is welcome, accepted, and cared for by healthcare providers. Transgender clients report barriers in healthcare settings including access constraints at the individual (Romanelli & Hudson, 2017) and institutional (Blodgett, Coughlan, & Khullar, 2018; Bradford, Reisner, Honnold, & Xavier, 2013; Gonzales & Henning-Smith, 2017) levels and discriminatory behavior from health care providers (Aylagas-Crespillo, García-Barbero, & Rodríguez-Martín, 2018). Healthcare providers face barriers including education (Blodgett et al., 2018), experience (Paradiso & Lally, 2018), and institutional standards (Chen et al., 2018; K. A. Clark, White Hughto, & Pachankis, 2017). To offer higher quality healthcare and improve healthcare experiences for transgender clients, some clinics specialize in transgender healthcare (Nisly et al., 2018; Reisner, Bradford, et al., 2015). As transgender healthcare is complex with varying vocabulary, we begin with a few definitions. We utilize the term transgender to be consistent with published research (Hudson, 2018), though some individuals in the transgender community may prefer other vocabulary such as trans (Stryker, 2017).

Winter et al. (2016) assert that a transgender person is someone assigned one gender at birth whose internal lived experience is of another gender. A person assigned male at birth who knows herself to be a female is a male to female transgender person, alternately called a transgender female. Correspondingly, someone assigned female at birth who knows himself to be a male is a female to male transgender person, or transgender male. A person who identifies as transgender non-binary could be referred to as male to X or female to X (Winter et al., 2016). A person who feels a congruence between their birth-assigned gender and their gender identity is cisgender (Levitt & Ippolito, 2014).

Winter et al. (2016) estimate 0.5-1.3% of the global population identify as transgender female and 0.4-1.2% as transgender male, resulting in 25 million transgender people globally. As of 2016, nearly 1.4 million people in the United States of America (USA) identify as transgender (Flores, Herman, Gates, & Brown, 2016). Transgender people face social stigma despite diagnostic guidelines declassifying being transgender as a mental illness (Aylagas-Crespillo et al., 2018; Poteat, German, & Kerrigan, 2013; Zucker, 2015). The contemporary sociopolitical context is unfavorable to people whose sex and gender identity are incongruent (Bith-Melander et al., 2010; Logie et al., 2019; Reisner et al., 2016; Winter et al., 2016).

Discrimination and stigma continue to negatively impact the health and welfare of transgender people (Bith-Melander et al., 2010; Bradford et al., 2013; Shires & Jaffee, 2015) who face widespread disparities in healthcare outcomes (Bradford et al., 2013; Downing & Przedworski, 2018; Kattari, Walls, Speer, & Kattari, 2016; Kcomt, 2019) such as higher rates of mental health concerns (Reisner, Vetters, et al., 2015). Organizations that research social determinants of health, such as Healthy People 2020, look at ways in which societal elements influence the health and well-being of various groups, often minorities (DeSalvo, 2015). Society overtly and covertly stigmatizes people who deviate from societal norms (Aylagas-Crespillo et al., 2018; Logie et al., 2019), including socially prescribed gender norms. Stigma serves to reinforce societal norms and standards (Levitt & Ippolito, 2014; Poteat et al., 2013). Logie et al. (2019) assert that stigmatization becomes internalized in transgender people and results in low self-esteem which can manifest in increased risk-taking activities such as drug use or unprotected sex. External stigma creates difficulties in finding housing and employment, leading some transgender people to resort to underground economies such as drug and sex trades, further reinforcing stigma (Logie et al., 2019). Providers with a lack of knowledge in transgender healthcare and experience may allow stigma to influence the care they provide to clients (Poteat et al., 2013; White Hughto et al., 2017; White Hughto, Reisner, & Pachankis, 2015). Additionally, transgender people of color typically do not receive culturally inclusive, high quality healthcare (Bradford et al., 2013; DeSalvo, 2015; Howard et al., 2019; Office of Disease Prevention and Health Promotion [ODPHP], 2019). Transgender people are at risk of having diminished standards of health and lower health markers than cisgender people (Winter et al., 2016; Wylie et al., 2016). However, Castañeda (2015) and McCann and Sharek (2016) find that gender affirmation therapies promote a higher quality of life for transgender clients.

Gender affirmation therapy is an individualized process along a care continuum; however, there is a lack of standardized care and evidence-based guidelines that support healthcare providers and transgender clients (Coleman et al., 2012; Hembree et al., 2017; Shuster, 2016). Medical interventions often start with psychotherapy to help with gender dysphoria (GD) and may advance to hormone treatments as a next phase (Castañeda, 2015). Speech therapists can assist clients in learning how to use their voices in accordance with masculine and feminine societal norms (Casado, O'Connor, Angulo, & Adrián, 2016). There are many surgical procedures to alter primary and secondary sex characteristics, and client-reported outcomes vary (Winter et al., 2016). Provider comfort and knowledge in working with transgender clients contributes to variances in outcomes of gender affirmation therapies (Poteat et al., 2013).

Guidelines from the World Professional Association for Transgender Health (WPATH) recommend primary care providers serve as the main point of access to gender affirmation care; however, if providers are uncomfortable or unsure about appropriate care for transgender clients, they should refer the clients to specialists (Coleman et al., 2012). Due to inadequate transgender-related education (Cooper, Chacko, & Christner, 2018; Coutin, Wright, Li, & Fung, 2018; White Hughto et al., 2017) and lack of experience in working with transgender clients (Manzer, O'Sullivan, & Doucet, 2018; White Hughto et al., 2017), healthcare providers report uncertainty regarding their ability to speak to transgender clients in appropriate ways and in their knowledge specific to transgender healthcare needs (Poteat et al., 2013; White Hughto et al., 2017). Barriers to provider knowledge begin at an institutional level, with many providers reporting little or no formal education on transgender health (Bristol, Kostelec, & MacDonald, 2018; Chisolm-Straker et al., 2018; Kameg & Nativio, 2018; Obedin-Maliver et al., 2011). Providers face further institutional barriers such as health intake forms, electronic medical record systems, and testing and diagnostic tools only accounting for static binary gender options (Aylagas-Crespillo et al., 2018; Roberts & Fantz, 2014; Winter et al., 2016).

Barriers in the healthcare system are not limited to healthcare providers; transgender people face obstacles as well (K. R. Clark, Vealé, & Zaleski, 2018; Gonzales & Henning-Smith, 2017). For instance, transgender clients experience discrimination in healthcare settings (Aylagas-Crespillo et al., 2018; Cruz, 2014; Poteat et al., 2013). Negative interactions with providers and staff contribute to transgender people delaying access to care (Bith-Melander et al., 2010; Cruz, 2014; Poteat et al., 2013), an increase in mental health concerns (Christian et al., 2018), and spiritual health distress (Beagan & Hattie, 2015). In order to adapt to the unique needs of transgender people, some clinics specialize in transgender healthcare (Hudson, 2018; Nisly et al., 2018).

Clinics specialize in transgender healthcare to offer improved healthcare experiences and higher quality of care for transgender clients (Nisly et al., 2018; Reisner, Bradford, et al., 2015). However, clients receiving care at specialized clinics voice varied experiences such as long wait times and establishing peer support (Eyssell, Koehler, Dekker, Sehner, & Nieder, 2017). Currently, there is minimal research about clinics that specialize in transgender healthcare (Hudson, 2018). Therefore, the purpose of this research is to describe the lived experiences of transgender adults seeking gender affirmation care at a clinic specializing in transgender healthcare.

We follow the introduction chapter with a review of the literature, including an overview of sociopolitical factors, social determinants of health and well-being for transgender people, therapy continuum, healthcare provider barriers to inclusive care, transgender clients' healthcare experiences, and clinics specializing in transgender healthcare. Next, we disclose our research paradigm and culture of inquiry, theoretical lenses, and personal and professional lenses. Then, we explain the research method used for this study. Last, we provide study results and our discussion.

Literature Review

The purpose of this chapter is to review relevant literature pertaining to transgender people and their healthcare encounters. This chapter commences with a synthesis of transgender sociopolitical developments. Next is a discussion on the social determinants of health and well-being for transgender people, followed by a concentrated review regarding the gender affirmation therapy continuum. Thereafter, a review of the current research literature about healthcare provider barriers to inclusive care, and transgender clients' healthcare experiences follows. Next, we discuss clinics specializing in transgender healthcare. The chapter ends with a summary of the literature and a focused research question.

Transgender Sociopolitical Developments

Gender variances occur throughout history and across cultures causing difficulty in gathering complete information about transgender people (Lombardi, 2001; Reis, 2004; Reisner et al., 2016; Somasundaram, 2009; Wylie et al., 2016). The following discussion will include language developments, transgender historical developments, developments of standards of care, public health developments, and the development of clinics specializing in transgender healthcare.

Language developments. The presence of transgender people in society raises the question of how biological sex and social gender roles are related (Diamond & Butterworth, 2008; Levitt & Ippolito, 2014). For much of the 20th century, people used the term transsexual to describe what is currently termed transgender; however, the term transsexual is globally still in use (Casado et al., 2016; Lombardi, 2001; Somasundaram, 2009). Some people choose not to identify under these categories and prefer non-binary, genderqueer, two-spirit, or other terms (Diamond & Butterworth, 2008; Lombardi, 2001; Reisner et al., 2016; Winter et al., 2016).

There are various ways of describing gender diverse communities including acronyms such as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) which we have chosen to use in this study in an attempt to be inclusive. There are published studies where the acronym does not have the Q represented and, in such cases, we have left it out in order to remain true to the study.

Inconsistency in language can extend to social interactions when speaking to or about a transgender person (Logie et al., 2019). Transgender people often prefer pronouns matching their gender identity, yet due to the nature of preferences, variances occur (Bith-Melander et al., 2010). Transgender people report others' perceiving them as their identified gender is important to overall well-being, colloquially known as passing or blending (Bith-Melander et al., 2010; Hancock, Childs, & Irwig, 2017; Logie et al., 2019; McCann & Sharek, 2016). Some transgender people see passing as a privilege for those who have the financial means to procure medical interventions to alter appearance (Bith-Melander et al., 2010; Logie et al., 2019).

The converse of passing is getting clocked which is when someone realizes they are in the presence of a transgender person rather than a cisgender person (Bith-Melander et al., 2010). People who are uncomfortable in the presence of a transgender person may act on these feelings (Levitt & Ippolito, 2014). Transphobia, the fear of transgender people, manifests at personal and institutional levels (Aylagas-Crespillo et al. 2018; Stryker, 2017) and is closely related to the concept of cisnormativity (Levitt & Ippolito, 2014). Cisnormativity describes ways in which people, cultures, and institutions enforce congruence with one's birth-assigned gender as desirable and superior to being transgender (Aylagas-Crespillo et al., 2018; Castañeda, 2015). In an attempt to pass and to avoid misgendering and transphobia, transgender people may elect to alter appearances which has been done in different ways across cultures (Levitt & Ippolito, 2014) based on each cultures' socially enforced identifiers of gender norms.

Transgender historical developments. The complexities of the global history of transgender issues are rooted in the social constructs of gender and gender roles which vary with time and across cultures (Reis, 2004; Reisner et al., 2016; Somasundaram, 2009; Winter et al., 2016). We chose to focus on the transgender identity inclusion in the medical model in the USA which has roots both in the USA and Europe. Hirschfield founded the Institute for Sexual Science, where scholars researched and advocated for gender minority groups from 1919 until 1933 when the Nazis destroyed it (Somasundaram, 2009; Stryker, 2017). In the late 1940's, an endocrinology student of Hirschfield, Dr. Benjamin, helped move the American medical understanding away from transgender identity as a mental disorder, towards a physical one and introduced sex reassignment surgery to Johns Hopkins Hospital (Castañeda, 2015; Reis, 2004; Somasundaram, 2009).

Medical and legal developments parallel social movements for the advancement of transgender visibility and integration with society (Bristow, 2001). The landmark Stonewall Inn riots of June 27, 1969, in New York City was a demand and demonstration amongst gay, lesbian, and transgender people for equal rights (Bristow, 2001). The Stonewall Inn did not enforce any policies requiring customers dress in articles of clothing corresponding to gender assigned at birth; therefore, Stonewall Inn was a congregating place for sexual minorities to socialize (Bristow, 2001; Stryker, 2017). A police raid of the venue led to the protest (Bristow, 2001), which was the largest and longest lasting of the various demonstrations and riots for LGBTQ rights of the 20th century (Stryker, 2017). Pride festivals around the world commemorate Stonewall Inn protests (Bristow, 2001). Similarly, the HIV/AIDS crisis of the 1980s to the mid-

1990s disproportionately affected both gay men and transgender people (Bristow, 2001) in ways that tied the progress of both groups to each other (Bristow, 2001; Castañeda, 2015). These historical events highlighted the need for research regarding LGBTQ healthcare and standardizing care.

Development of standards of care. Healthcare professionals historically diagnosed transgender clients under many conditions, often reflecting dominant cultural paradigms regarding gender (Martinez-Velez, Melin, & Rodriguez-Diaz, 2019; Somasundaram, 2009; Stryker, 2017). The American Psychiatric Association's (APA, 2013) current Diagnostic and Statistical Manual, Fifth Edition (DSM-V) replaces the diagnostic code for Gender Identity Disorder with GD. Zucker (2015) reports that the APA intentionally removed the word *disorder* to reduce stigma. Current views support transgender identity as a gender variance rather than a mental illness (Castañeda, 2015; McCann & Sharek, 2016; Newsome, Chen, & Conklin, 2018; Roberts & Fantz, 2014). Zucker (2015) reports a structural change to the DSM-V reinforces the idea that being a transgender person is a gender variance by removing GD from the previous chapter on Sexual Dysfunctions and Paraphilias and placing it into its own chapter. The DSM-V defines GD as having clinical psychological unease that may be as severe as distress about the incongruence between one's assigned gender and one's lived gender identity experience (APA, 2013). A GD diagnosis allows for a billing code enabling professionals to provide services and interventions in the context of what is now called gender affirmation care (Castañeda, 2015; Newsome et al., 2018; Roberts & Fantz, 2014).

In an attempt to synthesize knowledge and provide guidelines for current medical and psychological transgender care (Coleman et al., 2012; Wylie et al., 2016) the WPATH published the first *Standards of Care for the Health of Transsexual, Transgender and Gender-*

nonconforming People in 1979 (Coleman et al., 2012). Thirty years later, the Endocrine Society established alternative standards for regulation of hormone therapy in transgender clients (Hembree et al., 2017; Unger, 2016). Public health developments have not always worked in concert with care standards

Public health developments. The American Public Health Association (1999) passed a resolution regarding the need for healthcare providers to offer sensitive care and resources to transgender people. Lombardi (2001) responds to the resolution by enumerating strategies including: assessing a person’s whole experience and not being overly reliant on technical or medical criteria; providing young people with space to question gender identities; publicly advocating against discrimination or denial of care to transgender people; finding ways to help transgender people overcome barriers to care; promoting more sensitivity towards transgender people in education programs, research, and policy; and engaging transgender communities and organizations to ensure cultural appropriateness. Transgender sociopolitical developments continue to unfold, especially as more people seek gender affirmation healthcare (Roberts & Fantz, 2014).

Development of clinics specializing in transgender healthcare. Community health clinics specializing in the care of transgender clients began emerging in the USA in the late 1960s and early 1970s (Hudson, 2018). Community health centers catering to the LGBT community faced challenges including lack of funding, unsupportive public policies, and the HIV/AIDS epidemic which was exacerbated by lack of federal acknowledgement of the medically underserved LGBT population (Hudson, 2018). In the 1980s and 1990s, access to gender affirmation care and healthcare tailored to gender affirmation services was identified as a clinical gap, leading to the development of clinics specializing in transgender healthcare

(Reisner, Bradford, et al., 2015). Fenway Health, a pioneering clinic in the field of LGBT healthcare in the USA, adopted a multimodal approach to transgender healthcare (Hudson, 2018; Mayer et al., 2001; Reisner, Bradford, et al., 2015).

Fenway Health. Mayer et al. (2001) state that Fenway Health in Boston, Massachusetts developed as an early model of specialized LGBT healthcare in response to the biopsychosocial needs of LGBT individuals affected by the AIDS epidemic. Though Fenway Health already existed prior to the AIDS epidemic, its focus shifted to the LGBT community to respond to their unique care needs (Hudson, 2018). Fenway Health opened as a grassroots clinic in 1971, evolving over time to become a model for specialized transgender healthcare (Reisner, Bradford, et al., 2015).

Mayer et al. (2001) state that the Fenway model incorporates primary care services, mental health and addiction services, complementary and alternative medicine, nutrition services, social work, and specialty care providers pertinent to the needs of LGBT clients. Specialty services within the Fenway model include obstetrics, gynecology, family planning services, HIV/AIDS, gerontology, dermatology (Mayer et al., 2001), dental care, vision care, and gender affirmation healthcare for transgender clients (Hudson, 2018). Mayer et al. (2001) report Fenway Health also offers health promotion programs including topics focusing on stress reduction, community education, prevention of domestic and homophobic violence, and parenting. By offering numerous specialty, mental health, and health promotion programs, primary care providers can readily refer clients to other providers onsite, offering a greater spectrum and coordination of care. Furthermore, continuity of care occurs in this model as providers follow hospitalized clients at a local medical center throughout their stay (Mayer et al., 2001). In 1995, caring for transgender clients became the focus of Fenway Health upon the identification of the growing need for transgender individuals to receive comprehensive care (Reisner, Bradford, et al., 2015).

Hudson (2018) writes Fenway Health became the first federally qualified health center in the USA for LGBT individuals in 2002. Reisner, Bradford, et al. (2015) discuss Fenway Health's 2007 development of a modified informed consent, removing barriers and increasing accessibility to gender affirmation care. Fenway's informed consent requires clients to complete a hormone readiness questionnaire. However, Fenway's informed consent does not involve mental health services, eliminating the previous requirement for transgender individuals to undergo extensive mental health evaluations and therapy or live full-time as their affirmed gender prior to beginning hormone therapy. Since implementing a modified informed consent, the number of individuals accessing gender affirmation care at Fenway Health increased exponentially (Reisner, Bradford, et al., 2015). Of the 24,000 clients cared for by Fenway Health in 2015, 1,200 clients identified as transgender or gender nonconforming (Hudson, 2018). The multimodal approach taken by Fenway Health serves as a model for other clinics specializing in transgender healthcare (Reisner, Bradford, et al., 2015). However, despite the development of specialized clinics to address their biopsychosocial needs (Hudson, 2018), social determinants of health (SDOH) unfavorably affect transgender individuals (Corliss, Shankle, & Moyer, 2007; Reisner, White, Bradford, & Mimiaga, 2014).

Social Determinants of Health and Well-being for Transgender People

Harrington (2018) acknowledges the health and well-being of all humans should be of concern to everyone. Globally, the Gross National Income (GNI) accounts for the economic wealth of countries. The USA's GNI ranks in 11th place out of 25 of the top wealthiest countries in the world with a birth life expectancy of 78.7 years. USA's northern neighbor, Canada, ranks

21 out of 25 based on GNI; however, Canada's birth life expectancy is 82.3 years (Harrington, 2018). Usually, the higher a country's GNI, the higher the country's life expectancy (The Conference Board of Canada, 2019). Interestingly, despite the USA's higher ranking, Canadians average an extra four years of life compared to Americans. Marmot (2005) acknowledges that the SDOH are at the root of the Americans' shorter life expectancy and widespread inequities. Historically, the USA's inequities related to SDOH are associated with issues of class, gender, and race (White Hughto et al., 2015). This section commences with a general discussion regarding the SDOH, followed by a synthesis specific to policies and programs, health services, and social interactions.

The ODPHP (2019) categorizes SDOH as policies and programs, healthcare services, social interactions, individual actions, and genetic makeup. Multiple factors correlate with individual and population health outcomes such as health behaviors, sexual orientation, and gender identification (DeSalvo, 2015; Felsenstein, 2018). Personal health behaviors include individual actions such as nutrition, exercise, alcohol intake, and cigarette smoking which may adversely or positively influence one's health status. Changing adverse health behaviors is critical to the development of a healthier population.

Historically, transgender people faced multiple barriers in education, housing, access to healthcare, and employment, contributing to health disparities (Aylagas-Crespillo et al., 2018; Stryker, 2017; Winter et al., 2016). To attain equity in the USA, social justice changes are needed (Braveman & Gottlieb, 2014). An interrelationship exists between education, health, and employment with changing human behaviors and reducing health disparities (Corliss et al., 2007; ODPHP, 2019; Reisner et al., 2014). For example, Grant et al. (2011) shared higher education provides skills, knowledge, and networking opportunities that increase employment security.

Gainful employment offers the opportunity to obtain health insurance coverage and augments disposable income for food and housing (Grant et al., 2011). However, despite federal and state laws prohibiting most health insurance companies from discriminating against the healthcare of transgender people, discrimination continues to occur (Wylie et al., 2016). For individuals who self-identify as transgender and transgender people of color (TPOC), a critical aspect of changing behavior relates to disparities that persist concerning health and well-being (Howard et al., 2019; Pascoe & Smart Richman, 2009; Seelman, Colon-Diaz, LeCroix, Xavier-Brier, & Kattari, 2017; Smith & Turell, 2017). Recently, Howard et al. (2019) identified a gap in the research literature related to the healthcare experiences of TPOC. Understanding the impact of SDOH and the relationship to health disparities specific to white transgender individuals and TPOC is a critical step towards racial and gender health equity as society works toward reducing state and national healthcare costs, stigma, and discrimination (Bradford et al., 2013; DeSalvo, 2015; Howard et al., 2019; ODPHP, 2019; White Hughto et al., 2015).

White Hughto et al. (2015) assert that stigma and discrimination are vital components to consider when assessing SDOH. Stigma is a social construct that establishes control and power over segments of society. Stigma can be the structural, interpersonal, and individual stereotyping of a person or group of people. Structural stigma is associated with gender-confirming sex norms, stigmatizing policies and practices, economic and gender inequalities, barriers to (inclusive) healthcare, and inadequate provider education. Interpersonal stigma includes: healthcare and workplace discrimination; family displacement; hate crimes; and sexual, verbal, and physical assaults. Individual stigma is associated with suppression of self-expression, and situational and environmental refrainment (White Hughto et al., 2015). Similar to stigmatization, discrimination of transgender people contributes to unfavorable SDOH and well-being such as housing and employment (Eliason, Dibble, & Robertson, 2011; Levitt & Ippolito, 2014; Reisner et al., 2014; Seelman et al., 2017; White Hughto et al., 2015).

National and state laws exist to avert discrimination (Civil Rights Act, 1964; U.S. Const. amend. XIV). The Civil Rights Act (1964) and the current United States Constitution prohibits discrimination (U.S. Const. amend. XIV). Additionally, these legal documents prohibit the unjust or prejudicial treatment of individuals based on race, age, sexual orientation, gender identity, color, ability, religion, and nationality in public spaces (Equality Act, 2019). Civil and constitutional rights intersect with federal laws to safeguard all citizens of the USA from discrimination (Equality Act, 2019). Examples of citizenship rights in the USA include voting, housing, education, employment, non-violence, non-harassment, healthcare, and insurance coverage (American Civil Liberties Union [ACLU], 2019; Aylagas-Crespillo et al., 2018; Kcomt, 2019). Unfortunately, the civil and constitutional rights and laws in the USA do not equally apply to transgender and cisgender individuals (ACLU, 2019; Aylagas-Crespillo et al., 2018; Bradford et al., 2013; Kcomt, 2019; Pascoe & Smart Richman, 2009). Moreover, Grant et al. (2011) and Howard et al. (2019) report TPOC face higher rates of discrimination, in the form of transphobia, racism, and homophobia, compared to cisgender people of all races. Changes to healthcare policies will facilitate the deconstruction of discrimination and stigma in institutional health care settings (Radix & Maingi, 2018). Intersectional stigmas, such as transphobia, racism, and homophobia, are associated with increased healthcare disparities (Bith-Melander et al., 2010; Logie et al., 2019; Poteat et al., 2013; Reisner et al., 2016; Winter et al., 2016). The intersectionality of a person's social and political identity influences how people experience life differently due to factors such as race, class, and gender (Crenshaw, 1989; Diamond & Butterworth, 2008). The following discussion concentrates on the intersection of stigma and transgender discrimination related to policies and programs, health services, and social interactions.

Policies and programs. In recent years, changes in local, state, and federal policies reduced health disparities among the transgender population (ACLU, 2019; United States Department of Health & Human Services, 2018). However, despite the enactment of the USA's constitutional civil rights and recent state laws such as marriage equality, gender-neutral bathrooms, and in some states, the endorsement of Title VII's employment discrimination laws, only 18 out of 50 states prohibit discrimination against transgender people (ACLU, 2019). For example, as of 2019, about 40% of LGBTQ people live in a state that has non-discriminatory sexual orientation and gender-identification healthcare insurance laws (Movement Advancement Project, 2019). Grant et al. (2011) acknowledge that institutional stigma and discrimination remain evident in many state health insurance policies, education, employment, and housing sectors.

Health insurance. Under Medicare and the Affordable Care Act, transgender health insurance discrimination is evident in the USA (Transgender Law Center, 2016). Shires and Jaffee (2015) note Medicare has no restrictions on hormone therapy for the cisgender population. However, Medicare only covers hormone therapy for transgender clients during the phase of transition and not for maintenance (Shires & Jaffee, 2015). Insurance coverage related to gender affirmation is often restricted to psychotherapy and hormone therapy (Roberts & Fantz, 2014). Grant et al.'s (2011) study involved 6,450 transgender and gender non-conforming participants from all 50 of the USA states, highlighting several national health inequalities. Notably, approximately 20% of 6,450 transgender participants reported having no health insurance coverage. Of a subgroup of uninsured TPOC participants, 31% were African American and 36%

were undocumented non-citizens. Specific to transgender women versus transgender men, 22% of transgender female and 19% of transgender male people had no health insurance. Nineteen percent of study participants with health insurance were denied care services by primary care providers' offices, health centers and clinics, and emergency departments. Additionally, at healthcare facilities, 2% were physically attacked and 28% were verbally harassed (Grant et al., 2011). Christian et al. (2018), Corliss et al. (2007), and Gridley et al.'s (2016) works confirm continued trends in health insurance coverage disparity and hostile treatment at healthcare establishments for transgender versus cisgender people. Transgender individuals, particularly TPOC, delay accessing healthcare because of inadequate insurance and or fear of maltreatment (Christian et al., 2018; Grant et al., 2011; Gridley et al., 2016; Howard et al., 2019). In turn, delaying healthcare treatment negatively impacts overall health and increases healthcare costs (Kcomt, 2019). Challenges for transgender people also exist in the academic sector (Corliss et al., 2007).

Education. The Educational Amendment Act affords transgender people protection against gender identity discrimination (ACLU, 2019). However, Grant et al.'s (2011) and Shires and Jaffee's (2015) research show discriminatory societal behaviors towards transgender people that are not limited to the healthcare sector but are equally prevalent along the educational continuum with lifelong negative consequences on gross income, health and security, and employment and housing. Grant et al.'s (2011) findings acknowledge that throughout K to 12, undergraduate, and graduate studies, transgender people experience higher rates of harassment than cisgender peers in the form of bullying, verbal, physical, and sexual violence from peers and educators. For example, 1,876 participants report the physical assault (35%) and sexual assault (12%) during K-12 from a peer, teacher, and or staff. Additionally, 6% admit to school expulsion because of gender identity expression. Pronounced racial differences for TPOC are evident with increased instances of maltreatment for African American, American Indian, Latino, and multiracial people. Within higher education, bullying (35%), physical assault (5%), sexual assault (3%), and expulsion from school (2%) directly relate to transgender, TPOC, and gender non-conforming identities (Grant et al., 2011). Christian et al. (2018), Grant et al. (2011), and Levitt and Ippolito (2014) acknowledge that despite experiencing educational stigma and discrimination, transgender individuals attain higher levels of education compared to the general population. This association is related to an increase in the number of transgender people returning to post-secondary education after a life-changing event such as an employment termination. Regardless of educational level, unemployment is higher and annual income less for transgender compared to cisgender people (Christian et al., 2018; Grant et al., 2011; Levitt & Ippolito, 2014). Existing research on harassment, bullying, assaults, and discrimination presents convincing evidence of negative correlations between academic experiences, employment, housing, and health outcomes (Bradford et al., 2013; Kcomt, 2019; Romanelli & Hudson, 2017; Shires & Jaffee, 2015).

Employment and housing. Employment and housing regulations vary across state jurisdictions (ACLU, 2019). Nonetheless, Title VII of the 1964 Civil Rights Act and the Fair Housing Act can legally protect transgender people against employment and housing discrimination at the federal level (ACLU, 2019). However, Grant et al. (2011) recognize numerous employment discriminatory practices against transgender people and TPOC. For example, twice as many transgender people as opposed to cisgender people are unemployed. High unemployment and employer discrimination results in transgender people seeking income through sex and drug trades, negatively impacting individual and population health and well-being. Ninety percent of 6,450 study participants admit experiencing workplace harassment, maltreatment, and discrimination. Furthermore, 47% of participants state transgender identity as the reason for employment dismissal, hiring rejection, or a failed promotion. Nationally, income security correlates with housing stability noting that 32% of the study participants are homeowners in contrast to 67% of the general population. The prevalence of homelessness for transgender people (2%) is double that of the general population. At homeless shelters, 29% of transgender people are refused entry by staff, 55% endure harassment, and 22% experience sexual assault from staff and or other homeless residents (Grant et al., 2011). These findings are consistent with other research outcomes that indicate similar rates of employment and housing disparities (Martinez-Velez et al., 2019; Poteat et al., 2013; Romanelli & Hudson, 2017; Xavier et al., 2013). Specific to TPOC, Grant et al. (2011) report at least double the rate of unemployment and housing discrimination rates in comparison to white transgender people. Another critical component to SDOH includes access to and quality of healthcare services.

Health services. The ODPHP (2019) defines health services as accessing quality healthcare. American citizens consider access to healthcare a fundamental human right (Swendiman, 2012). However, the healthcare system does not equally afford healthcare access rights to transgender compared to cisgender people (ACLU, 2019; United States Department of Health & Human Services, 2018). The U.S. Census Bureau estimates 8.5% or 27.5 million people do not have health insurance (Berchick, Barnett, & Upton, 2019). A lack of health insurance limits accesses to preventive healthcare, which is associated with an increase in the prevalence of chronic illness and diseases such as anxiety, depression, substance abuse, addictions, and a positive HIV status (Poteat et al., 2013; Reisner, Vetters, et al., 2015; Reisner et al., 2014; Romanelli and Hudson, 2017; Seelman et al., 2017). In contrast, other studies comparing the health of adult transgender and cisgender people note no statistically significant outcomes related to healthcare access, substance abuse, smoking, or HIV status (Seelman, Miller, Fawcett, & Cline, 2018). The above conflicting study findings emphasize a research gap related to transgender healthcare access and disparities compared to the cisgender population.

Howard et al. (2019) contribute to the dialogue related to the lived experiences of TPOC versus white transgender people. TPOC's unique identity regarding gender and race is associated with increasing challenges related to healthcare services when compared to cisgender and white trans populations (Howard et al., 2019). Explicitly, Howard et al. (2019) acknowledge that 38% of TPOC perceive inferior quality of care received from healthcare providers. Twenty percent of TPOC attributed a lack of quality of care to stereotyping and racism. TPOC associated increased healthcare satisfaction with LGBT friendly healthcare settings and racially diverse healthcare providers (Howard et al., 2019). In general, transgender individuals who access healthcare in the community and tertiary care settings identify inadequate education preparation for healthcare providers (Bradford et al., 2013; Corliss et al., 2007; Felsenstein, 2018; Gendron et al., 2013). Consistent application of guidelines would assist practitioners to offer competent care specific to the assessment, diagnosis, intervention, and treatment needs of transgender people (Bradford et al., 2013). A limited number of study findings confer that transgender individuals' perceptions regarding healthcare professionals' educational deficiencies prevent the delivery of competent and safe care (Bradford et al., 2013; Eliason et al., 2011; Felsenstein, 2018; Poteat et al., 2013). Lastly, social interactions influence SDOH (ODPHP, 2019).

Social interactions. The ODPHP (2019) interprets social interactions to include a wide array of factors that influence the social and physical well-being of individuals and populations. These factors influence a person's physical, mental, social, and spiritual well-being (Pascoe &

Smart Richman, 2009; Seelman et al., 2017). The ODPHP (2019) highlights examples including environmental exposures to hazards and toxins, noises, crimes, violence, schools, transportation, and opportunities for social interactions. Subsequently, health insurance, education, employment, housing, and healthcare services interconnect with social factors, which in turn influence individual and population determinants of health and well-being (ODPHP, 2019). Almost a decade of research in the USA between Bradford et al. (2013), Grant et al. (2011), Kcomt (2019), and Pascoe and Smart Richman (2009) denotes discriminatory practices against transgender people increasing rates of health inequalities for transgender people versus cisgender people. The evidence of transgender health inequalities in a systematic review, meta-analysis, and a cross-sectional research study corroborates an increase in the number of transgender people dropping out of high school due to discriminatory practices in academic environments. As compared to the cisgender population, increased educational dropout rates correlate with: higher rates of homelessness; employment in the sex and drug trades; ingestion of cigarette smoking, alcohol and street drugs; and higher rates of mental health disorders, suicide, and positive HIV status (Bradford et al., 2013; Grant et al., 2011; Kcomt, 2019; Pascoe & Smart Richman, 2009). An assessment of the impact of SDOH on transgender people warrants the need for ongoing research.

Several healthcare disparities exist related to transgender SDOH (Grant et al., 2011). Notably, a disproportionate number of transgender people experience health insurance, healthcare, education, employment, housing, and social interaction discrimination (Felsenstein, 2018; Grant et al., 2011; Pascoe & Smart Richman, 2009; Reisner et al., 2014). Howard et al. (2019) acknowledge TPOC experience higher rates of stigma, discrimination, and racism (Grant et al., 2011; Howard et al., 2019). A literature review specific to transgender SDOH highlights research gaps including limited studies focused on the lived experiences of TPOC (Howard et al., 2019), discriminatory healthcare policies and procedures (Grant et al., 2011; Shires & Jaffee, 2015; Transgender Law Center, 2016), and educational inequities from K to 12 that contribute to numerous disparities related to SDOH (Grant et al., 2011). Furthermore, research gaps exist related to the assessment, implementation, and evaluation of quality transgender focused education for healthcare professionals (Bradford et al., 2013; Corliss et al., 2007; Felsenstein, 2018; Gendron et al., 2013), and the culture of healthcare environments on the SDOH of transgender people (Howard et al., 2019). Societal, academic, and healthcare institutional changes are imperative to leveling health inequities for transgender people (Bradford et al., 2013). One example of necessary changes includes implementing federal and state laws to improve the healthcare transgender people receive along the therapy continuum.

Therapy Continuum

Transgender people have varying needs in approaching gender affirmation which exists along a therapy continuum of nonsurgical and surgical options (Coleman et al., 2012). Transgender therapy is a complex and individualized process based on the goals of the client (Coleman et al., 2012). To help navigate the gender affirmation process, two sets of guidelines provide standards of gender affirmation care for transgender clients (Shuster, 2016; Unger, 2016). Within these guidelines, the most utilized options for gender affirmation care include psychotherapy, hormone therapy, voice and communication therapy, and surgery (Coleman et al., 2012; Hembree et al., 2017). People may choose to solely use psychotherapy to alleviate GD, integrating gender identity and transitioning gender roles without medically altering physical appearance (Budge, 2013). Others may choose to alter their appearance in addition to psychotherapy to achieve gender affirmation (Coleman et al., 2012).

Guidelines. There are two sets of guidelines, created by the WPATH and the Endocrine Society, that healthcare providers utilize when caring for transgender clients (Hembree et al., 2017; Shuster, 2016; Unger, 2016). Shuster (2016) asserts, there are "no diagnostic tests to assess the effectiveness of transgender medical interventions, and no scientific evidence to support the guidelines" (p. 319). Additionally, Coleman et al. (2012) and Hembree et al. (2017) recognize healthcare professionals should use the guidelines with flexibility as they are primarily based on evidence-based medicine; however, some areas of care lack information and evidence. The WPATH and the Endocrine Society guidelines suggest the first step towards gender affirmation is to participate in a mental health assessment. This evaluation assesses current gender identity and dysphoria in addition to the history and emotional development of these feelings. A licensed mental health provider also evaluates the perception and impact of stigma on the transgender client, as well as the availability of support from friends, family, and the community (Coleman et al., 2012; Hembree et al., 2017). Coleman et al. (2012) state that a mental health assessment can, but does not always, conclude with a formal diagnosis of GD. A provider needs to be sure GD is not secondary to another mental health diagnosis related to other aspects of health or psychosocial adjustment. Optimal management of mental health diagnoses concurrent with GD is necessary before initiation of gender affirmation treatment. In the case of a primary diagnosis of GD, mental health providers present gender affirming options, write a letter of recommendation for hormone therapy or surgery, offer a referral to another clinician and, provide referrals for individual, family, or group therapy (Coleman et al., 2012).

Psychotherapy. The WPATH guidelines highly recommend but do not require psychotherapy to proceed with additional gender affirmation therapies (Coleman et al., 2012). Clients typically seek out psychotherapy for personal growth and to help navigate gender transition (Budge, 2013). Budge (2013) suggests the use of four techniques in interpersonal psychotherapy for transgender clients who are transitioning. The first technique is the evaluation of current gender roles. Although many transgender individuals strongly wish to live as another gender, some physical, emotional, and social losses need acknowledgment for a smooth transition. These losses extend to social and familial relationships that are redefined by self, friends, family, peers, and society as a result of transitioning. The second technique encourages the expression of how identity transition affects a person, environmental surroundings, and community. Facilitating new social skills is the third technique, which includes learning basic interpersonal skills to interact with society as a specific gender. The fourth technique is assisting with role transitions by helping transgender clients build social supports (Budge, 2013). Psychotherapy aims to explore gender identity and gender roles within an individual's social environment, to address the impacts of stigma and barriers on mental and physical health, and to help facilitate the coming out process (Coleman et al., 2012). An additional therapy option transgender clients may utilize is hormone treatment (Hembree et al., 2017).

Hormone therapy. As part of the transition process, many transgender clients seek hormone therapy (Coleman et al., 2012; Hembree et al., 2017). Initial guidelines provided by the WPATH require a mental health assessment and a letter of recommendation from a licensed mental health provider to initiate hormone therapy (Coleman et al., 2012; Unger, 2016). The letter of recommendation includes information about the client’s gender identity, the diagnosis of GD, any additional mental diagnoses, the duration of the relationship between the provider and the client, clinical rationale supporting the request for hormone therapy, a statement of informed consent, and a statement that the referring mental health care provider is available for consultation with the care coordinator (Coleman et al., 2012; Unger, 2016).

Standing apart from the WPATH guidelines, an expedited informed consent model emerged in recent years (Cavanaugh, Hopwood, & Lambert, 2016). Schulz (2017) notes in the expedited informed consent model of healthcare, transgender individuals seeking hormone therapy do not need a mental health assessment. Instead, transgender clients have one appointment with a medical provider discussing social, financial, occupational, and relational impacts that initiation of hormone therapy may cause, serving as an informed consent process (Schulz, 2017). Although encouraged, this model does not require a mental health assessment, empowering transgender clients to get the care they feel necessary relating to access to hormones and surgery rather than having access determined by a healthcare provider (Cavanaugh et al., 2016; Schulz, 2017).

The existing guidelines from the WPATH and the Endocrine Society for transgender hormone therapy are loosely based on recommendations that currently exist for testosterone therapy in cisgender hypogonadal men and estrogen therapy for cisgender postmenopausal women (Hembree et al., 2017; Unger, 2016). The Endocrine Society recommends living full-time as one's gender affirmed self for a year before initiation of hormones (Hembree et al., 2017; Unger, 2016); however, this step may be unreasonable or potentially dangerous for transgender people based on their living conditions and is often bypassed (Unger, 2016). Endocrinologists and primary care providers tailor hormone therapy to clients' personal transition goals while accounting for risks and comorbidities (Coleman et al., 2012; Unger, 2016). Hormone therapy for female to male (FTM) clients includes testosterone and for male to female (MTF) clients includes estrogen (Hembree et al., 2017; Steinle, 2011). Follow up recommendations after hormone initiation include quarterly visits for the first year then subsequent visits every six to twelve months (Coleman et al., 2012; Unger, 2016). Lab work is necessary at each follow up to ensure electrolytes, lipid panels, hematocrit, bone mineral density, and testosterone or estradiol levels are stable (Coleman et al., 2012; Unger, 2016).

Testosterone. Testosterone is a hormone used in gender affirmation care for clients transitioning from female to male, suppressing secondary female sex characteristics and creating masculine features (Steinle, 2011). Unger (2016) reports the FDA has not approved oral testosterone in the USA due to concerns about its metabolic process within the body. Transdermal options are available, although weekly intramuscular or subcutaneous injections are the most frequently utilized modes of administration. Long-acting testosterone is available to extend the time between doses to every 12 weeks (Unger, 2016). Typically, testosterone dosages start at half the anticipated dose needed and titrate up (Nakamura et al., 2013; Unger, 2016). Early effects of testosterone treatment are dose-dependent, but within six months of starting testosterone therapy, higher doses are no more effective than lower doses (Nakamura et al., 2013). After intramuscular or transdermal dosages lead to maximum masculinization of the client, testosterone pellets implanted subcutaneously can maintain these effects long term by releasing steady amounts of testosterone over three to four months (Unger, 2016).

Within six months of initiating testosterone therapy, clients may experience a cessation of menses, increased facial and body hair, increased acne, changes in fat distribution, an increase in muscle mass and libido, a deeper voice, clitoral enlargement, and a decrease in the size of the vaginal epithelium (Coleman et al., 2012; Hembree et al., 2017; Unger, 2016). If puberty has occurred before the initiation of testosterone therapy, transgender males may experience some permanent feminine features such as a shorter stature, various degrees of feminine fat distribution, and wider hips (Unger, 2016). While providers prescribe testosterone to FTM clients, estrogen is typically prescribed to MTF clients (Coleman et al., 2012).

Estrogen. Estrogen is a hormone used in gender affirmation treatment for individuals transitioning from male to female. Estrogen administration is oral, intramuscular, subcutaneous, or transdermal (Hembree et al., 2017; Unger, 2016). After the age of 40, the WPATH recommends transdermal formulas due to metabolic concerns (Coleman et al., 2012; Unger, 2016). Estrogen alone is typically not enough to achieve the desired effects, so providers often co-prescribe estrogen with anti-androgen medications to suppress testosterone (Coleman et al., 2012; Unger, 2016). Anti-androgens may be oral, intramuscular, or implanted subcutaneously (Unger, 2016). There are no current recommended formulas of anti-androgens, though providers commonly prescribe Spironolactone (Hembree et al., 2017; Unger, 2016).

Initiation of estrogen therapy can lead to breast growth, increases in body fat, decreases in the growth of body and facial hair, and decreases in both testicular size and erectile function (Steinle, 2011). These changes happen at various rates for transgender women, typically taking between 18-24 months (Coleman et al., 2012; Steinle, 2011). The use of anti-androgen therapy may help maximize these changes while suppressing masculine features (Unger, 2016). Vocal pitch, a feature not altered by MTF hormone therapy, is often altered through voice and communication therapy (Hancock et al., 2017; Hancock & Helenius, 2012).

Voice and communication therapy. Vocal pitch is one of the strongest indicators of femininity or masculinity (Hancock et al., 2017; Hancock & Helenius, 2012). Many transgender people seek voice and communication therapy to develop vocal characteristics and nonverbal communication that align with their affirmed gender (Coleman et al., 2012; Hembree et al., 2017). Style, pitch, intonation, loudness, stress patterns, resonance, rate, and language choice is adapted to help create authentic communication (Coleman et al., 2012, Hancock et al., 2017).

Frequency and duration of voice and communication therapy vary by individual (Coleman et al., 2012).

Hormone therapy for transgender men deepens vocal pitch and tone (Coleman et al., 2012; Hembree et al., 2017). Hancock et al. (2017) find that transgender men taking testosterone therapy self-report their voice sounding neutral or masculine within three months of initiating hormone therapy. While testosterone hormone therapy may deepen the voice, feminizing hormone treatment does not appear to have any vocal effect (Coleman et al., 2012). In order to achieve vocal feminization, transgender women may choose to undergo vocal surgery (Coleman et al., 2012). Hancock and Helenius (2012) report the size and length of the vocal folds increase rapidly during male puberty and continue slightly changing until the individual is approximately 20 years old. Therefore, voice feminization surgical treatment should not take place before a transgender female reaches the age of 20 as the resulting pitch of voice may vary if performed before then (Hancock & Helenius, 2012). The WPATH recommends those who elect voice feminization surgery participate in postoperative voice and communication therapy to help protect vocal health (Coleman et al., 2012). Voice feminization surgery is one of many surgical options for gender affirmation care (Hembree et al., 2017).

Surgery. Gender affirmation therapy includes a licensed mental health professional assessing and providing a client with a written recommendation for gender affirmation surgery (Coleman et al., 2012; Hembree et al., 2017). The Endocrine Society recommends referrals indicating surgery is medically necessary from both a mental health provider and the clinician who initiated hormone therapy (Hembree et al., 2017). At minimum, breast or chest surgery requires one referral from a qualified mental health professional, and genital surgery requires two referrals from licensed mental health providers who independently assess the client and write letters of recommendation (Coleman et al., 2012). A surgeon is responsible for discussing different surgical techniques, advantages and disadvantages of each technique, limitations of procedures to achieve ideal physical outcomes, risks, and complications of the procedures (Coleman et al., 2012).

MTF chest or breast surgeries may include implants or lipofilling of breasts (Coleman et al., 2012). Genital surgeries include any or a combination of the following: penectomy, orchiectomy, vaginoplasty, clitoroplasty, and vulvoplasty (Coleman et al., 2012; Hembree et al., 2017). Facial feminization surgery, thyroid cartilage reduction, hair reconstruction, gluteal augmentation, and various other aesthetic procedures may increase a feminized appearance (Coleman et al., 2012).

FTM chest or breast surgeries may include mastectomy or creating a male chest through pectoral implants (Coleman et al., 2012; Hembree et al., 2017). Genital surgery includes one or more of the following: hysterectomy, salpingo-oophorectomy, vaginectomy, phalloplasty, scrotoplasty and implantation of erection, or testicular prosthesis (Coleman et al., 2012; Hembree et al., 2017). Penile transplant is currently in the experimental stages with some success transplanting the penis and associated vessels, nerves, and urethra en bloc from a cadaver to a transgender recipient; however, more exploration is necessary surrounding psychological acceptance of the transplant (Selvaggi et al., 2018).

Although surgical options are common, nonsurgical gender affirmation treatments are also available (Coleman et al., 2012). Nonsurgical options may include hair removal, breast binding or padding, genital tucking, and padding of hips or buttocks (Coleman et al., 2012). Due to the complexity of gender affirmation treatments, healthcare for transgender clients requires a multidisciplinary approach (Hembree et al., 2017; Paradiso & Lally, 2018).

The therapy continuum for transgender care is an individualized process requiring a multidisciplinary care team (Coleman et al., 2012; Hembree et al., 2017). Gender affirmation treatment exists on a continuum and providers inconsistently follow guidelines (Shuster, 2016). Providers lack education on the healthcare needs of transgender clients (Coutin et al., 2018; Kameg & Nativio, 2018; Obedin-Maliver et al., 2011) and face barriers in offering inclusive care to transgender clients (Poteat et al., 2013).

Healthcare Provider Barriers to Inclusive Care

Healthcare providers face barriers in providing care to transgender clients (Bristol et al., 2018; Chisolm-Straker et al., 2018; Obedin-Maliver et al., 2011). Within their care team, every transgender client should have a primary care provider to address overall healthcare needs as well as communicate and coordinate care between specialty providers (Coleman et al., 2012). Both providers and transgender clients recognize barriers to inclusive care (Poteat et al., 2013). Provider barriers include lack of education on transgender health issues (Kameg & Nativio, 2018), lack of experience working with transgender clients (Paradiso & Lally, 2018), and institutional barriers (Castañeda, 2015).

Care team. Healthcare for transgender clients may be complex due to the individuality of gender-affirming treatments, mental health status, and comorbidities present (Paradiso & Lally, 2018). Although primary care providers should be the main point of access to healthcare for all clients (Coleman et al., 2012), transgender healthcare often requires a multidisciplinary approach including primary care providers, mental health providers, endocrinologists, gynecologists, urologists, plastic surgeons, and speech therapists (Coleman et al., 2012, Hembree et al., 2017). It is important to have a central provider coordinating care between specialty providers ensuring the client is getting appropriate care and treatment (Coleman et al., 2012). Along with administering overall healthcare needs, primary care providers also assist with preventive care, maintenance of hormone therapy, referrals for other gender affirmation treatments, and mental health referrals (Coleman et al., 2012; Shire et al., 2017). Endocrinologists or primary care physicians can initiate hormone therapy, though endocrinologists typically do not follow a client long-term unless the client is a complex case with multiple comorbidities (Shires et al., 2017). Shires et al. (2017) suggest obtaining hormones through a primary care provider is beneficial for transgender clients as establishing a primary care provider increases the likelihood of receiving routine health screenings.

Hembree et al. (2017) note healthcare providers who care for transgender clients should be familiar with the distinction between GD and conditions that present similarly, be competent in using the DSM-V for diagnosis, and regularly attend relevant professional meetings. The WPATH recommends practitioners not comfortable providing care for a transgender client utilize the guidelines for assistance or refer the client to an expert (Coleman et al., 2012).

Shuster (2016) acknowledges existing care guidelines for transgender healthcare, but how strictly providers follow guidelines varies. Guidelines assume binary gender identity when identity formation and affirmation are fluid processes, leading to uncertainty for providers. Experienced providers recognize limitations of the guidelines and use them as a template, putting more trust in clients. However, less experienced providers follow guidelines closely, believing that strict adherence acts in the best interest of clients. Inconsistent adherence to the guidelines impedes or enhances access to gender affirmation therapy (Shuster, 2016). Healthcare providers struggle to care for transgender clients (Bristol et al., 2018; Chisolm-Straker et al., 2018; Obedin-Maliver et al., 2011) due to barriers such as lack of knowledge of transgender clients’ healthcare needs (Krakower et al., 2017).

Provider education. Obedin-Maliver et al. (2011) assert that in medical schools in the USA and in Canada, the median content-related time focused on LGBT health is five hours. Furthermore, 6.8% of 132 medical schools surveyed report no content hours in preclinical years and 33.3% report no content during clinical years, indicating a lack of unity in the way medical students learn about LGBT health concerns (Obedin-Maliver et al., 2011). While many medical schools teach LGBT issues within the context of human sexuality (Eliason et al., 2011), only 72% of schools report teaching students the difference between sexual behavior and gender identity (Obedin-Maliver et al., 2011). As medical schools fail to adequately educate providers on LGBT health issues, researchers study ways to better educate students (Cooper et al., 2018; Gendron et al., 2013). Gendron et al. (2013) suggest training increases healthcare providers' knowledge and improves levels of comfort in working with transgender clients, indicating adequate education improves provider understanding of LGBT health concerns. Additionally, Cooper et al. (2018) conclude that medical students' knowledge of LGBT health issues significantly increases after a one-hour didactic lecture, noting education on transgender health needs improves competency in caring for this community. Medical professionals mirror societal homophobia and heterosexism if not educated on LGBT issues, (Eliason et al., 2011; Nathan, Ormond, Dial, Gamma, & Lunn, 2019), indicating that education is essential to increase health care providers' comfort in working with and decrease internal bias against transgender people (Gendron et al., 2013). The lack of formal education providers receive creates challenges for specialists, particularly emergency medicine physicians who often lack knowledge on transgender health needs (Bristol et al., 2018; Chisolm-Straker et al., 2018).

Chisolm-Straker et al. (2018) report 88% of emergency medicine providers care for transgender clients. Despite the high volume of providers who care for transgender clients, between 82.5% (Chisolm-Straker et al., 2018) and 85% (Bristol et al., 2018) of emergency medicine providers have no formal education on LGBT health needs. Similarly, primary care providers also indicate limited education on transgender healthcare needs (Krakower et al., 2017).

Lack of education on transgender health needs is a consistent theme in the primary care setting (Blodgett et al., 2018; Coutin et al., 2018; Kameg & Nativio, 2018). Primary care providers indicate limited education and experience with transgender clients' needs on issues such as HIV pre-exposure prophylaxis (Krakower et al., 2017) and understanding the need to ask medical versus curiosity-based questions regarding clients' gender affirmation (Blodgett et al., 2018; Manzer et al., 2018). Despite the transgender community believing primary care providers need further education on transgender health issues rather than referring to outside specialists (Blodgett et al., 2018), primary care providers are not prepared to understand the complexities of caring for transgender clients (Kameg & Nativio, 2018).

Coutin et al. (2018) find that in their analysis of 210 family medicine residents surveyed, 51% report having no classroom hours focused on transgender healthcare, while 63% of psychiatry and 50% of endocrinology residents report receiving between one and six hours of curriculum on transgender healthcare, indicating specialists may be better prepared to help transgender clients than primary care providers. Kameg and Nativio (2018) assert that primary care providers should be prepared to actively manage the care of transgender clients, but many refer to specialists due to lack of education, training, and experience working with transgender clients. While primary care providers may be less prepared than specialists, they are often the first line of contact for clients (Kameg & Nativio, 2018). Despite the WPATH providing continuing education opportunities for practitioners (Coleman et al., 2012), primary care providers continue to lack education to competently care for transgender clients (Kameg & Nativio, 2018). Education impacts provider experiences with transgender clients (Paradiso & Lally, 2018).

Provider experiences. Providers who work with transgender clients indicate uncertainty in the appropriateness of care they give (Poteat et al., 2013). While continuing education opportunities for practitioners are available (Coleman et al., 2012), many healthcare providers address their uncertainty by self-educating through reading academic journals, utilizing the internet to learn about LGBT issues, clarifying knowledge with clients, and reaching out to colleagues for assistance (Manzer et al., 2018). Further, many healthcare providers face challenges in self-educating on LGBTQ issues, particularly due to the lack of resources to learn from and fear of offending clients if providers ask to clarify knowledge (Paradiso & Lally, 2018). While many providers recognize they lack the proper language repertoire in respect to pronouns, gender identities, and sexualities (Manzer et al., 2018), providers believe they do not have enough exposure to transgender clients in the workplace to learn on the job (Paradiso & Lally, 2018) despite many working with transgender clients (Chen et al., 2018; Chisolm-Straker et al., 2018; Manzer et al., 2018). Congruent with providers indicating a lack of experience working with transgender clients, providers' comfort in caring for transgender clients varies as well (Eliason et al., 2011). Cisgender female providers report higher levels of comfort and more positive attitudes towards transgender clients than cisgender male providers (Eliason et al., 2011; Kanamori & Cornelius-White, 2016), indicating internal discriminatory client preference that could disrupt the nonjudgmental attitude needed to create a caring, open environment for transgender clients (Manzer et al., 2018; Rossman, Salamanca, & Macapagal, 2017). Independent of limitations caused by education and levels of comfort in caring for transgender clients, providers are further restricted by healthcare institutional barriers (K. A. Clark et al., 2017).

Institutional barriers. Providers face barriers due to institutional policies and standards contributing to inconsistent care for transgender clients (Chen et al., 2018; K. A. Clark et al., 2017). Castañeda (2015) suggests frequent definition and guideline changes relating to transgender healthcare create challenges for institutions looking to care for transgender clients. As a result of these frequent changes, healthcare institutions face difficulties with comprehensive health intake forms, electronic medical records, and testing and diagnostic tools (K. R. Clark et al., 2018; Rosendale, Goldman, Ortiz, & Haber, 2018; Samuels, Tape, Garber, Bowman, & Choo, 2018).

***Comprehensive health intake*.** Healthcare providers and transgender clients report challenges with comprehensive health intake forms in part due to the use of traditional male or female gender categorization (Blodgett et al., 2018; Manzer et al., 2018). Many providers do not inquire about gender identity beyond gathering information about gender assigned at birth (Eliason et al., 2011). As a result, transgender clients report intake forms need to allow flexibility in gender choices (Noonan et al., 2018). Transgender clients report having negative experiences in interacting with healthcare providers and clinic staff due to misgendering (Bauer, Zong, Scheim, Hammond, & Thind, 2015). Transgender clients, healthcare providers, and clinic staff could avoid some negative interactions if comprehensive health intake forms identified preferred pronouns, gender identity, surgical history, and anatomic inventory (Rosendale et al., 2018). Currently, health intake forms do not typically account for preferred pronouns, gender identity, and other transgender health concerns (Rosendale et al., 2018). Another concern among transgender clients is lack of privacy assurance surrounding gender identity (Samuels et al., 2018). Transgender people often find it essential to have their gender identity match their appearance (Austin & Goodman, 2018), but when it does not, transgender clients might feel like they have less privacy in keeping their gender identity confidential (Samuels et al., 2018). Noonan et al. (2018) assert that as a remedy, clinic staff and healthcare providers should receive more training and include transgender-appropriate intake questions specific to gender identity to better respect transgender clients. Similar to comprehensive health intake forms, electronic medical record (EMR) systems often result in incomplete and inaccurate data (Noonan et al., 2018).

Electronic medical records. Researchers suggest binary EMR systems do not thoroughly reflect health records of transgender clients (Manzer et al., 2018; Noonan et al., 2018; Samuels et al., 2018). Current issues with EMR systems include restrictive binary options of gender and sexuality (Manzer et al., 2018, Noonan et al., 2018; Rosendale et al., 2018) which do not properly capture sex, gender, and sexual orientation for all clients (Samuels et al., 2018). Tate, Ledbetter, and Youssef (2013) compare the current one-step binary system to a two-step data collection process. Implementing a two-step system would improve the accuracy of medical records in respect to transgender clients as it would allow for differentiation between gender identity and assigned gender. Thus, a two-step system would give healthcare providers more certainty in knowing the history and identity of transgender clients (Tate et al., 2013). EMR systems list binary options creating challenges for providers ordering tests and procedures not congruent with a client’s listed gender (Gonzales & Henning-Smith, 2017; Gupta, Imborek, & Krasowski, 2016). For example, a provider might need to order a pregnancy test for a FTM client or a prostate ultrasound for a MTF client, but as many EMR systems require procedure orders to be congruent with clients’ listed genders, institutional systems place barriers on providers’ ability to properly care for transgender clients (Gupta et al., 2016).

***Testing and diagnostic tools*.** Despite having established standards of care for gender affirmation, healthcare providers face institutional barriers in providing routine care to transgender clients due to lack of set standards in areas such as radiology, fertility care, and laboratory testing (Chen et al., 2018; K. R. Clark et al., 2018; Gupta et al., 2016). Clark, K. R. et al. (2018) compile limited imaging considerations for transgender clients, but most clinics remain unaware of the routine screening needs of their transgender clients. Current screening recommendations include providing annual mammograms for FTM clients above age 50 with a history of hormone use and for MTF clients above 40 years of age. MTF clients who have stopped hormone therapy and FTM clients who have taken testosterone should also receive bone densitometry scans. With limited institutional standards regarding the imaging needs of transgender individuals, healthcare providers are often unable to appropriately recommend routine imaging, resulting in transgender clients receiving inconsistent care (K. R. Clark et al., 2018).

Gupta et al. (2016) report a lack of standardization in laboratory testing. MTF and FTM transgender people who utilize hormone therapy often have results that do not coincide with cisgender male and female standardized blood work, making it challenging for providers to interpret transgender clients’ test results. Creating standard laboratory values for FTM and MTF people would make it easier for healthcare providers to standardize care (Gupta et al., 2016). Greene et al. (2019) recognize unique reference ranges for blood work of FTM or MTF clients that differ from cisgender people and those who do not undergo hormone therapy. Institutions could implement standardized reference ranges to improve laboratory care for transgender clients (Greene et al., 2019).

Lack of standardized care by institutions and non-inclusive care creates challenges for transgender clients (Blodgett et al., 2018; Bradford et al., 2013). Provider barriers, such as lack of education (Blodgett et al., 2018) and experience (Poteat et al., 2013), further impact clients. Institutional barriers to inclusive care include binary comprehensive health intake forms (Rosendale et al., 2018) and EMR systems not adequately displaying gender identity and gender affirmation status (Samuels et al., 2018; Tate et al., 2013). Furthermore, non-standardized testing and diagnostic tools lead to inconsistent, inadequate routine care (K. R. Clark et al., 2018; Gupta et al., 2016). The barriers above create variation in clients' experiences while receiving care (K. R. Clark et al., 2018).

Transgender Clients' Healthcare Experiences

Many transgender people report a lack of access to healthcare due to individual (Romanelli & Hudson, 2017) and institutional barriers (Blodgett et al., 2018; Bradford et al., 2013; Gonzales & Henning-Smith, 2017). Transgender people with healthcare access describe subpar experiences primarily in the form of fragmented relationships with healthcare providers (Christian et al., 2018). Also, transgender people face discrimination within the healthcare setting (Blodgett et al., 2018), potentially increasing mental (Christian et al., 2018) and spiritual health distress; both elements are important considerations when providing inclusive care (Beagan & Hattie, 2015).

Healthcare access barriers. Transgender people face individual obstacles to accessing healthcare, including a lack of health literacy, the unfamiliarity of available services, and hesitancy to utilize and engage in available services out of fear of discrimination or stigmatization (Romanelli & Hudson, 2017). Additional barriers include the prohibitive cost of transition-related care because of limiting insurance policies (Romanelli & Hudson, 2017) or insufficient insurance due to unemployment (Xavier et al., 2013). Extensive travel to multiple clinics and the associated costs are also restrictive (Romanelli & Hudson, 2017; Rosentel, Hill, Lu, & Barnett, 2016).

Transgender people encounter institutional barriers when accessing healthcare. Some healthcare providers deny care to transgender clients solely based on client gender identity (Shires & Jaffee, 2015). Additionally, gender affirmation care is not always available (Marshall, Allison, Stewart, Thompson, & Archie, 2018) because there is an inadequate number of inclusive and trans-knowledgeable medical (Bradford et al., 2013) and mental health providers (Coleman et al., 2012). Access to specialists is difficult (Austin & Goodman, 2018; Bradford et al., 2013; Sanchez, Sanchez, & Danoff, 2009), owing to long waitlists (Blodgett et al., 2018). Furthermore, geographically scattered services require transgender people to piece together care needs (Noonan et al., 2018), resulting in a lack of care coordination and case management (Gridley et al., 2016). Fragmented services are more apparent for transgender people living in rural settings (Blodgett et al., 2018; Raynor, McDonald, & Flunker, 2014; Seelman et al., 2018).

Kano, Silva-Bañuelos, Sturm, and Willging (2016) report that primary care providers are the entry point for transgender people living in rural areas. Few rural primary care providers are comfortable caring for transgender clients because they often lack educational opportunities specific to transgender healthcare needs and are unaware of, and lack access to, resources such as transgender healthcare guidelines (Kano et al., 2016). As a result, rural clinicians collaborate with their colleagues in urban settings, making referrals for transgender clients to specialty care services related to comorbidity concerns and the gender affirmation process (Blodgett et al., 2018; Raynor et al., 2014; Seelman et al., 2018). Referrals to specialists in larger cities require transgender people living in rural areas to travel long distances to access additional healthcare services (Blodgett et al., 2018). Once transgender clients receive referrals, they also encounter long waitlists (Blodgett et al., 2018) because larger metropolitan areas lack a sufficient number of trans-knowledgeable healthcare providers (Noonan et al., 2018; Sanchez et al., 2009).

Similar to cisgender people, transgender people desire a reciprocal relationship with healthcare providers, seeking a balance of autonomous decision making and open dialogue about healthcare needs (Blodgett et al., 2018; Romanelli & Hudson, 2017). This dynamic relationship is challenging to achieve when healthcare providers are not knowledgeable or supportive of transgender clients' healthcare goals (Austin & Goodman, 2018).

Relationships with healthcare providers. Transgender clients report primary care providers need more education about transgender-specific healthcare (K. R. Clark et al., 2018; Marshall et al., 2018; Salkas, Conniff, & Budge, 2018; Samuels et al., 2018; Schimmel-Bristow et al., 2018), leaving some to question the competency of providers (Poteat et al., 2013). Uninformed providers are not aware of trans-specific healthcare guidelines and consequently do not know how to care for transgender clients (Gonzales & Henning-Smith, 2017).

A dearth of care protocols contributes to fragmented care (Noonan et al., 2018; Romanelli & Hudson, 2017), forcing many transgender people to spend part of their limited appointment time educating the healthcare providers of unique care needs instead of addressing primary concerns (Bradford et al., 2013). Transgender clients also spend time redirecting care conversations as providers tend to focus on the gender affirmation process rather than the purpose of the appointment (Blodgett et al., 2018; K. R. Clark et al., 2018, Xavier et al., 2013). Additionally, transgender people encounter discriminatory behaviors from healthcare providers, contributing to a delay in accessing care. (Bith-Melander et al., 2010; Cruz, 2014; Poteat et al., 2013).

Discrimination. Healthcare providers promote discriminatory behavior when selectively caring for the general health needs of transgender clients and referring clients to other providers for transgender specific healthcare, claiming transgender care is out of their scope of practice (Blodgett et al., 2018). Moreover, explicit discrimination by healthcare providers and staff, such as the intentional misuse of pronouns despite the transgender clients' verbal gender identification and possible legal name change (Blodgett et al., 2018), the deliberate limitation of binary gender choices on health intake forms, and demoralizing comments by healthcare providers and staff, may cause transgender people to feel uncomfortable (Blodgett et al., 2018; Gonzales & Henning-Smith, 2017) leading to avoidance or delay in care (Christian et al., 2018; Kano et al., 2016; Samuels et al., 2018). Consequently, many transgender clients withhold their felt gender identity from primary care providers (Rossman et al., 2017) in anticipation of disrespectful care or stigmatization (Xavier et al., 2013). Addressing a transgender person by their chosen pronouns and societal acceptance of identified gender are essential to a transgender person because it encourages them to live authentically and contributes to higher rates of mental wellness (Austin & Goodman, 2018; Levitt & Ippolito, 2014). However, living full-time as one's felt gender and pursuing gender-affirming therapies and procedures are also associated with increased reports of healthcare discrimination experiences among transgender people (Bradford et al., 2013; Levitt & Ippolito, 2014; Shires & Jaffee, 2015). Discriminatory behaviors of providers (Blodgett et al., 2018), fragmented care, and lack of reciprocal relationships between clients and providers, lead to a delay or avoidance of healthcare (Christian et al., 2018; Kano et al., 2016; Samuels et al., 2018), resulting in adverse health outcomes such as increased mental health distress (Christian et al., 2018; Seelman et al., 2017).

Mental health. Mental healthcare is critical to the overall well-being of transgender people (Kattari et al., 2016), as they are more likely to attempt suicide or experience suicidal ideations than cisgender people (Christian et al., 2018; Reisner et al., 2014). Similarly, Reisner, Vetters, et al. (2015) report higher rates of depressive episodes, anxiety, self-harm, and subsequent inpatient and outpatient mental health treatment among transgender people compared to cisgender people. Shipherd, Green, and Abramovitz (2010), report mental health concerns are not unique to transgender clients; therefore, providers do not need specialized training. In contrast, Coleman et al. (2012) and Kattari et al. (2016) state that a trans-affirmative mental health provider may better mediate the concerns than a mental health provider without specialized training in transgender mental health. A non-inclusive mental health professional may not offer the support and validation that a transgender client seeks to relieve anxious, depressive, and suicidal feelings (Coleman et al., 2012; Kattari et al., 2016).

Transgender people report a greater improvement in mental health when seeking guidance from a transgender inclusive provider (Kattari et al., 2016). Participants in studies by Elder (2016) and McCullough et al. (2017) seek mental health providers that self-identify as transgender or a transgender non-conforming person, as they do not need to explain what it means to be transgender or the specific mental health concerns of a transgender individual. McCullough et al. (2017) also note that TPOC feel most comfortable and seek out therapists that identify as a person of color, referencing that these therapists understand the additional layer of discrimination that TPOC experience. Elder (2016) and McCullough et al. (2017) report that transgender people find trans-affirmative mental health providers as welcoming, engaged listeners. Supportive therapists encourage clients' exploration of gender identity, help build peer and community support groups, and advocate with and on behalf of the clients to help navigate and break down barriers often built from discriminatory or stigmatizing behaviors by healthcare providers, educators, and family (Elder, 2016; McCullough et al., 2017).

Coleman et al. (2012) affirm transgender-inclusive mental health professionals are an essential part of the care team. Trans-knowledgeable therapists help transgender clients actualize comfort with their gender identity and realize successful personal and professional relationships leading to a higher quality of life. Trans-affirmative mental health professionals also assist transgender clients explore gender identity roles and expose the detrimental impact stigma and discrimination have on mental health. Also, a trans-culturally competent mental health professional guides clients through the creation of a supportive timeline for implementing gender identity changes. Pacing gender and role changes can help minimize challenges transgender clients may experience as they move toward their desired gender identity (Coleman et al., 2012). Mental health professionals also help transgender clients develop interpersonal skills and resilience strategies to counteract the potential ongoing negative experiences transgender people will face as they transition to their felt gender identity (Singh, Hays, & Watson, 2011).

Participants in a study by Elder (2016) state a negative therapy experience and subsequent worsening of mental health distress when receiving care from non-inclusive mental health providers. These encounters include exposure to non-empathetic and transphobic behaviors, such as therapists wanting to cure GD or intentionally ignoring gender diversity (Elder, 2016). McCullough et al. (2017) also highlight the need for mental health providers to acknowledge and understand the additional layer of marginalization felt by TPOC. Negative interactions with therapists and providers highlight the need for trans-specific mental health education (Elder, 2016). Additionally, unpleasant past therapy experiences, fear of therapy, and stigmatization by friends and family can lead a transgender person to avoid mental healthcare (Shipherd et al., 2010). Improved access to trans-knowledgeable and inclusive mental health services, is needed within the healthcare sector (Felsenstein, 2018) because unmanaged mental healthcare needs can lead to internal stigmatization and a disconnect between mind, body, and spirit (Bockting & Cesaretti, 2001).

Spirituality. Spirituality is a way for people to understand and connect with themselves and broaden conscious worldviews by authentically awakening an internal path of unconditional compassion, love, and kindness (Young & Koopsen, 2011). Similarly, Halkitis et al.'s (2009) study, which involves 498 participants from the LGBT community, defines spirituality as a relationship with self in the world constructed from personal beliefs and practices. Beagan and Hattie (2015) acknowledge that counselors contribute to holistic care (physical, psychological, emotional, and spiritual dimensions) of LGBTQ individuals.

Beagan and Hattie's (2015) findings substantiate Christian et al. (2018) and Reisner, Vetters, et al. (2015) outcomes related to a high incidence of psychological and emotional instability in transgender individuals. Mental and emotional instability surfaces due to, but not limited to, anxiety and depression (Beagan & Hattie, 2015; Reisner, Vetters, et al., 2015), suicidal ideation (Beagan & Hattie, 2015; Christian et al., 2018), and disconnect with one's sexual or gender identity related to guilt and shame that primarily stems from religious teachings such as Christianity (Beagan & Hattie, 2015). Shipherd et al. (2010) claim that no specialized training is necessary to assist transgender clients with mental health issues. In contrast, Kattari et al. (2016) asserts that trained mental health counselors are best qualified to guide psycho-spiritual care of transgender clients.

Rosenkrantz, Rostosky, Riggle, and Cook (2016) identify that much of the current research regarding spirituality and transgender individuals focuses on conflicts between transgender identities and spirituality or religion. The authors view religion as organized places of worship to a god, gods, or goddess, whereas spirituality is the ability to transcend beyond one's self to unconditionally love all people and things in the universe (Rosenkrantz et al., 2016). Religion and spirituality may be a source of shame, guilt, inadequacy, low self-esteem, trauma, and suicidality because religious communities or families may reject transgender individuals (Hattie & Beagan, 2013). A study conducted by Rosenkrantz et al. (2016) shows that although religion and spirituality may cause negative experiences and feelings, clinicians should inquire about the positive aspects of gender identity, religion, and spirituality. Rosenkrantz et al. (2016) interviewed 314 individuals from the LGBTQ community, exploring positive relationships between religion, spirituality, and their LGBTQ identity. Forty-five percent of participants felt a stronger sense of self-love and self-acceptance due to their religion or spirituality. Many individuals within the LGBTQ community report struggling with their identity as they are coming out. Forty-three percent of participants reported they were able to turn to religion or spirituality in their turmoil of struggling with their identity to construct a profound sense of purpose, authenticity, and a meaningful sense of self. A sense of religiousness or spirituality contributes to an ability to feel compassion and empathy for others and encourages forgiveness. Spiritual or religious exploration may empower LGBTQ individuals while they face stigma and discrimination and support positive coping. Experiences with LGBTQ oppression helps to open up views to others' perspectives and enhances one's ability to empathize with others. Religion and spirituality may serve as a positive resource to increase self-acceptance, self-esteem, well-being, and support authentic living (Rosenkrantz et al., 2016).

Halkitis et al. (2009) affirm spirituality as an essential part of LGBT individuals' well-being when compared to organized religions. Beagan and Hattie (2015) acknowledge faith traditions such as Judaism, Native spirituality, Buddhism, and Hinduism are farther along in embracing the well-being of LGBTQ individuals in contrast to Christianity. Explicitly, findings noted that all five individuals who ascribe to Judaism out of 35 LGBTQ participants denied feelings of conflict and shame related to gender identity within the framework of Judaism. Thirty-two out of 35 participants embrace spirituality through activities such as yoga, journaling, meditation, and artistic mediums. Furthermore, mental healthcare providers, such as qualified counselors, are best situated to assist LGBTQ clients along their spiritual journey (Beagan & Hattie, 2015).

Bockting and Cesaretti (2001) support trans-affirmative mental health professionals have the opportunity to support a holistic approach to transgender healthcare that includes mind, body, and spirit. Mind-body disconnection is frequent among transgender clients when the clients first realize and explore their felt gender identity which does not match the gender assigned to them at birth. The resulting self-conflict causes a disconnect or polarity and breaks the connection with the spirit (Bockting & Cesaretti, 2001). Mental health providers can help transgender clients work through this dissonance and resolve gender role conflicts by providing professional and empathetic therapy sessions (Beagan & Hattie, 2015; Elder, 2016). Resolving gender role conflicts can bring about feelings of symmetry between body and mind, reinforcing a feeling of oneness or wholeness, brought together by the spirit (Bockting & Cesaretti, 2001). Despite the importance of the intersectionality of mind, body, and spirit, there is a lack of research specific to the LGBTQ community and spirituality (Beagan & Hattie, 2015) which may present a healthcare barrier to providers offering holistic care.

In summary, transgender people face a multitude of obstacles when attempting to access quality healthcare (Kcomt, 2019). Access to and expense of traveling to multiple specialists is a burden for many transgender people, particularly those living in rural areas (Seelman et al., 2018). Underinformed (Rossman et al., 2017) and non-inclusive (Christian et al., 2018) providers, fragmented care (Gridley et al., 2016), and discriminatory behaviors of healthcare providers (Gonzales & Henning-Smith, 2017) all create barriers for transgender clients. Increased incidences of physical and mental health concerns are associated with the above barriers (Kattari et al., 2016), all of which create a spiritual disconnect (Bockting & Cesaretti, 2001). To improve healthcare for transgender individuals, some clinics specialize in transgender healthcare (Ding, Ehrenfeld, Edmiston, Eckstrand, & Beach, 2019; Hudson, 2018; Nisly et al., 2018; Reisner, Bradford, et al., 2015).

Clinics Specializing in Transgender Healthcare

Some clinics specialize in transgender healthcare to offer a higher quality of care and better healthcare experiences to the transgender community (Ding et al., 2019; Hudson, 2018; Nisly et al., 2018; Reisner, Bradford, et al., 2015). Hudson (2018) affirms there is little research about clinics specializing in the care of transgender individuals. Clinics specializing in transgender healthcare create a unique, inclusive approach to gender affirmation care (Hudson, 2018; Nisly et al., 2018), resulting in varying client experiences (Eyssell et al., 2017).

Approaches of specialized transgender healthcare. Hudson (2018) affirms clinics specializing in transgender healthcare take an integrated, inclusive approach towards client care. Multimodal strategies allow specialized clinics to improve life trajectories by acknowledging clients' intersecting experiences related to race, age, and socioeconomic status. One approach to specialized, integrative care includes social workers identifying resources for housing, legal assistance, education, and employment (Hudson, 2018). Nisly et al. (2018) state that clinics specializing in transgender healthcare create physically inclusive, welcoming spaces by incorporating gender inclusive bathrooms, lobbies, and clinic rooms. Inclusive, welcoming spaces offer a better healthcare experience for clients. Collaboration with transgender individuals is essential in the design of specialized clinics to bring out generalizability, validity, and reliability in the development of quality healthcare (Nisly et al., 2018).

Clients' experiences at specialized clinics. Eyssell et al. (2017) surveyed 415 transgender people regarding their gender affirmation experiences at specialized clinics. Approximately 95% of the participants supported establishing a peer support network within clinic settings. Due to the limited number of clinics specialized in transgender healthcare, participants voiced concerns of long wait times, having to travel long distances to receive care, and having limited choice of providers. Participants also feared specialized clinics becoming institutionalized by larger medical systems leading to de-personalized care and pathologizing their identities by focusing on diagnoses, particularly clinics with economic motivations. As gender affirmation care becomes increasingly specialized, individualized treatment is a concern. Therefore, creating a more transparent and individualized care model could improve clients' experience. Individualized care acknowledges clients' unique social situations, offers flexibility in adjusting care plans and surgical schedules, and allows for variability along the therapy continuum (Eyssell et al., 2017). Alternately, some clients raise concerns of specialized clinics, giving preference to primary care providers in offering gender affirmation care (Blodgett et al., 2018).

Blodgett et al. (2018) voice concerns surrounding clinics specializing in transgender healthcare. Primary care providers often refer and transfer responsibility of clients' gender affirmation care to specialized clinics when available due to providers’ belief that gender affirmation care is outside their scope of practice. However, clients surveyed believe gender affirmation care is within the scope of practice of primary care, and the education required to provide quality care is attainable. Clients surveyed affirm that an ideal healthcare model includes one primary care provider who has training on the needs of transgender clients educating colleagues within a nonspecialized clinic on transgender clients’ care needs (Blodgett et al., 2018).

In conclusion, specialized clinics offer higher quality of care (Ding et al., 2019; Reisner, Bradford, et al., 2015) and take integrated approaches to healthcare (Hudson, 2018; Nisly et al., 2018). Eyssell et al. (2017) claim clients continue to voice concerns and varying experiences related to distance to specialized facilities and wait times, limited choices in providers, institutionalized clinics, and lack of individualized care. Due to the varying needs and concerns regarding gender affirmation care from specialized clinics (Eyssell et al., 2017) and the lack of research specific to such clinics (Hudson, 2018), additional research is warranted.

Summary and Research Question

In the United States, the sociopolitical climate for transgender people remains challenging (K. R. Clark et al., 2018; Gupta et al., 2016; Kcomt, 2019; Paradiso & Lally, 2018; Reisner et al., 2014) despite the declassification of GD as a mental illness by the American Public Health Association, the APA, and the WPATH (Coleman et al., 2012; Kcomt, 2019; Reisner et al., 2016; Roberts & Fantz, 2014; Zucker, 2015). SDOH, stigma, and discrimination negatively impact transgender individuals’ well-being and correlate to widespread healthcare disparities (Bradford et al., 2013; Kcomt, 2019). There is an interrelationship between education, health, and employment in changing human behaviors and reducing health disparities (Corliss et al., 2007; ODPHP, 2019; Reisner et al., 2014). Gender affirmation therapy exists along a continuum based on individual needs requiring a multidisciplinary approach (Coleman et al., 2012) with limited guidelines (Shuster, 2016). Healthcare providers face barriers, including education, experience, and institutional standards, in providing care to transgender clients (Aylagas-Crespillo et al., 2018; Chisolm-Straker et al., 2018; Gonzales & Henning-Smith, 2017; Obedin-Maliver et al., 2011; Samuels et al., 2018). Transgender clients also report obstacles in healthcare settings including access constraints at the individual and institutional levels (Kcomt, 2019; Poteat et al., 2013; Romanelli & Hudson, 2017; Smith & Turell, 2017) and discriminatory behavior from healthcare providers (Bradford et al., 2013; Gonzales & Henning-Smith, 2017; Martinez-Velez et al., 2019). Based upon the above barriers, transgender people may choose not to (Bith-Melander et al., 2010; Christian et al., 2018; Cruz, 2014; Sanchez et al., 2009) or do not have access to healthcare (Bith-Melander et al., 2010; Martinez-Velez et al., 2019; Salkas et al., 2018), and because of this, transgender people experience higher rates of mental health distress (Christian et al., 2018; Reisner, Vetters, et al., 2015) and mind, body, spirit disconnect (Bockting & Cesaretti, 2001). To offer higher quality healthcare and improve healthcare experiences for transgender clients, some clinics specialize in transgender healthcare (Ding et al., 2019; Hudson, 2018; Nisly et al., 2018; Reisner, Bradford, et al., 2015). However, there is a lack of literature regarding clinics specializing in transgender healthcare (Hudson, 2018) and the experiences of transgender individuals receiving care at such clinics. Therefore, the research question is: What are the lived experiences of transgender adults receiving gender affirmation care at clinics specializing in transgender healthcare?

Research Lenses

The purpose of this chapter is to review relevant research lenses that influenced the development, implementation, and interpretation of this study. Our experiences and beliefs impacted the design and implementation of this study. By disclosing relevant theories and lenses, we hope to increase the reliability of our study. First, we discuss our research paradigm and culture of inquiry. Then, we discuss theoretical lenses followed by personal and professional lenses.

Research Paradigm and Culture of Inquiry

We framed our study in a critical inquiry paradigm. A critical inquiry paradigm views the role of research, in part, as critiquing systems that inhibit social justice (Creswell & Creswell, 2018). The reason for selecting this paradigm was twofold. First, when discussing our personal paradigms, we realized that together we are poly-paradigmatic. However, we decided to frame the overall project in a single paradigm. At the time of research design, amongst our individual paradigms, one researcher was a post-positivist, three held critical inquiry, and one was a constructivist. Therefore, the mode paradigm was critical. We allowed each researcher to voice their perspective, incorporating consensus-based decision-making as much as possible. The interplay between group and individual paradigms led to rich, albeit lengthy discussions which strengthened our study.

The second reason we selected critical inquiry as our group paradigm was because we were epistemologically and ontologically ambivalent as to the origins of transgender identities. A critical inquiry paradigm does not view humans as capable of pure and unbiased objectivity; therefore, the locus of inquiry moves to critique structures that obstruct social justice (Creswell & Creswell, 2018). Accordingly, we started with the value that transgender people deserve respect, dignity, and a voice. Accordingly, we started with the value that transgender people deserve respect, dignity, and a voice.

Given our research paradigm, phenomenology was the most appropriate culture of inquiry to understand the lived experiences of transgender adults receiving gender affirmation care at clinics specializing in transgender healthcare. Phenomenology allows researchers to bracket their biases during data analysis (van Manen, 2014), appealing to us because we could distance our judgments and preconceived notions of the phenomena. Our culture of inquiry influenced our selection of thematic analysis as a means of analyzing data. Thematic analysis explores the experiences of study participants in order to derive meaning and further understand a phenomenon (Willig & Stainton-Rogers, 2017). Throughout data analysis, we continued to bracket our biases to consciously understand our existing beliefs and further immerse ourselves in the data. In addition to our paradigms and culture of inquiry, two theoretical lenses informed our study.

Theoretical Lenses

Our theoretical lenses guided this study and informed its development. In this section, we discuss holism theory and intersectionality. We then explain their connection to our study.

Holism theory. Holism theory acknowledges that a person’s mind, body, and spirit are integrated into a whole being in relationship with oneself, others, and the universe (Erickson, 2007; McMillan, Stanga, & Van Sell, 2018). Within the theory of holism, the whole is greater than the sum of its parts (Erickson, 2007; McMillan et al., 2018). A disruption to one part of a system results in disturbances to the rest of its parts, and one part cannot function independently without the whole (McMillan et al., 2018). Western medicine, or the biomedical model, focuses on breaking down a person into parts rather than regarding the individual as a whole (McMillan et al., 2018). In contrast, holism often responds to biological reductionism by regarding individuals as inseparable beings (Freeman, 2005; McMillan et al., 2018). While many transgender people report having negative healthcare experiences (Bauer et al., 2015), holism fosters caring and healing for clients (Erickson, 2007). Using a holistic lens offers a means of understanding and deriving meaning from others' experiences (Erickson, 2007).

After reviewing existing literature, we noticed we were utilizing a reductionist viewpoint in understanding the factors contributing to transgender individuals' experiences. We failed to incorporate mental health and spirituality into our literature review, so we revised our literature review in an attempt to be more holistic. Implementing a holistic lens also encouraged us to incorporate an art-based portion to our study. We felt some participants may feel more comfortable expressing themselves through a visual-arts modality rather than through text alone. Utilizing an art-based method along with text allowed for a more synergistic approach to data collection (Leavy, 2015). Another means of applying a holistic lens was to incorporate a bracketing ceremony. The bracketing ceremony included bringing an object of beauty or meaning as a way to change the space and energy of the room and bring forethought to the process. To ground and center ourselves before actively engaging in the bracketing, we opened the ceremony with readings from *The Pocket Pema Chödrön* (Chödrön, 2017). Additionally, we engaged in journaling and verbalizing our biases. Applying a holistic lens throughout data analysis encouraged us to not reduce participants' lived experiences into fragmented aspects of life. Our lens encouraged us to look for interconnectedness and relationships in order to make meaning out of participants' experiences, overall leading to a more well-rounded study.

Intersectionality. As a conceptual framework, intersectionality developed to discuss ways in which race, gender, class, and other sociopolitical abstractions have concrete impacts in people’s daily lives (Crenshaw, 1989; Diamond & Butterworth, 2008). Crenshaw (1989) introduced the concept of intersectionality, asserting that amongst federally protected classes, two categories include people who are black and people who are women; however, black women were not a designated protected class. Viewing groups along a single axis of black or woman implied that black women can only claim discrimination if experiences aligned with white women or black men. Legal cases exist in which plaintiffs faced discrimination as black women. Judges dismissed cases because the single axis categories of analysis of race or gender could not crossover without creating new legal precedent (Crenshaw, 1989). As literature emerged, intersectionality expanded to include new categories such as gender identity and sexual orientation (Diamond & Butterworth, 2008). Since we used a phenomenological culture of inquiry, we wanted to understand the lived experiences unique to transgender people, such as disclosing identity and gender affirmation in connection to healthcare experiences, while also including a larger overview of SDOH such as intersectional stigmas.

When reviewing literature, it was apparent the transgender community faces health disparities (Poteat et al., 2013; Reisner et al., 2016; Winter et al., 2016). Hoping to capture these disparities within their lived experiences receiving gender affirmation care, we decided to add a demographic form to our digital questionnaire. Intersectionality was valuable while we framed our project as it accounts for multiple overlapping identities and experiences. Intersectionality and holism connect to phenomenology as they focus on lived experiences and the social justice ethos of our paradigm of critical inquiry.

Personal and Professional Lenses

Our personal and professional lenses influenced the development and completion of this study. In this section, each researcher describes her or his notable experiences that shape how she or he views the world.

Elizabeth Crandall (she/her/hers). B.S. Several elements including family life, education, employment, abilities, and life experiences influence my personal and professional lenses. I am a ciswoman raised in a single-parent household in suburban Minnesota. I grew up with two sisters, one brother, and amazing maternal grandparents who co-parented with my mom for several years. My brother has several physical and cognitive disabilities, and I was employed as a PCA to care for him when I was 14 years old. I began college when I was 16, graduating with a science degree. During my time in college, symptoms of genetic disorder lead me to transition to use a wheelchair to improve independence. I had over a dozen surgeries, and I spent a lot of my time in hospitals, clinics, and therapy centers while working on my undergraduate degree. I genuinely did not think I would make it through because of everything I was dealing with. When I did graduate, I decided to use my experiences as a patient to motivate pursuing medical education. My background as a person with a disability gave insight into being part of a minority group, eventually fostering a passion for social justice and equity due to the lack of compassion and consideration I often see directed towards people with differing abilities.

As a person with a disability, I have had varying experiences in medical settings. While very different than the experiences transgender individuals face, when I go in to a clinic for an appointment, it is the norm for almost every symptom I have to be attributed to my genetic disorder because the disease I have is rare and relatively unknown. Providers often bring in medical students to observe my appointments because otherwise they might not see my condition outside of a textbook. My intent with this study is to better understand the transgender community so that when I ultimately finish my formal education, I can offer inclusive care.

I follow a critical paradigm with values of communication and social justice. I value people, perspectives, trying to recognize what I do not know, and increasing my awareness of what I should learn. When starting this project, I had little experience working with transgender individuals. I came into this project with a beginner's mind, being as open as possible to new information and ideas. Early in this project, I began working in a local emergency department, and I have seen several interactions between the transgender community and healthcare providers consistent with the literature. My hope is that even if I never work at a specialized clinic or exclusively with the LGBT community, by completing this study I will be knowledgeable about the community's needs, compassionate of others' life experiences, and able to offer well-informed, holistic care.

Rebecca DeBaker (she/her/hers). B.S., BSN, PHN, RN. My lived experiences are a beacon that guide and influence my academic, professional, and personal view of research. The following thoughts serve to explain how I moved from a positivist to critical and constructivist paradigms and how these ways of knowing reflect my interpretation of reality and lead my understanding of the research process.

I started my academic life in a positivist paradigm. My allopathic nursing school education taught a cause and effect model, one that values fixed, orderly, and predictable outcomes. I learned to view the client as a passive recipient of medical doctrine rather than an active participant in health and wellness care. This mindset carried into my professional life as I started work in a hospital setting. We stripped our clients of individuality and humanness. We ignored clients' meaningful experiences, personal realities, and core beliefs they carried that are influential to health and wellness. I worked in the western medicine model for five years until I grew tired of silencing my fundamental beliefs of inclusion, acceptance, equity, individuality, holism, and the honoring of multiple realities. I quit my job and transitioned into work that supports my beliefs and aligns with the critical and constructivist paradigms.

The critical and constructivist models support my core values and influenced how I approached our research project. I believe the only way to perform ethical and socially responsible inquiry is through an ongoing equal partnership between the study participants and researchers. Ideally, the participants and researchers interpret the data and develop tools and educational material that will empower the study population. Research participants should be treated as equal partners in the process because it is the only way to produce meaningful results that change systems and break cycles of discrimination and stigmatization. In addition, I recognize that reality is created by the individual and all self-actualized realities are valuable to learning about the lived experiences of individuals.

Balancing the desire to include participants as equal partners in the research process but also respecting the potential for feelings of exposure or vulnerability, we decided it was most important to keep participants’ identities confidential and not engage potential participants in data analysis. This deviates from the critical and constructivist lenses of partnering with participants, but still allows for voices to be heard, lived experiences shared and respected, and individual realities captured. By sharing their lived experiences, our participants help lay the framework of quality healthcare in a clinic specializing in gender affirmation health.

I do not have experience caring for and have had little interaction with the transgender community. I have, however, witnessed tasteless, uninformed, conversations and treatment of transgender individuals by emergency room providers at a local emergency department. This unjust and alienating behavior of healthcare providers grates against my belief that all humans should be treated with respect, compassion, and allowed to live as they wish. Therefore, I wanted to embark on this research project to educate myself about what compassionate, inclusive, and holistic transgender healthcare looks like from the lens of transgender people. I hope to take what I learn and educate healthcare providers, in an effort to correct the discriminatory and alienating treatment many transgender people experience.

Brandon Lorge (he/him/his). M.A., B.A. Prior to engaging in self-reflection regarding my paradigm, I would have assumed I had a post-positivist one because I thought that this is how a spiritual person would reconcile their epistemology with faith, however defined. While engaging in the process, I have come to a Critical paradigm with a strong axiology regarding ethical research and treating people first and foremost as people and not just subjects of research.

I was born with a cleft lip and palate that required around 15 reconstructive and corrective surgeries starting when I was a few months old. The many appointments to see specialists and consultations meant that as I grew up I spent a lot of time in doctors and orthodontists offices. I also had some complications from the surgeries that required extra follow up. I learned how to spot when I was being treated like a person and when a specialist was more interested in looking at the abnormality. While I carry with me a lot of respect for healthcare providers, I also have times when I know I’m just a number or a chart and not a whole person. Therefore on this project I determined that it is important to me to find ways to gather transgender people’s experiences in their own words regarding their healthcare in order to give them a voice and not perpetuate the number on a chart mentality for others.

My corporate career in information technology has taught me how to interact with people of other cultural backgrounds. I have spent many years working in a diverse and blended team of South Asian and European American coworkers. I have had to learn how the Asian school system socializes people to ask questions very differently than in America. I also observe how technical conversations will move from English mother tongues. The lack of code switching makes it easier to drive the conversation.

Parallel to these lessons, I have also been working on my master's degree at the Saint Catherine University. This historically women's institution admits men into the holistic health care program. My experience has been as the only male in the classroom for all but three courses. While I have always felt welcome by my classmates and professors, I have also realized that my presence changes the dynamics in the classroom. I have had times where I have refrained from answering a question or framed it in a slightly different way than I might have in an all-male classroom. I simply have no way of knowing what an all-women's class looks like and what dynamic I bring versus how each class has its own unique group dynamics. I have observed the way in which women and men are socialized to communicate in our society is quite different and have learned to incorporate some of the ways in which my female classmates have interacted with me in my interactions elsewhere. In both work and school contexts, I have grown acutely aware that much of our communication is socially constructed. I think it gives me a window into the ways in which minorities, especially transgender people navigate the world.

As a spiritual person I have come to hold dearly the principle that all people hold a spark of the Divine within them. For me, it is crucial that all people are lifted up and brought into communion, including the oppressed and marginalized. We all bear the divine image and are invited to the table. *May all beings be happy and free and may my own words and actions contribute to that happiness and freedom for all.*

Ellen Schneider (she/her/hers). BSN, PHN, RN. I received my undergraduate education at an all-women's Catholic school that emphasized social justice. Throughout my education there was a focus on serving the community and identifying where change is necessary to better provide health and wellness to all. I currently work as a Registered Nurse at a level one trauma hospital in the role of a charge nurse on a Cardiac Progressive Care unit. As a healthcare professional my behaviors predominantly lie in the post-positivist paradigm. Currently I am working on a Master of Arts in Holistic Health Studies at St. Catherine University, to broaden my perspectives of healthcare and incorporate a more inclusive model of care in conjunction with the current biomedical model.

I grew up in a rural community on a hobby farm in Minnesota. I had little exposure to minority communities until I attended St. Catherine University in St. Paul for my undergraduate degree. Working at an urban hospital I have committed myself to serving minority populations in need of care and respect. I have provided care for a small number of transgender clients within the acute care setting. I also have had the opportunity to witness gender affirmation interventions in a very close transgender friend. This experience has directly influenced my participation in this research, as I have seen firsthand the shortcomings of standards of care for transgender people. Through my direct experiences providing care for transgender individuals, as well as accompanying someone through their transition, it has been made clear to me that work is needed to adequately educate providers about transgender health. I believe education is critical and the first step in providing more equitable care for the transgender population. Working for a hospital that does not have specialty providers for the transgender population has opened my eyes to the lack of quality and knowledgeable care provided, that I am hoping physicians who have specialized provide transgender clients in specialty clinics.

Kendra-Ann I. Seenandan-Sookdeo (she/her/hers). MN., BN., RN., CEIM. Over my lifetime on Mother Earth, I have transitioned through the positivism, post-positivism, critical, and constructivism paradigm. Innately framed in a constructive paradigm, my lived experiences guide my personal, academic, and professional lens. I intend to enlighten readers about how I experience reality, my ways of knowing, and the ethics and values that guide my research lens. To remain true to our study's culture of inquiry, I intentionally structured the following conversation within the framework of hermeneutic phenomenology.

I was born in Guyana, South America, into a multi-cultural, racial, ethnic and religious family with a secure lineage connection to my maternal and paternal grandmothers. My early experiences with family and our Guyanese community deeply impacted me and I developed a passion for social justice issues. My journey from South America to Canada, and most recently, the United States of America (USA), has also informed my lens of inquiry. My life experiences in the USA lit a fire in me regarding the health disparities deeply rooted in the American colonial structures. The recent events of COVID-19 serve to highlight healthcare disparities among people of color, lower income, and marginalized people.

In Canada, my graduate nursing professors and other professional mentors in nursing, medicine, psychology, pathology, and bench science research have informed my research lens. Along the way, I continue to embrace my ancestral ways. Thus, my ontological framework, in reality, is a colourful tapestry woven from threads informed by my ancestral, physical, social, emotional, mental, spiritual, academic, and professional environments. I hold sacred that reality is constructed based on individual contextual perspectives. Accordingly, no one reality, truth, and or untruth exists. Realities are grounded in the stories of the individual. These realities are intertwined into lived experiences that transform into the perspectives of the whole. This ideology conveys individual and multiple cognitive realities, which align with a constructivist paradigm. Grounded in my grandmothers' teaching that "we need first seek to understand self" before we can understand the essence of external experiences. When a person understands self, they can begin to understand their external environments. As a result, I continually seek self-awareness as my path towards seeking balance in understanding the multiple realities that uniquely exist in each of us.

My acquired Earthly knowledge facilitates a journey towards enlightenment. Axiology is the branch of philosophy that seeks to understand values that support the construction of new knowledge that is influenced by parts of a whole. The parts of the whole transform into collective truths. Individual beliefs, attitudes, values, and ethics influence how newly acquired knowledge is processed and used. The essence of truth uncovers beliefs, ethics, and values of lived experiences. Knowledge discovery is a sacred process. This sacred process unfolds as I seek stillness. By seeking stillness, I seek to attain clarity. Stillness allows me to understand individual and collective truths to engage in non-judgmental interactions. When an interaction ends, I evolve due to the exchange of interconnected energies between humans. Consequently, I am continually evolving. I walk with goodness, kindness, compassion, caring, and curiosity. Sometimes my path unfolds in an organized garden and other times within the Amazon Jungle's tranquility and tribulations. In the mist, I remind myself that my purpose on Mother Earth is to understand myself by seeking balance through stillness, which is my way towards self-actualization. My journey continues. Hence, my acquired Earthly knowledge continues to facilitate a journey towards enlightenment.

As I seek a dual degree in the Master of Arts in Holistic Health Studies and a Doctor of Nursing Practice, my lived experiences continue to shape my lens. As a nurse, my practice continues to be grounded in holistic healthcare. I attribute my holistic nursing approach to my upbringing in South America and Canada. Reflecting on my thesis research journey, I am informed by the individual and collective essence within the words of our participants' transcripts and photographs. My mind, body, spirit, and soul are gratefully forever changed. The poem below, titled *May 17, 2020: I Am K-AiSS* is my initial attempt to capture my holistic health research journey plus.

May 17, 2020: I Am K-AiSS

I am from green, white, golden arrowhead, black, red land of many waters where vibrant ecosystem nourishes dense rainforest, threatened by foreign invaders steeped in gloomy historical present-day social justice issues, deforestation, poverty, education, abuse, gender equity, child labour, racism, discrimination, microaggressions, stigma.
I am from friendly blistery snowy cold red maple leaf scored with shadows of historical present-day injustices of Indigenous People, access to justice, prison reform, homelessness, gender equity, racism, discrimination, microaggressions, stigma.
I am from red, white, blue heavy-hearted fragmented immigrant surviving 10, 000 lakes where murky waters flow immoral historical present-day inequities, climate change, LGBTQIA+ rights, affordable healthcare, mental and physical ability, racism, discrimination, microaggressions, stigma.
From the spirited energy of ancestors, past-present day life experiences, rainbow transcripts-photographs lived research participants' experiences, I will globally drift, dance in storms seeking justice, equity, for all. Namaste.

Method

The purpose of this chapter is to describe the research methodology used to answer the research question: What are the lived experiences of transgender adults receiving gender affirmation care at clinics specializing in transgender healthcare? To capture participants' perspectives, a phenomenological approach guided our multi-method research of a digital questionnaire and art-based participatory photography. First, we discuss our rationale for our research design. Next, we outline sampling procedures and recruitment strategies, instrumentation, and data collection procedures. We follow with a description of data analysis procedures then an overview of design rigor. Finally, we end with a discussion of ethical considerations and design specific limitations. This study received approval from St. Catherine University's Institutional Review Board.

Rationale for Research Design

As a team, we gathered to consider the design details about our research study, which was influenced by numerous factors. The principal factor in guiding design centered on the purpose of our research question. Thus, with intention, as a group we uncovered our collective research paradigm (worldviews) and selected hermeneutic phenomenology as our culture of inquiry. Based on our evolving decisions, we selected our methods. Creswell and Creswell (2018) acknowledge that multiple forms of data collection methods endorse a comprehensive understanding of phenomena. After deliberation, we elected to use a digital questionnaire with an option to participate in art-based participatory photography. Within this framework, our data collection and thematic analysis transpired. The proceeding describes the rationale for the above-stated sub-categories.

Rationale for critical paradigm. In accordance with our culture of inquiry, we first sought to understand our individual and collective research knowledge and philosophical wisdom, revealing a complexity of unique threads interwoven into patterns specific to our collective research paradigm, the critical paradigm. Consequently, the critical paradigm framed our study within a hermeneutic phenomenological culture of inquiry. Similar to hermeneutic phenomenology, the critical paradigm involves an interpretive process (Creswell & Creswell, 2018; van Manen, 2014). Particular to the critical paradigm is the focus on marginalized groups of people (Creswell & Creswell, 2018) such as the transgender community. Asghar (2013) notes that the critical paradigm values the opinions of the oppressed, engages with advocacy, unmasks hidden power structures, and allows for positively influencing social justice issues of marginalized groups. One strength of the critical paradigm is the transitioning theory into practice (Asghar, 2013). We chose this paradigm because, as a team of researchers, we seek to create social change within healthcare environments. Thus, based on our literature review, the critical paradigm complements our research population needs and our culture of inquiry. The research methods we used to compile the participants stories flowed from the collective awareness of our research team's ontological (the essence of meaning), epistemological (coming to know), and axiological (dealing with values and ethics) paradigms (Rallis & Rossman, 2012). We chose methods that value our participants' perspectives while maintaining their anonymity.

Rationale for hermeneutic phenomenology. Van Manen (2014) describes hermeneutic phenomenology as the study of human science, guided by an interpretative culture of inquiry to understand the lived experiences of people rather than preconceived notions. Hermeneutic phenomenology is used widely in healthcare investigations (van Manen, 2014). As a culture of inquiry, hermeneutic phenomenology offered us a way of uniquely capturing transgender peoples' perspectives specific to their lived healthcare experiences (Creswell & Creswell, 2018). Van Manen (2014) explains that research knowledge is generated from the written narratives of participants. The core of understanding text narratives is rooted in the notion that multiple realities exist. Accordingly, to understand the individual and collective contextual lived experiences, researchers engage in an interpretive process to understand the phenomena of interest. Reflection on texts assists researchers in identifying themes and patterns that unearth the essence of the individual and collective lived experiences. While interpreting meaning from texts, researchers engage in a process known as bracketing (van Manen, 2014). To fully capture the essence of participants' narratives, thematic analysis is used to analyze individual phenomenon and the collective phenomena (van Manen, 1990). As with all cultures of inquiries, hermeneutic phenomenology incorporates strengths and limitations.

Hermeneutic phenomenology permits researchers to capture rich and in-depth narratives of participants' unique lived experiences (Creswell & Creswell, 2018). To authentically learn and construct meaning from participants' stories, we individually and collectively engaged in the process of bracketing biases. Van Manen (2014) acknowledges that bracketing supports authenticity to individual participants' perceived meaning and the collective meaning of the whole. Bracketing brings to the surface an awareness of researchers' prejudices and values which are put aside in order to understand the phenomenon of interest from the perspective of participants. Bracketing facilitates a non-judgmental analysis of participants' stories, increasing the study's internal validity (van Manen, 2014). Our study enabled us to capture a collection of information-rich lived experiences which helped us identify patterns and strengthen our research outcomes (Creswell & Creswell, 2018). We hope our study results inform transgender healthcare teams regarding best practices. However, hermeneutic phenomenology is not without limitations.

Several disadvantages exist to using hermeneutic phenomenology as a culture of inquiry. First, the actual establishment of reliability and validity is difficult due to the nature of using subjective data (Rallis & Rossman, 2012). Influencing policy changes based exclusively on subjective data is limiting (Creswell & Creswell, 2018). Van Manen (2014) notes research participants may unintentionally describe their preconceived notions or perceptions during data collection rather than their true lived experiences. For participants' genuine voices to emerge, researchers need to separate from the text to engage in an ongoing exploratory bracketing process (van Manen, 2014). Although, within the mindset of a critical paradigm, the research team wonders if bracketing is consciously or unconsciously achievable. Bracketing is complicated by the notion that the team of researchers' paradigms range from post-positivism to constructivism. Lastly, the subjective nature of the research data limits the generalizability of the research findings (Creswell & Creswell, 2018). To deeply understand the essence of participants' lived experiences, we designed a multi-method data collection process using a digital questionnaire and art-based participatory photography.

Rationale for digital questionnaire. We chose a digital questionnaire for several reasons (see Appendices A and B for digital questionnaire instructions and digital questionnaire). The digital questionnaire format allowed participants to reflect on, describe, and explain the phenomena they experienced in a setting of their choosing without researchers present. This protected participants' anonymity and potentially allowed for deeper reflection by removing any felt pressure to hurriedly reply (Barchard & Williams, 2008). Digital questionnaires with open-ended questions offer the opportunity to provide more in-depth answers by allowing participants time to think about the questions in a private space before answering (Roller & Lavrakas, 2015; Vogt, Vogt, Gardner, & Haeffele, 2014). This method also reduces the chance of introducing researcher bias via facial expression or tone of voice (Roller & Lavrakas, 2015). Digital questionnaires are also cost-effective for the researcher (Orcher, 2007; Roller & Lavrakas, 2015), convenient for participants due to online availability over an extended period of time (Roller & Lavrakas, 2015; Vogt et al., 2014), and have the potential to draw a larger sample size (Barchard & Williams, 2008). Despite the strengths of digital questionnaires, there are also several limitations.

Digital questionnaires are restrictive in that the questions need to be straightforward and clearly written as no follow-up questions can be asked to clarify for further understanding by either the researcher or the participant (Roller & Lavrakas, 2015). Also, respondents are more likely to skip open-ended questions, causing bias and missing data (Orcher, 2007; Roller & Lavrakas, 2015; Vogt et al., 2014). Additionally, open-ended questions are time consuming and respondents feel they need well-crafted answers, potentially causing test-like anxiety (Vogt et al., 2014).

There are digital accessibility and data security concerns as well. Some potential participants may not have the technology to access an online questionnaire while others might have difficulty navigating the technology, leading to higher nonresponse rates and creating bias (Roller & Lavrakas, 2015; Vogt et al., 2014). Lastly, there is risk of a malicious data breach by an outside party, so a digital questionnaire is not 100% secure (Paulus, Lester, & Dempster, 2014).

Rationale for art-based participatory photography. We chose to add an art-based component to our study because visual arts can be used to gain a deeper understanding of the human experience (Holm, Sahlström, & Zilliacus, 2019) (see Appendix C for optional photograph submission). To enrich the answers to the questionnaire questions, provide another way to collect qualitative data (Creswell & Creswell, 2018), and answer our research question, we included an art-based participatory photograph option. Additionally, art-based participatory photography, i.e., the use of research participants' photographs, is a way to "deal with the power differences in research" (Holm et al., 2019, p. 316-317). There are several strengths of this art-based methodology. First, a photograph gives a voice to marginalized groups, allowing for research participants to be represented in ways not captured through digital questionnaires (Holm et al., 2019). Second, photography has the potential to transform participants, researchers, and those reading the research by capturing emotions that may not be able to be expressed in words (Leavy, 2015). Third, photography provides more in-depth knowledge that the participant would not otherwise disclose on a questionnaire and enhances an empathic understanding by facilitating participants to share viewpoints (Holm et al., 2019; Paulus et al., 2014). Fourth, a photograph promotes sensitivity, social reflection, and self-awareness (Leavy, 2015). Furthermore, photography allows for a holistic and synergistic approach to data collection, creating a more well-informed study (Leavy, 2015) while expanding our epistemological beliefs (Holm et al., 2019).

Leavy (2015) reports limitations to an art-based methodology include evaluating data. There is no standard means of evaluating art-based research, leading to challenges in deriving meaning from works. Furthermore, privacy is a limitation due to the potential of participants including identifying characteristics in their photographs (Leavy, 2015). Participants may include photographs of themselves or other human subjects, violating their own or others' privacy (Paulus et al., 2014).

Sampling Procedures and Recruitment Strategy

With a culture of inquiry rooted in hermeneutic phenomenology, it was imperative that we sample a population experiencing the phenomenon: individuals who self-identified as transgender. Study participants included adults actively seeking gender affirmation healthcare from a specialized transgender clinic in a midwestern state in the USA. Below outlines the site recruitment process, along with purposeful sampling and participant recruitment.

Site recruitment. We initially used snowballing for site recruitment to connect with decision-makers within clinical settings. To request bridging connections with leaders in specialized transgender clinics, members of the research team reached out to community contacts using text, Facebook, and email. To assess potential clinic recruitment sites, we compiled a list of five clinics that self-identified on the Internet as specializing in the care of gender affirmation. We sent emails directly to five clinical sites to assess interest in participating in the study, and we received a response from one clinic out of five. The recruitment site's philosophy is to break down healthcare barriers related to access, poverty, discrimination, and oppression. The decision regarding our recruitment site was based on the fact that the greater community views the site as specializing in transgender healthcare. The clinic expressed interest in being involved in the study because many of their clients welcomed the opportunity to participate in past research studies as a way to share their voice and highlight that they are an underserved population that deserves a choice in their healthcare. The purpose of recruiting from a specialized clinic was to capture the perceptions of transgender people receiving gender affirmation care. The recruitment from a specialized clinic serves to inform and support the dissemination of transgender individuals' healthcare perceptions to a larger healthcare community.

Coordination with the recruitment site began several months before the questionnaire launched. We initially established correspondence with an executive through a face-to-face meeting, where we discussed in detail what this study encompassed and the responsibilities of the recruitment site. Future communication occurred via email detailing the questionnaire instructions, as well as asking for feedback and asking about potential capabilities as to how the questionnaire could be sent to potential participants. We identified a site staff champion at the clinic in advance of the research study commencing. The champion was not a healthcare provider involved directly with transgender clients' care and was able to communicate with clients via the online patient portal.

Purposeful sampling and participant recruitment. We used purposeful sampling, a non-probability sampling procedure, which allowed us to obtain information-rich experiences regarding our phenomenon from a well-informed group of individuals (Creswell & Creswell, 2018). The recruitment clinic sent emails to potential participants, filtering emails pertaining to this study to be sent only to individuals currently attending the clinic who identify as transgender and are their own legal guardians.

We constructed inclusion and exclusion study criteria. The inclusion criteria were based on the following 1) individuals who self-identify as a transgender adult, 2) individuals who self-report that they are 18 years of age or older, 3) a transgender person receiving gender affirmation care from clinics specializing in transgender healthcare, 4) the ability to read and write in English, 5) individuals who are their own legal guardian. We also provided a disclaimer for participants stating participants must have access to a device capable of taking a photograph and have the ability to upload an image if they chose to participate in the photograph submission. The exclusion criteria included 1) transgender individuals who are less than the age of 18, 2) individuals who do not self-identify as transgender, 3) transgender individuals who are 18 years of age but are not seeking gender affirmation care from clinics specializing in transgender healthcare, and 4) individuals who are not their own legal guardian. Next, we detail instrumentation.

Instrumentation

In this section, we detail our instrumentation. We provide an overview of our digital questionnaire which included an optional art-based participatory photograph and demographic form. We follow with a review of researchers as instruments.

Digital questionnaire. In order to create a credible and reliable questionnaire we referenced books and academic articles about digital questionnaires, our research advisor’s feedback, a leader within the transgender population, utilized research team collaboration. Guided by our group paradigm, culture of inquiry, and research question, we formulated a digital questionnaire.

Gathering in-depth information through two structured, open-ended questions allowed our participants to describe their lived experiences and opinions within our research question (Turner, 2010). The questions included: 1) *Please describe your experience with gender affirmation healthcare (also known as trans healthcare) at clinics specializing in transgender healthcare* and 2) *Is there anything else you would like to share with us related to your gender affirmation healthcare experiences at clinics specializing in transgender healthcare? For example, describe experiences you consider ideal or not ideal, and describe what these experiences mean to you.* (See Appendix B for digital questionnaire). We recognized participants may not wish to fully express their experiences using words, so we asked participants to upload an original photograph and description, allowing for creative expression by way of using an art-based outlet.

First, we assessed the content validity of our digital questionnaire to ensure the questions coincide with the purpose of the research and culture of inquiry (Vogt et al., 2014). To ensure the validity of our questionnaire questions, we emailed our questions to an executive at the recruitment site for initial review and approval. Based on their feedback, we decreased the number of questions on our digital questionnaire from four to two. We then conducted a pilot of the entire digital questionnaire. Asking one person who self-identified as transgender and sought healthcare at a specialized clinic, we established the timing of the digital questionnaire and gained feedback on our questionnaire instructions, questions, and art-based component. We assessed timing from start to completion of the questionnaire and gathered any technical issues with the online delivery platform. Based on the pilot results, we decreased the estimated time to complete the questionnaire but kept the content and delivery platform as originally designed. The online delivery along with the content of the questionnaire were consistent across participants, providing reliability of our digital questionnaire (Creswell & Creswell, 2018). We administered the questionnaire online without face-to-face interaction with the researchers. Thus, we offered the participants a telephone number that was routed to a voicemail checked daily by one of the researchers to ask clarifying questions regarding the questionnaire.

Art-based participatory photography. We presented the participants with instructions to capture an original photograph and write a one to three sentence description of the photo, specifically asking how their photo embodies their lived experience of receiving care within clinics specializing in gender affirmation healthcare (see Appendix C for optional photograph submission). While allowing for a creative way for participants to express their lived experiences, the photograph description took additional time to analyze and gather themes. To more fully understand our participants, we also employed a demographic form.

Demographic form. To better understand our participants, we gathered demographic information (see Appendix D for the demographic information). In asking for this information, we hoped to learn more about our participants and how their age, ethnic background, housing status, type of community where they live (urban, suburban or rural), education level, and employment status may impact their lived experience of receiving care from clinics specializing in gender affirmation healthcare. Hughes, Camden, and Yangchen (2016) note that demographic information allows researchers to better identify their sample and determine if the study has a representative sample. Questions on a demographic form may be considered sensitive, and challenges may arise when participants are asked to classify themselves into categories in which they do not identify. If demographic categories are too broad or vague, it could lead to an inaccurate description of the sample (Hughes et al., 2016). Collecting demographic information supports our dual theoretical lens of holism and intersectionality as researchers.

Researchers as instruments. As researchers, we prepared ourselves by engaging in academic readings related to the transgender community. We also read about qualitative and phenomenological research designs and engaged in lengthy discussions to design and implement a study that was balanced with our group paradigm and culture of inquiry.

Three research group members visited the recruitment clinic site to vet our research idea and establish an in-person connection. Throughout the research process, we became aware of how important it is to honor a person’s pronoun preference when addressing people. One researcher worked to incorporate this into their interactions with others by offering up their preferred pronouns and asking the same of those with whom they spoke. This same researcher also became an informal educator to a group of emergency room providers regarding the basics of addressing transgender people. This was a small attempt to lift up the voice of transgender people and, hopefully, allow for a more respectful initial interaction between the provider and the transgender client. Another researcher attended a workshop from a community-based health advocacy training organization on the impact of pronouns and language use for gender minorities.

Having a team of researchers with varying paradigms, backgrounds, life experiences, and ages allowed for dynamic, lengthy discussions during the entire research journey. This process often called out our individual biases and gave way to constant reflexivity and subsequent bracketing. This strengthened our research design, potentially removed preconceptions, helped frame our assumptions, and put the participants and their lived experiences at the center of our decision making (Creswell & Creswell, 2018).

In an attempt to set aside biases, we engaged in a bracketing ceremony. We co-located in a room suitable for reflection and meditation. Beginning with a short reading on mindfulness, we meditated to ground and center ourselves. Next, we silently and individually journaled our personal biases. After this was complete, we read our lists of biases aloud and took notes. Once the group list of biases was compiled, a team member read it aloud to the group to ensure accuracy. A research team member digitally disseminated the combined list to the group to read during data analysis. We recognize that we are human, and the complete removal and containment of our biases was impossible; thereby, we acknowledge their presence and influence on our inquiry process.

All of the aforementioned efforts reinforced our collective value of social justice and strengthened our effectiveness as instruments to successfully collect, analyze, interpret, and report on the lived experiences of our participants. This strengthened our knowledge as novice researchers, making us acutely aware that our past experiences and lenses of the world influenced our research process (Creswell & Creswell, 2018).

Data Collection Procedures

The site champion sent out a pilot email to the researchers from the recruitment site email to ensure the link to the study worked correctly and participants would be able to submit their responses. We configured a questionnaire within the platform of Qualtrics to be accessible to potential participants via mobile phone or computer. After successful completion of the pilot, the site champion sent the recruitment email containing the link to the study to approximately 300 potential participants on January 13, 2020 (see Appendix E for recruitment email). Upon clicking the link in the email, participants went to the homepage for the digital questionnaire on Qualtrics. This page contained downloadable links to crisis resources and an invitation to St. Catherine University's Holistic Health Studies Research Day, a public event where we hoped to present our study results (see Appendices F and G for the crisis resource list and invitation to research day). Circumstances beyond our control led to the cancellation of the event. Potential participants completed a screening questionnaire to assess their eligibility for this study (see Appendix H for eligibility criteria screening). If potential participants met all eligibility criteria, a consent form appeared (see Appendix I for the online consent form). To confirm understanding of key aspects of the informed consent, potential participants completed an informed consent clarification form (see Appendix J for informed consent clarification form). Qualtrics allowed unlimited attempts for participants to complete the clarification form.

After participants demonstrated understanding and agreement of the informed consent, the digital questionnaire instructions appeared (see Appendix A for digital questionnaire instructions). Next, demographic questions and the questionnaire questions appeared with text boxes below each question for participants to type in their answers (see Appendices D and B for the demographic form and digital questionnaire). Participants then had the option to upload a photograph into the Qualtrics questionnaire along with a description of the photograph consisting of one to three sentences (see Appendix C for optional photograph submission). Participants who declined to participate in the optional photograph submission were able to submit their responses for the digital questionnaire. For participants who opted into the optional arts-based aspect of the study, Qualtrics presented a page to upload a single original photograph with a text box below the photo box to type a description. After submitting a response, participants again had access to downloadable links for crisis resources, an invitation to research day, and the informed consent (see Appendices F, G, and I for crisis resources, invitation to research day, and online consent form). On January 23rd, 2020 the recruitment clinic sent out one reminder email to potential participants (see Appendix K for reminder email).

The researchers configured Qualtrics to delete partial survey responses, particularly if participants did not formally submit. Each page of the digital questionnaire and optional photograph submission had “next page” and “back” buttons, and only the last page of the study had a button labeled “Submit.” There were no time restrictions for participants throughout any steps of the questionnaire process. Participants’ responses were not recorded by Qualtrics if participants closed out of the Qualtrics link without clicking “Submit” and receiving the final confirmation. If participants exited without clicking “Submit,” they were able to enter back into the survey and start from the beginning again, as none of their data saved. Responses were anonymized; therefore, Qualtrics did not record any personal data and removed contact association. We took care to secure participants’ files, and responses were only viewable by users granted permission.

After participants submitted responses into the Qualtrics database, the research team’s advisor downloaded data from Qualtrics and uploaded the data to Box, an online password protected data repository. The information on Box was then shared with the research aides who had signed a confidentiality agreement (see Appendices L and M for research aide job description and confidentiality agreement). Although submitted anonymously, participants’ responses may have accidentally included names of clinics, providers, or friends, or participants may have submitted photographs with identifiable human characteristics. The research aides de-identified data before making it available to the researchers. The above actions minimized linkage of questionnaire responses, photograph submissions, and descriptions of photographs to participants, preserving participant privacy. The research aides documented the number of questionnaires and photographs deleted due to exclusion criteria. De-identified data was then provided to the research team for the analysis process.

Data Analysis Procedures

We used thematic analysis to examine the participants' written words. Van Manen’s (1990) thematic analysis is a process of deriving themes from qualitative data. A theme captures an aspect of the essence of a lived experience or phenomenon. Within thematic analysis, simplified ideas or themes are put together into a whole to understand participants' experiences (van Manen, 1990).

After receiving de-identified data from the research aides, each research member individually read and analyzed the first five responses of the study according to van Manen’s (1990) process. As part of van Manen’s (1990) approach to data analysis, we used several steps to generate themes: sententious reading, selective reading, and detailed reading. Sententious reading is identifying which phrases within a text can best capture the essence of the whole. By using selective reading, we identified several key phrases throughout the text to connect to the phenomenon. We used detailed reading by individually identifying how each sentence of participants' responses contributed to the lived experience (van Manen, 1990).

We then met and compared themes we drew from the first five responses, holding a discussion concerning the rationale of the themes we individually chose. From there, we collectively decided on several initial themes and created a working thematic matrix that housed the definitions of our themes. Since themes that lead to the most data are not necessarily the most relevant or appropriate to the research question, we individually re-read the first five responses with the themes and definitions in mind to ensure our definitions encompassed the responses. We then regrouped, discussed changes we thought necessary, and refined our themes. As a team, we reanalyzed the initial five participants' responses utilizing the updated thematic matrix then continued to analyze the remainder of the participants' responses.

We also used van Manen's (1990) thematic analysis to analyze the art-based participatory photography element of this study. Six participants submitted photographs; however, two photos did not meet inclusion criteria because participants submitted images with identifiable personal characteristics. Therefore, two photos were excluded from study data. Although we had originally intended to analyze the written descriptions, once we received the de-identified data, we found that two of the responses included written text within the digital photograph upload. We made the collective decision to include texts within photographs in our thematic analysis.

In qualitative data analysis, all themes are derived from human judgement (van Manen, 1990). To help validate the subjective nature of data analysis, we employed a team data analysis strategy. We began each data analysis session by re-reading aloud our list of bracketed biases. We then continued to discuss all data collected and analyzed each response and photograph as a group. After establishing initial themes from each response, we went back and re-read participant responses to reflect on how we categorized them relative to the working definitions of our themes. Re-reading participant responses ensured we accurately captured what the participants described in their responses.

In addition to van Manen's (1990) thematic process, we also incorporated some processes outlined by Vogt et al. (2014) in order to offset potential challenges of thematic analysis. As we utilized an inductive and deductive approach to generate themes, our themes had the potential to reflect our bias or subjectivity in our results (Vogt et al., 2014). We had our research question and list of topics from our literature review present to help negate the potential effect of bias or subjectivity as we created our thematic matrix, refined subsequent versions, and read through each of the participant responses. As we created themes, we were able to reference our research question and topics found in the literature review in order to reflect on the relevance of themes derived from our data analysis to the purpose of our study. Although we were aware of our literature review topics throughout data analysis, we were intent on looking for novel themes. By having pre-existing themes or topics, data analyzed is likely to directly relate back to our research purpose (Vogt et al., 2014). Looking outside these themes allowed us to not constrain ourselves and unintentionally bias our results.

Design Rigor

Reliability and validity are crucial on two levels in research: instrumentation and process. In this section, we discuss the process level of maintaining reliability and validity through replicability, reflexivity, investigator responsiveness, and an active analytical stance. These factors ensure a consistent and transparent study, demonstrating, demonstrating rigor.

Each step of the data collection design and analytical process was clearly articulated in detail with the intent it could be replicated for future research. We opted to use Qualtrics as it is a tool that allows more consistent replicability by eliminating the variables of body language, intonation, and other face-to-face interactions. Before sending the digital questionnaire to the clinic to distribute, each member of the research team submitted responses to the digital questionnaire and uploaded a photograph to ensure the technology was accurately configured. Reflexivity encourages intentional reflection of the relationship between the researcher and design of the study, promoting researchers' thoughtful engagement in the processes of observing perspectives, attitudes, and beliefs (Paulus et al., 2014). We practiced reflexivity by critically reflecting throughout all stages of the design development. We consistently examined choices throughout design, data collection, and data analysis, opting for those most true to our paradigm and culture of inquiry to capture the purpose of our research. Reflexive practices encourage transparency within the study and research process.

As a research group, we discussed at length our individual and group paradigms, theoretical lenses, culture of inquiry, and methodology which drove this study. Through rich discussion we were able to confer the potential areas of agreement and disagreement among researchers. Thoughtful dialogue also allowed us to reflect on the design process, ensuring consistency through our paradigms, culture of inquiry, and means of data collection to increase reliability (Leung, 2015). During the design and content development we reviewed, edited, and worked collaboratively on all sections while maintaining clear and open communication. We took notes of our decisions and kept all versions of this study as its design evolved. This allowed us to take a final assessment of each step before moving forward with the study in an effort to increase the validity of the research.

To uphold rigor and credibility through our data collection process we contacted and worked in concert with a clinic that specialized in transgender healthcare. To gather the true lived experience of individuals, we asked members from the transgender community to review the questions and language used. In order to establish credibility as researchers, we held a bracketing ceremony before implementation of data analysis to bring forward potential individual and collective prejudices and values that may influence our interpretation of the data. We reviewed these biases before every data analysis session we held, keeping them in the forefront of our minds as we analyzed and interpreted our data. Our thesis includes a Research Lenses chapter stating personal and professional biases that may reveal themselves through the research process. Our Research Lenses chapter also articulates the research paradigm, culture of inquiry, and theoretical lenses used in research design, adding to transparency and credibility within the rationale of our design.

We practiced investigator responsiveness by means of creativity, sensitivity, and flexibility throughout the research design. Our study evolved and took several shapes as we found new perceived gaps in research that led to our final design and research question. Continuous review of literature throughout each step of the research design was crucial as new developments in this field continue to surface.

We used an active analytical stance throughout our research process. After our data collection period came to a close, there were a total of 21 responses. Twenty of the responses met our inclusion criteria. Our maximum number of participants was 300, and we were aiming for a larger *n* size. Engaging in an active analytical stance, we discussed options to further increase our response rate. Ultimately, we opted to not make any changes as we had already sent out a reminder email that did not yield additional responses. We did not feel sending a second reminder email would change our responses in richness or size, so we decided to focus on thoroughly analyzing the responses we did receive.

To safeguard the confidentiality of our participants, we opted to not include participant numbers or aliases in the responses included in our Results or Discussion chapters. In this way, readers would be less likely to identify individuals who partook in this research. Not including participant numbers or aliases discounted the richness of the narrative of our participants, losing the thread that connects the responses into a full story. Mindful to not lose individual voices, we reviewed our themes listed within our results, ensured each participant was represented at least once, and confirmed participants were evenly represented.

Ethical Considerations

Our research participants come from a vulnerable population that is subject to harassment and discrimination (Bradford et al., 2013; Kcomt, 2019). The protection of the participants' anonymity and the confidentiality of their responses was at the forefront while we designed, implemented, and analyzed data for our research study. Each researcher completed modules within the Collaborative Institutional Training Initiative to gain a deeper understanding of research ethics. This training allowed us to understand and be cognizant of the additional risks for the participants of our study. These risks included informed consent, anonymity and confidentiality, coercion, and potential emotional distress as a result of participating in the study.

Informed consent. Creswell and Creswell (2018) detail informed consent as an essential and ethical aspect of research with human subjects. It provides participants with the necessary details of the study, such as benefits and risks, voluntary withdrawal from the study, identifies the level and involvement of participation, and acknowledges the protection of human rights (Creswell & Creswell, 2018).

We obtained electronic informed consent from our participants to protect their anonymity, but this removed the face-to-face interaction between researcher and participant and the option for our participants to immediately ask clarifying questions about the study. To remediate the lack of in-person interaction, we presented an informed consent clarification form within the digital questionnaire that all participants completed before moving forward to the questionnaire. We provided a phone number with voicemail that participants could call if they had questions, and we provided the phone number and email address of the chair of the St. Catherine University Institutional Review Board.

We also listed the risks and benefits of participating in our study and clearly stated that participants could voluntarily withdraw from the study at any time up until clicking “Submit” at the end of the questionnaire. Each participant was given instructions on how to download the consent form and save a personal copy of the document. Since our questionnaire and art-based participatory photograph instructions were delivered and responses were received through an online platform, we subsequently informed the participants that there was a risk of malicious data breach of anonymity and confidentiality by a third party (Mahon, 2014).

Anonymity and confidentiality. Given that we conducted online research with a vulnerable population, we considered it imperative that we implement measures to minimize accidental disclosure of personally identifiable data. Disclosure could result in emotional distress of the participants (Mahon, 2014). To protect the anonymity of our participants, we hired research aides with Collaborative Institutional Training Initiative certification and previous research experience to de-identify questionnaire answers and photograph descriptions; only the research aides and research advisor had access to identifiable data. De-identification of participant responses was completed before any data was released to the researchers. In addition, the research aides deleted photographs with human subjects or identifiable human characteristics. We chose to turn off the Internet browser and IP address tracking in Qualtrics, prohibiting the use of Qualtrics to track the participants to the electronic devices used to participate in the study (Barchard & Williams, 2008). The participants' questionnaire responses, photographs, and photograph descriptions were stored in Box. After data analysis was complete and verified, research aides destroyed all identifiable data.

Risk of coercion. To address the ethical consideration of coercion, our informed consent stated the study was voluntary and participants could close out of the questionnaire at any time without submitting their responses. The instructions and informed consent emphasized that after submitting their response, participants could no longer withdraw from the study. We had the site champion send the link to the digital questionnaire, eliminating researcher and clinic provider involvement. We also informed the participants that taking part in our study did not have any negative or positive impact on current or future relationships with the recruitment clinic or with St. Catherine University.

Emotional distress. We recognized asking participants to reflect on their experiences with gender affirmation care may evoke negative and positive memories of healthcare experiences. As a result, at the beginning of the questionnaire and after submittal, we provided a downloadable PDF of a list with phone numbers and online links to local and national mental health resources. Additionally, participants had the option to stop answering the questions at any time.

Design-Specific Strengths and Limitations

For some in our group, this was the first time designing and implementing a research project. Others had previous experience with research, yet previous studies were not framed or designed similarly. While we worked to incorporate our best reflexive and analytical stances, we also lacked the depth of experience of seasoned or professional researchers. Another limitation was our short time frame. Our data collection period was set for the month of January; we then went into analysis and interpretation. This time frame dictated some of the choices we were able to make. We realized our analysis time frame was too brief to do a robust artistic analysis of the digital uploads, so we analyzed the text accompanying and within the artistic data instead.

Another design choice was to use Qualtrics with open-ended questions. We decided to allow participants to have the greatest amount of time and flexibility we could give during our collection window by allowing them to write answers to their questions regarding their experiences in a time and place of their choosing. However, we understand that writing answers on a smartphone is cumbersome and may have been off putting to potential respondents. Completing a survey through a smartphone or tablet might attract younger generations but may not work well for elders (Regmi, Waithaka, Paudyal, Simkhada, & van Teijlingen, 2016). Our anonymous electronic recruitment without personal connection to our potential respondents may have negatively impacted the response rate.

In order to safeguard participant anonymity, we configured Qualtrics to not ask for participant authentication such as a username or password or collect submission IP addresses. Our configuration of Qualtrics did not prevent individual participants from submitting multiple times or forwarding the link to others. The anonymous questionnaire did not allow for us to see information on how many responses were started and not submitted, so we were unable to analyze rates of abandonment in order to evaluate the digital questionnaire method.

Prior to selecting the online format, we decided that participants’ self-identifying as transgender was sufficient to meet inclusion criteria. Since language is subjective, terms like non-conforming or words from other cultures could also qualify participants. The subjectivity of language might have left non-binary people in ambiguity because they may not know whether we intended to only include male to female or female to male transgender under a binary gender rubric.

We provided a telephone number with voicemail as a means for participants to connect with us. Our instructions informed participants that they may give up their anonymity if they call. This design choice potentially did not allow for immediate clarification, causing a delayed response by the researchers; however, we did not receive any phone calls during the data collection window.

Since our recruitment was via email, potential participants without email addresses could not participate. This could also include people who did not have access to the Internet during our recruitment and data collection period. While we appreciate the recruitment clinic's willingness to send the digital questionnaire link to their clients, we acknowledge that there was a cost to us as researchers. Our reliance on the recruitment clinic and inability to have full visibility into their email generation selection criteria due to medical privacy constraints led to some loss of researcher control in the recruitment process.

In addition to the above limitations, a few participants made comparisons between clinics which we had not anticipated in the study design. We had requested our research aides anonymize the data before we saw it in order to reduce our risk of introducing personal and professional bias in case a clinic or individual was discussed with whom a researcher was familiar. This had the unforeseen impact of making it difficult to discern between clinics when participants went back and forth in their responses. While our research purpose and question are not comparative in nature, de-identified data led to difficulties while engaging in data analysis.

As we are not part of the transgender community, we may have analyzed and interpreted responses differently than members of the transgender community. Compounding our potential differences in analyzing and interpreting responses, the anonymous nature of our questionnaire design negated the ability to take our findings to our participants to strengthen validity and cultural sensitivity. In addition, surrounding our use of the term transgender instead of trans, we were not culturally attuned to the language transgender people prefer. We used language found in research literature which prompted our use of the term transgender. Engaging in dialogue with people in our social and professional networks, we found some trans people prefer the term trans rather than transgender. Lastly, our data and analysis are contextual and not generalizable.

Results

The purpose of this chapter is to describe the results of our study, which asks: What are the lived experiences of transgender adults seeking gender affirmation care at clinics specializing in transgender healthcare? We begin by giving a description of the study participants based on the collected demographic information. Next, we provide observational data. Then, we describe five themes that emerged from our review of the questionnaire data when we inductively and deductively applied van Manen's thematic analysis: *Clinic Operational Experiences, A Sense of Belonging, Participants' Views of Providers*, *Anxiety and Relief,* and *Personal Agency.* Lastly, we discuss the theme of *Lens on Duality* which emerged from the optional arts-informed digital photograph upload.

Description of Participants

We recruited a purposeful sample of twenty-one self-identified transgender adults from a clinic specializing in transgender healthcare in the midwestern USA. A designated clinic staff emailed approximately 300 potential participants. Thus, our questionnaire response rate was about seven percent. One eligible participant completed the demographic form but did not answer our study questions. The anonymous nature of our study design precluded us from confirming the incompleteness of the questionnaire. Consequently, our dropout rate was five percent. As shown in Table 1, the final data analysis sample was conducted on responses from 20 participants who were clients at one community clinic specializing in transgender healthcare. The study sample's race was predominantly white. Half of the participants categorized themselves as young adults. At the time of the research study, almost half of participants had a bachelor's degree and were employed on a full-time basis. Over half lived in an urban environment, while less than half resided in a suburban domain. The majority of participants identified as renters versus homeowners. In addition to synthesizing our demographic data below, we summarize critical observational data related to participants' responses to questions.

Table 1

Participant Demographics

Participant Demographics n = 20	
Characteristics	n (%)
Age range (years)	
18-25	8 (40)
26-35	10 (20)
36-45	1 (5)
46-65	1 (5)
Race	
White	18 (90)
Black	1 (5)
Prefer not to say	1 (5)
Highest level of education achieved	
High school	5 (25)
Community/Technical College	3 (15)
Bachelor's degree	9 (45)
Master's degree	2 (10)
Prefer not to say	1 (5)
Employment	
Full-time	9 (45)
Part-time	5 (25)
Unemployed	1 (5)
Disability/Medical Leave	1 (5)
Student	4 (20)
Housing	
Renter	12 (60)
Homeowner	3 (15)
Prefer not to say	1 (5)
Area of residence	
Urban	12 (60)
Suburban	6 (30)
Rural	1 (5)
Prefer not to say	1 (5)

Observational Data

Here we describe observational data pertinent to our results. Participants spent an average of 24.45 minutes completing the written questionnaire and photograph description, with length of time spent ranging from 3.23 minutes to 92.4 minutes. Responses varied in length ranging from 17 to 627 words, with an average word count of 215 words. Several participants compared and contrasted experiences at multiple clinics specializing in transgender healthcare as well as experiences from non-specialized clinics. Other participants reported their only experience receiving gender affirmation care was from a single specialized clinic. Due to our inclusion criteria, we only analyzed comments pertaining to clinics specialized in gender affirmation healthcare. We recognize the value of the participants' voices, and thus included comments which did not meet the inclusion criteria in observations.

One such instance is that of a participant noting being misgendered by another clinic. As researchers, we could not determine whether the participant described a clinic specializing in gender affirmation; therefore, the comment was not included in our data analysis and results. The above participant reported the misgendering created a space in which they did not feel safe and did not trust the healthcare providers in the clinic.

A second participant commented on being misgendered by clinic staff as they accompanied their significant other to an appointment at a specialized clinic. Although the event took place at a specialized clinic, the participant shared an experience where they were not the primary client at the clinic. We include the above in observational data and not in the data analysis as this participant was in the role of a support person when clinic personnel misgendered them. The participant brought this to the attention of the clinic, and at subsequent appointments the participant was always asked their preferred pronouns. Although this participant was initially misgendered, they reported feeling comfortable expressing concerns. To this participant the correction of misgendering created a welcoming and affirming space for both clients and guests. This participant went on to include experiences of their self as the primary client, which we included in the analysis and results. In addition to noting the above observational data, we discuss six themes that evolved during our analysis process.

Themes

To describe the lived experiences of transgender adults seeking gender affirmation care at clinics specializing in transgender healthcare, we generated six themes. The first theme from the digital questionnaire is *Clinic Operational Experiences,* followed by *A Sense of Belonging, Participants' Views of Providers, Anxiety and Relief,* and *Personal Agency.* From the words within the photographs and written descriptions of the photographs, we created a theme of *Lens on Duality*. The following describes each of these themes and supporting comments from the participants. The term *[sic]* is used throughout the Results chapter to remain true to participants' words, with only minor edits to safeguard anonymity.

Clinic operational experiences. This theme describes the general experiences of participants that pertain to a clinic or access to gender affirmation care, including comments on positive and challenging experiences. Participants made positive comments about gender affirming practices and interactions with staff, secondary support, and the informed consent process. Within challenging experiences, participants commented on: long wait times to establish care, scheduling, and gatekeeping; gender affirming practices; and secondary support. Secondary support includes systems outside of the appointment which may include databases of therapists, aspects of legal support, and online patient portals. The majority of participants made comments pertaining to *Clinic Operational Experiences* within their questionnaire responses. First, we discuss positive experiences. Then, we discuss challenging experiences.

Positive experiences. Participants used terms such as *pleasant, great, positive*, *genuine, recommend,* and *good* to describe their positive experiences within clinical settings. About half of participants made general statements surrounding their positive experiences such as, *My experience has been completly [sic] positive*, and *It's been great! At this point I only want to receive health care from providers who specialize in working with trans people*. Other participants made comments such as, *It's been super helpful to me*, and *I haven't had any difficulties with the clinic itself* when discussing their positive experiences. Some participants voiced more specific comments surrounding their positive experiences receiving gender affirmation care such as, *It has changed my life*. Participants overall report positive experiences at specialized clinics in terms of gender affirming practices and interactions with staff, secondary support, and informed consent.

Participants elaborated on their experiences accessing care, including gender affirming practices at specialized clinics and experiences with staff. One participant discussed inclusive paperwork within clinics, stating, *The forms I fill out have spaces for me to provide how I identify and how I was assigned at birth spots*. Another participant commented on consistent scheduling within the clinic they attend leading to familiarity with their provider. This participant wrote, . . . *and the clinic tries to keep you consistently scheduled with the same doctor so they're familiar with you and your medical history*. Another participant commented on being pleased with their provider's quality of care, also commenting on clinic funding, stating, *[Clinic A] seems underfunded, but they make up for that with a higher level of care provided by my doctor*. The above participants wrote about various aspects of the clinic operations, such as the forms having places for birth-assigned gender as well as current gender identity, scheduling that supports continuity of care, and making up for apparent lack of funding by providing a higher quality of care. Another participant elaborated on their positive experiences:

> *Overall, all these experiences combined give me the impression that the care I receive at [Clinic A] comes from a place of genuine care and sympathy, as opposed to offering potentially mediocre health care for a quick buck, and as such I again can easily recommend [Clinic A] or other similar clinics to anyone who needs healthcare pertaining to one's transgender identity.*

While many participants noted positive experiences with gender affirming practices and clinic staff, the above participant specified the healthcare they received was *genuine* and came with *sympathy*. Participants also discussed secondary support within specialized clinics.

Several participants discussed secondary support systems available to clients. Participants voiced satisfaction over systems offering databases of therapists, legal support throughout the gender affirmation process, and assistance with health insurance and billing. One participant discussed having resources for therapy and legal support, stating, *The secondary support of a database of therapists and legal support as I go through legal changes of identity have [sic] been paramount*. Another participant appreciated assistance with insurance and billing, stating, *People there have always been really helpful to me, talking me through everything from the health insurance and billing process and details they need to the legal processes behind name changes.* Both participants discussed various aspects of secondary support, reporting assistance through changing their legal identity. When discussing the resource of an online patient portal, one participant stated:

> *Lastly, I'm also happy with the services I receive outside of the clinic, such as calling whenever I need to discuss new dosages or to confirm information online via the patient portal. It always helps me feel like I'm in the know regarding my healthcare, and I couldn't ask for anything more. I'm also very happy with the information I'm able to access outside of the clinic, such as with the patient portal website. From here, I'm able to check important information such as future appointments, active prescriptions, and any unpaid bills. It definitely helps in my case since I do suffer from social anxiety, and as such calls aren't always a viable option. In addition, it helps greatly in case the clinic is closed, as I can still access the information I need at any given moment, which helps in times of urgency.*

This participant noted that having an online patient portal helped them feel knowledgeable about their healthcare. Participants discussed informed consent within their responses.

A few participants discussed informed consent as a mode of acquiring hormone therapy. One participant noted the benefits of informed consent within a specialized clinic by stating:

> *By far the most important thing about the gender affirming healthcare I've received is the informed consent basis for acquiring transition hormones. . . . An informed consent basis for receiving a prescription helps to fast-track the process and makes hormones more financially accessible because fewer appointments are required to obtain a prescription.*

This participant highlighted the importance of informed consent in relation to gender affirmation care as it accelerates the initiation of hormone therapy and decreases cost by reducing the number of clinic visits. Participants addressed challenging experiences within the theme *Clinic Operational Experiences*.

Challenging experiences. Participants used words and phrases such as *discouraging* and *fear* when discussing difficult experiences. At specialized clinics, participants reported challenges in terms of access, gender affirming practices, and secondary support.

Participants voiced various access issues including long wait times, scheduling, and gatekeeping. About a quarter of participants discussed long wait times as a barrier to receiving care. Participants used phrases such as *worst aspect* to describe their experiences with long wait times at clinics. When discussing long wait times, participants wrote about the difficulty of finding a clinic with a short wait list. One participant wrote:

> *I first called [Program A], but the six month waiting list was discouraging, and I started looking elsewhere. I posted on [a social media platform] asking if there were any places that would have a shorter waiting list, and one commenter directed me to [Clinic A]. I was able to get an appointment in the beginning of July, so in the end it hadn't saved me much time, but having the appointment scheduled was a huge relief for me.*

This participant had difficulty finding a specialized clinic with a short waiting period, ultimately waiting an extended time for their first appointment. Other participants reiterated the challenge of long wait times by stating, *The worst aspect was being able to recieve [sic] the healthcare in the first place. For my first apointment [sic] i [sic] had to wait a very long time.* A second participant shared, *Honestly, the only problem I've ever had with specialized clinics is getting in the door*. These participants all had difficulty getting an initial appointment.

In addition to long wait times, one participant brought in the factors of affordability and insurance while accessing gender affirmation care. This participant wrote:

> *When I was first looking for hormone care, I was confused about how insurance would work with the initial clinic that I applied to, and ended up cancelling my appointment*

> *after some time waiting in fear that I wouldn't be able to afford to see a doctor. Fortunately I didn't give up and I later made an appointment with [Clinic A] though I did have to wait a few more months before there was an opening.*

This participant was concerned they would not be able to be seen, as they could not afford the cost of care. When this participant was able to navigate insurance and afford an appointment, they dealt with an extended wait time similar to what other participants reported.

One participant voiced concern of accessibility of the clinic they attend due to scheduling. This participant stated that not having an online way to schedule an initial appointment at a clinic is not accommodating individuals with social anxiety or vocal dysphoria:

> *Honestly, the only non-ideal thing I can think of is you have to call in to make an initial appointment instead of having some sort of web form as an alternative option, since the latter would be easier for people with social anxiety or substantial vocal dysphoria to get their foot in the door. But even on the phone they're nice and understanding, so it's not like they're intentionally trying to make it harder.*

This participant indicated that having a different means to schedule appointments could also increase accessibility.

One participant, who self-identified as non-binary, discussed the concept of gatekeeping:

> *I had a consult with someone to determine whether I would be a good 'fit' for their transgender healthcare clinic and at first it felt like it was very gatekeeping, like people who say you need dysphoria to be trans and that nonsense. It made sense looking back on it now, though.*

While this participant was previously concerned that gatekeeping was a barrier to access a clinic, with hindsight they were able to see why this clinic policy was in place. This participant also faced another challenge while accessing gender affirmation care. Continuing in their response, they discussed an experience where a clinic used their birth name rather than their preferred name, colloquially known as using dead names. This participant voiced:

> *There are still missteps, such as systems programmed to use dead names or medical staff not entirely knowledgeable about trans healthcare, but personally if I've chosen to put my care in the hands of transgender healthcare specialized clinics I feel pretty safe and confident that I'll be treated with care and dignity.*

This participant discussed challenges while receiving gender affirmation care but despite these experiences still felt comfortable within specialized clinics.

One participant further discussed secondary support as a challenge within specialized clinics. This participant felt that the clinic's online portal has poor usability stating, *[Clinic A's] online portal for test results isn't easy to navigate*. This participant voiced improvements could be made to secondary support options. Participants' experiences within clinic settings contributed to fostering a sense of belonging.

A sense of belonging. Our definition of *A Sense of Belonging* includes wholesome healthcare experiences that begin with the establishment of inclusive spaces. These spaces encapsulate a physical domain that is safe and open. Furthermore, one participant shared, *even the atmosphere of the place feels more welcoming than other health clinics, maybe its [sic] because there's not really a lingering antiseptic smell.* The definition includes personable interactions with clinic staff who are authentic, compassionate, and supportive. A sense of belonging fosters feelings of respect. Additionally, our definition encompasses a level of comfort to share one's gender identity without concern of being misgendered, and the ability to actively engage in asking questions regarding one's healthcare.

Half of our study participants wrote narratives depicting the importance of a sense of belonging. For example, three participants concisely shared the significance of how a safe, open, welcoming environment, and respectful atmosphere supported the perception of a sense of belonging. One participant stated, *I feel like my identity is [sic] respected, and the fact that many employees are also queer and trans I feel very at home with the staff.* While the second participant wrote, *I did not know I could be so comfortable in a health care setting as I have been* . . . [and the] *staff are phenomenal.* Lastly, the third participant shared, *I feel safe knowing that there are many health care professionals in this clinic who are educated and patient with trans people, regardless of their age or life experiences.*

A number of other participants also supported the notion of clinics as welcoming inclusive spaces. These participants extended the conversation to include the importance of a compassionate and supportive staff. In addition, the value of being in spaces where *I feel like the staff at the clinic understand [sic] how important getting names and pronouns right are,* which encapsulates the essence of a sense of belonging.

The following few quotes capture the experience of not being misgendered: *The staff were very kind and understanding of my needs as a trans person. I was referred to by my chosen name at all times, and have been not [sic] been misgendered by them.* While the other participant shared … *as well as not making assumptions about what type of gender affirmation care someone is getting (i.e., "which way" they are transitioning).* Another quote illustrates the magnitude of not misgendering:

> *[Clinic B] has always provided me with opportunities to use the name and pronouns I have chosen, and never requires me to identify myself with a name I do not use in front of a large group of people. I feel incredibly comfortable coming into [Clinic B] because it*

> *feels like I am in a community space where I will not/cannot be harmed by outside forces. Almost all walls and tables declare a message that promotes inclusion and radical acceptance, which tends to put me at ease. . . . I wish that I could have a primary care provider at [Clinic B] because of how welcomed and not out of place I feel there.*

Another participant underscored the importance of gender-neutral language:

> *I love that when I arrive other people's pronouns are available to me with out [sic]effort. The clinic makes it the norm to use gender neutral phrases and make others who might not be there for the same care aware that neutral pronouns are preferred unless stated otherwise. . . . It make [sic] me feel safe.*

The subsequent passage endorses the significance of inclusive spaces, embracing the act of not misgendering and the inclusion of staff who are *trans themselves*:

> *There is absolutely something to be said about being able to go to a clinic that has specific care for transgender individuals. As much as we are currently trying to have transgender identities be accepted in the public eye--I still often feel the pressure of being identifiably trans in public spaces; even with the expressed purpose of seeking gender affirmation healthcare. On an average basis--its [sic] just hard to tell who will or wont [sic] be accepting or even understanding among a random selection of strangers. So finally the point I'm getting to: being able to come to a clinic where I'll be identifiably trans (if only because I'm seeking trans-related healthcare), but also know that the people there are already very excepting [sic], if not also trans themselves in some areas, means a lot. . . . It's a safe space, and I feel more at ease with my surroundings and myself being there.*

Whereas, another participant expanded on the conversation of inclusiveness by comparing welcoming environments to environments that use non-respectful language. The use of ineffective therapeutic communication is illustrated in the following quote, *[Clinic A] was the only clinic that was willing to see me when I came out. The other clinics I went to said things like you're too fat to be transgender and this really isn't you.*

The words etched within the passage of a different participant who self-identified as a transgender woman embodies the theme *A Sense of Belonging.* The following participant illustrated a sense of belonging as their identity being respected.

> *Not only did I feel safe talking about my gender identity and any potential issues I've had on hormone replacement therapy thanks in no small part to the welcoming atmosphere prevalent throughout the clinic, I also have great things to say about the staff working there, as they've been very respectful of my identity and my initial request to hide my preferred name from my mother, who at the time was unaware of said name.*

Participants portrayed safe spaces as mindfully creating an environment filled with staff who are authentic and open minded. Inclusive and holistic spaces serve to support collaborative relationship building with therapeutic interactions where transgender people can feel . . . *safe talking about* [their] *gender identity and any potential issue* . . . Similar to other participants, the words within the above narrative echo how a safe and inclusive space helps transgender people to authentically speak about their gender identity. Inclusive spaces include informative interactions with healthcare providers.

Participants’ views of providers. This theme describes the participants’ views of healthcare providers that work at clinics specializing in transgender healthcare. We define this theme as providers’ knowledge of best practices relating to clients’ physiological and psychological needs along the transgender healthcare continuum. We further define this theme as reciprocal relationship building between providers and clients resulting in client-centered care.

Almost half of the participants individually defined their lens of providers using terms such as *knowledgeable*, *thorough, humble*, *understanding, kind/caring, invested,* and *provide options.* Two respondents provided narratives that summarize this theme. One participant spoke of their doctor as attentive and encouraging of the client's participation when creating a treatment plan, stating, *It felt like my doctor cared what happened to me, which was a foreign experience. My doctor listened to my concerns and gave me options to pursue. She also gave me a voice in how my treatment was proceeding*. A second participant highlighted a holistic approach to their healthcare as a bridge to wellness:

> *My doctor is knowledgeable, kind, and is very focused on understanding my needs in order to provide the best possible care. My doctor also made sure that my health as a whole was taken into account, not just things directly related to my transition, and I've been able to improve my health and quality of life because of it. In situations when my primary care physician would be more helpful, my doctor wrote a letter, specifically making sure to keep my transgender status confidential.*

The above participants described the care they received from providers who actively listened to their concerns, specifically expressing appreciation for an inclusive approach to healthcare. Another participant also defined this broader client-provider connection as the provider *knowing them well*, allowing for conversations about their *overall life* by embracing discussions about topics that are *not directly connected to physical health at that time* [of appointment]. A respondent echoed this sentiment, stating their provider *always remembers* them, despite a large caseload. A third participant specified that their provider had *good bedside manners*. Participants described gender affirmation healthcare providers as knowledgeable, caring, and invested in the well-being of the client.

One participant further highlighted the importance of a supportive provider, stating they appreciated, . . . *not having to worry about* . . . *doctors that dont [sic] liksten [sic] or react negativly [sic].* Additionally, one participant described how their provider expressed interest in their healthcare outcomes stating, *I also feel like my health provider is excited for me and my results, and when I share my experiences, they are invested in me getting the outcome I desire.* While several participants conveyed a positive, engaging relationship between client and provider, one respondent voiced a feeling of unease due to disjointed care:

> *That said, I do have some qualms about [Clinic A]. First, my doctor doesn't finish paperwork in a timely fashion, so learning what my test results are can be difficult. I also have to call in to get my results, instead of being called like they said they would. . . . My doctor also only has one day a week of work at [Clinic A], so it's difficult to be seen by her if she gets sick and cancels my appointment. I have had to be seen by another doctor, which felt really uncomfortable since I haven't built a relationship with them and speaking frankly felt weird.*

The same participant highlighted the need for communication between providers and clinics as a way to ensure coordinated care, specifically for clients who identify as non-binary:

> *I think it's also important that providers work with each other, even outside of their own clinic, to get help on how to individualize hormone therapy. For instance, I am non-binary and my hormone therapy preferences differ from those who are a trans woman. Being non-binary seeking hormone therapy means I'm fairly unique, so getting advice from other providers who have experience with people like me would help improve my*

> *transgender healthcare experience. I think that clinics that specialize in transgender healthcare should share and have access to each other's non-identifiable hormone therapy best practices to better streamline individualized hormone therapy plans.*

The above participant noted areas of improvement such as provider follow up, limited appointments, and provider to provider communication to better manage hormone therapy. Several participants highlighted the importance of supportive and engaging providers as imperative to alleviating anxieties associated with gender affirmation.

Anxiety and relief. Our theme of *Anxiety and Relief* encompasses anxiety inducing aspects of transgender-related care, including experiences with the clinic itself as well as the quality of healthcare provided. As a noteworthy theme, approximately one third of participants' responses included an aspect of anxiety or relief. Almost all of the participants who expressed anxiety or stress surrounding gender affirmation related healthcare also reported feeling a sense of relief or ease from the clinic or staff.

One participant described the overall anxiety inducing period leading up to the time of gender affirmation care:

> *The time before acquiring a hormone prescription is a very anxious time for many trans people. At least for my best friend and I, there was this feeling of being stuck in limbo, and the thought that it might never happen constantly hangs in the back of your mind, and at times it can feel like the hope of getting on hormones is the only reason to keep going.*

Participants reported anxiety surrounding gender affirmation care itself as well as characteristics of healthcare clinics. One participant commented on how the staff at the clinic helped create a sense of ease during an anxious time:

> *Everyone at the clinic was really nice and helpful from the start, which is pretty critical for healthcare for people predisposed to anxiety. Even though I'm always worried in medical settings, [Clinic B] somehow manages to make me feel at ease.*

A second participant noted, *The whole exp [sic] was pretty anxiety inducing, but my clinician was pretty understanding.* The above participants acknowledged a sense of anxiety relating to their healthcare experience and described staff and providers at the clinic as providing compassion and relief.

Several participants reported receiving gender affirmation healthcare from both non-specialized and specialized clinics. One such participant reported the clinic specializing in gender affirmation healthcare *helped to guide me through the early transition stages which really helped with my stress level.* Additionally, some participants have only received care at clinics specializing in gender affirmation care. A participant who reported receiving gender affirmation care solely at a specialized clinic voiced anxiety regarding initially receiving the right healthcare. This participant stated:

> *Personally, as a transgender woman I have not had healthcare pertaining to my transgender identity before receiving healthcare at [Clinic A], so I am unable to confirm any comparisons between trans healthcare from clinics that do specialize in trans healthcare and those that do not. I can say that, as someone who was initially very nervous and worried about getting the right healthcare, I can easily recommend [Clinic A] or any other clinic specialized in trans healthcare to anyone who is transgender and is in need of healthcare.*

Although one of the above participants received care at both specialized and non-specialized clinics, and the other received care only at a specialized clinic, both participants expressed a sense of relief from the care they received from clinics specialized in transgender healthcare.

Further, several participants described the specific ways in which they perceived their healthcare as anxiety reducing. One participant elaborated how the clinic helped ease their anxiety:

> *One example is when I initially made my first appointment, I was still living with my family at home, so they were unaware of my preferred name. I brought this up to the staff at the clinic and they made sure to only use my preferred name in private until I was ready to tell them, which I did shortly after receiving healthcare there. It helped me feel much more comfortable during a time where I felt very nervous and unsure, due to both my desire for trans healthcare and perceived issues with my health at that time.*

This participant described how their experience at the clinic helped ease their fears surrounding their health and gender affirmation care as they felt anxiety about their identity. One respondent explained how the healthcare they received led to an overall higher quality of life:

> *It has helped me discover a great deal about myself including some mental health issues I've never acknowledged and I'm living such a higher quality of life these past couple years I can hardly tell you how freeing that is.*

The above participant discovered underlying mental health concerns through their experience with gender affirmation healthcare, and in turn they were able to reflect and feel liberated. Participants wrote about their lived experiences prior to connecting with the clinic and brought these experiences with them as they engaged in care. The clinic team provided a sense of relief to participants' anxieties and positively contributed to their quality of life. An additional dimension of these lived experiences is personal agency.

Personal agency. The theme of agency emerged from participants' descriptions of feeling informed and empowered to make independent choices about their healthcare. Roughly half of the participants included personal agency in their responses. One participant reported having uncertainty around starting testosterone treatment, colloquially called *T*:

> *After getting a thorough understanding . . . she helped come up with a plan for starting T that I was comfortable with. That plan allowed me to start on a really low dose and see how it felt. I went into that appointment with the goal of learning more about T and I walked out wanting to start it. She didn't pressure me in any way, she just took the time to understand where I was at. She gave me the option of starting at a low level, as well as helped me better understand the potential effects. Together it gave [sic] helped ease my concerns enough for the excitement I had about the idea to come through. Once I started T I never looked back. I upped the dose at each following visit, and now I'm steady at a dose aimed at full masculinization.*

Here a participant highlighted the importance of making an informed decision. This participant reported feeling as if the provider left space open for questions, provided a non-pressuring appointment, and gave their client options. Another participant described two examples of agency in their overall interactions within the clinic:

> *One really unique thing I experience at [Clinic A] is that whoever is taking my vitals always lets me hold the temperature gauge in my mouth. It is such a simple thing that gives me some autonomy in my healthcare. Additionally, whenever anyone at [Clinic A]*

> *needs to touch me for some reason or another, they always check with me to see if it is okay. It empowers me to say no if I need to.*

Here, the participant highlighted how small actions like holding a thermometer can allow for agency in their care.

While the above participant indicates they were empowered to decline a provider's request, another participant felt differently. The second participant, who attended a few clinics, wrote comparisons between their experiences at each site. The participant stated that each clinic specializes in transgender care.

> *At various times at [Clinic A] and [Clinic C], the provider I was seeing had a student observing them. I was always asked if I was comfortable with the student being in the room with me but never felt like I could say no. I discussed incredibly personal things with my provider there that I typically would not want a complete stranger to know about me, but I didn't feel like I had the ability to say no. I have not yet experienced a student observer at [Clinic B], but I know that if I was asked if they could be there, I would be able to say no. I don't think that trans people have the option to say no in most cases. We are constantly pressured by more powerful forces to do what we need to in order to survive. Having choices and autonomy should not be a radical thing, but it is, and [Clinic B] does that radical thing.*

The above participant described feeling pressured to disclose private information to their provider in front of other people. Although the ability to request the students to leave was technically available, the participant indicated it was not presented in a way that was conducive to feeling free to exercise this right. The participant emphasized that the ability to say no to something is rare for transgender people due to power dynamics, highlighting how Clinic B is radical in offering choices and autonomy.

Another participant expanded on the above experiences writing, *She also gave me a voice in how my treatment was proceeding. For instance, I wanted to try a new drug to help stimulate gender affirming body changes, and she felt that it would be OK to try it, even though there weren't many studies on it. This level of engagement gave me advocacy for my health.* This participant reported the ability to co-create a personalized treatment protocol.

An additional aspect of *Personal Agency* participants voiced is one of self-discovery and improving self-expression. One participant stated:

> *I guess the big part of the journey is getting the tg* [transgender] *healthcare I need to feel more comfortable with myself as I try to shuffle/undo nearly 30 years of my body living on non-conforming hormones. If I can get to the clinic and feel safe and comfortable expressing my actual feelings there... well, then the rest just follows from there.*

Another participant wrote about freedom and happiness, asserting, *i [sic] feel like I'm freeing myself. I felt trapped in the wrong body my entire life until now. I am taking testosterone and it [sic] now been 11 months. I feel so much happier being a self made man.* ♡ The above participants reported feeling more comfortable and happier with themselves after receiving gender affirmation care and used a heart emoji for emphasis. The sum of the experiences highlighted above encapsulate the theme of *Personal Agency*. In addition to the above discussion regarding the written responses to the digital questionnaire, a theme of *Lens on Duality* arose from the arts-based aspect of our study.

Lens on duality. The final theme, Lens on Duality, materialized when we thematically synthesized the texts describing the photos and within the digital uploads. Lens on Duality is defined as contrasts, transitioning and navigating through space in life not as a fragment but within greater forces of light and darkness. In order to discuss the photographs, we created a title for each digital upload using the words of the participants.

We saw the theme of duality in the description of Figure 1, presented as Super Heroes: I do a photo series of super heroes suffering intense moments of existentialism. I feel like it’s a great metaphor for how it doesn’t matter how powerful a person is, mental health can affect anybody. For a superhero to not feel the value of their own existence shows duality between the physical strength and the awareness that mental health is a concern for all.

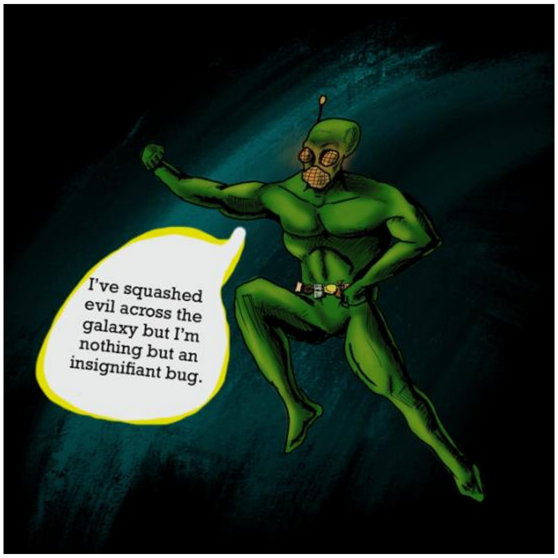

Figure 1. Super Heroes

The text within Figure 1, *I’ve squashed evil across the galaxy but I’m nothing but an insignificant bug*, shows duality between the galaxy and insignificance.

Figure 2, A Collage of Flowers, also had dualism in the text:

> *A collage of flowers, a lake, and a human shadow over flower petals. There are yellow flowers to the left of the photo and pink flowers to the right. Under the human shadow is a shadow of a pink flower leading into a rainbow's refraction.*

Figure 2. A Collage of Flowers

The concept of a shadow implied an absence, but it also implied the presence of something blocking the light. It represented duality in that there was a presence of the person implicit in the blocked-out figure caused by the absence of light. Similarly, the refraction of a rainbow implied a not seen object that caused the light to be different. Lastly, the yellow and pink colors of the flowers formed a duality with the darkness in the shadow.

While Figure 2 was accompanied by a descriptive text, the uploader of Figure 3 gave religious context to frame their photograph. *My religious upbringing always made me question my feelings with my gender. Catholic school allowed me to wear pants in 80's [sic]. Seeing Rome and Vatican City was a big deal to me, despite losing my religious beliefs.*

Figure 3. Seeing Rome and Vatican City

The duality of having and losing faith speaks to the participant's experience of seeing a religious epicenter, and how it is still meaningful even after faith is no longer a part of their life.

Figure 4 had the accompanying description, *Its [sic] a collage i [sic] made. Its [sic] super gay, as am I. I made it with my friends.*

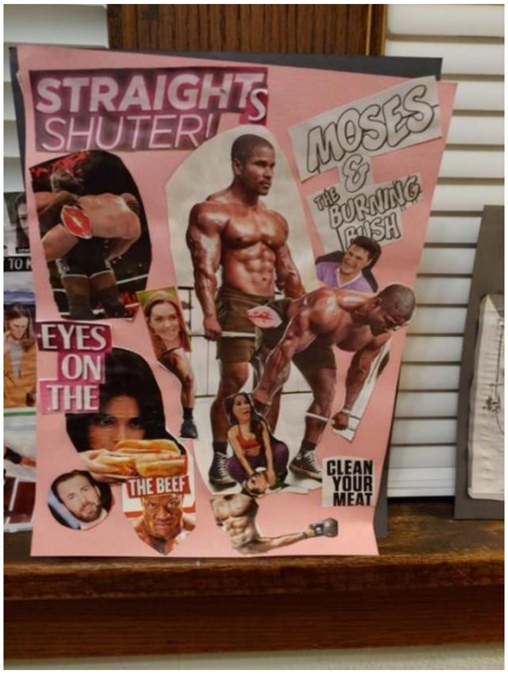

Figure 4. A Collage I Made

The texts within Figure 4 say: *STRAIT(S) SHUTER; EYES ON THE, THE BEEF; MOSES AND THE BURNING BUSH;* and *CLEAN YOUR MEAT*. Here, the apparent double entendres for male and female anatomy encompasses *Lens on Duality* between the explicit meaning and the hidden meaning. While this duality is inherent in all double entendre, we also noticed a second dimension of duality within the words on the collage as they referenced both male and female anatomy.

In sum, the theme of a *Lens on Duality* was apparent in the contrast between cosmic and a bug, the inherent presence in absence in the shadow, the meaning of religion even after the loss of faith, and the double entendres as they referred to male and female anatomy.

In this chapter we described participants' demographic information and observational data. Thereafter, we applied van Manen's thematic analysis to the data, deriving six themes: *Clinic Operational Experiences, A Sense of Belonging, Participants' Views of Providers*, *Anxiety and Relief*, *Personal Agency,* and *Lens on Duality*. The themes highlighted the importance of the way in which clinic teams assisted in improving overall life quality for participants, partnering with providers, and personal choices.

Discussion

The purpose of this chapter is to interpret the results of our study to answer our research question: What are the lived experiences of transgender adults seeking gender affirmation care at clinics specializing in transgender healthcare? We begin by discussing findings supported by the research literature. Next, we discuss unanticipated findings. We then discuss implications and end with our conclusion.

Findings Supported by the Literature

In this section, we first discuss clinical processes which inhibit or promote access to gender affirmation healthcare and their correspondence with the existing literature. We then discuss psychosocial well-being within the framework of word choices and interactions with clinical personnel.

Clinical processes. To the study participants, long wait times were a discouraging and negative aspect when seeking gender affirmation care. Participants reported the negative impacts of not being able to be seen by a provider or begin hormone therapy as exacerbating stress surrounding gender affirmation. Blodgett et al. (2018) and Eyssell et al. (2017) likewise report transgender clients encountering long wait times to receive gender affirmation care. Noonan et al. (2018) and Sanchez et al. (2009) discuss long wait times potentially stemming from lack of knowledgeable healthcare providers who understand the needs of the transgender community. Many participants looked for clinics with short wait lists but had difficulty finding a clinic where they could be seen quickly. Our study participants discussed an informed consent model as a means to counteract the long wait times they face and speed up acquisition of hormone therapy. Consistent with Reisner, Bradford, et al. (2015), who discussed modified informed consent significantly increased the number of individuals who accessed gender affirmation care at

Fenway Health, our participants indicated that informed consent fast-tracks receiving gender affirmation care, ultimately improving their quality of life through hastening the timeline to receive care.

One participant discussed coordinated care at the clinic they attend within the framework of consistent scheduling with the same provider. Coordinated care improved this participant's experience. Transgender individuals often need to piece together their care teams (Noonan et al., 2018) and lack coordinated care (Gridley et al., 2016). However, our participant indicated the specialized clinic they attend offers consistent scheduling and care coordination, overall enhancing their experience.

Similar to other specialized clinics which offer secondary support systems such as social work, referrals to outside providers, health promotion programs, and mental health support (Mayer et al., 2001), participants indicated that the clinics they attend offer secondary support systems, mentioning online patient portals, legal support, databases of therapists, and assistance with insurance. Participants generally liked having access to secondary support systems and felt the systems offered assistance and enhanced participants' experiences in areas other than primary healthcare needs. However, some participants thought clinics could improve secondary support systems.

Clinics do not always have spaces for preferred names and gender markers on intake forms. One participant discussed this when they were misgendered by a clinic. This study affirms other researchers' findings that intake forms and charts designed along static binary gender identities are associated with negative experiences for both providers and transgender clients (K. R. Clark et al., 2018; Rosendale et al., 2018; Samuels et al., 2018).

Psychosocial well-being. Woven into our participants' narratives was advocacy for the healthcare community to support the physical and mental well-being of transgender people. Participants commented that their physical and mental health improved after connecting with healthcare providers at clinics specializing in gender affirmation care. The participants focused on two facets that contribute to psychosocial well-being: word choice of the healthcare team and interpersonal interactions with staff and providers.

Words matter. Individually and collectively, the lived experiences of our participants emphasized valuing a sense of belonging. Participants viewed safe and inclusive spaces as going beyond the comforts of a physical environment. Participants portrayed safe spaces where staff and healthcare providers are mindful of word choices and not misgendering, facilitating respectful and therapeutic interactions. Conveyed in our results are the effects of language on a transgender person. The analysis of our participants’ transcripts supports the literature that SDOH negatively impact issues related to gender inequity (DeSalvo, 2015; Felsenstein, 2018; ODPHP, 2019; White Hughto et al., 2015). The current research demonstrates that transgender people face social stigma and discrimination in the healthcare sector (Aylagas-Crespillo et al., 2018; Felsenstein, 2018; Howard et al., 2019), leading to adverse consequences regarding the health of marginalized people (Logie et al., 2019; ODPHP, 2019). Hancock et al. (2017), Logie et al. (2019), and Manzer et al. (2018) led us to reflect on the value of word choices specific to transgender people.

Our study results are consistent with Hancock et al. (2017) and Logie et al. (2019), who found that respectful and trusting interactions include language that is specific to a person’s stated gender identity. Our findings substantiate that gender-specific language is essential in supporting transgender people’s identity, expression, and sexual orientation. Additionally, as illustrated in our results and supported by the research literature, communication should reflect the language that a person self identifies with such as transgender woman, transgender man, two-spirit, genderqueer, genderfluid, and non-binary (Diamond & Butterworth, 2008; Manzer et al., 2018; Reisner et al., 2016; Winter et al., 2016). The conscious use of gender-inclusive language proactively averts the use of discriminatory gender-specific language and supports therapeutic interactions.

Therapeutic communications facilitate transgender people feeling safe to speak about gender-specific identity needs. Bith-Melander et al. (2010), Cruz (2014), and Logie et al. (2019) acknowledge that mental well-being can be linked to a person's gender identification. Our results confirm the findings of Elder (2016) and McCullough et al. (2017), noting that respectful and therapeutic communications support mental health well-being. Our study participants valued not being misgendered and appreciated holistic interactions built on therapeutic communications. In the words of a participant, *I was referred to by my chosen name at all times, and have been not [sic] misgendered by them.* Another participant shared . . . *just hard to tell who will or wont [sic] be accepting or even understanding* . . . reflecting how words matter and can be anxiety-provoking. A primary aspect of human interactions involves verbal communication. Consequently, nontherapeutic communications, whether intentional and or unintentional, from staff and healthcare providers may serve to increase mental health distress in transgender people (Elder, 2016).

Interpersonal interactions with staff and providers. Similar to results reported by Blodgett et al. (2018) and Romanelli and Hudson (2017), our study participants appreciated reciprocal connections with healthcare providers, defining these interactions as open and engaging conversations. The conversations allowed time for client education and encouraged autonomous decision making, empowering clients to make informed healthcare decisions. One participant felt supported by their provider when starting on hormone therapy because the provider and participant engaged in open dialogue about dosage options and care goals. Congruent to findings reported by Hudson (2018), our participants realized informed care was offered through the individualized and inclusive healthcare model provided by clinics specializing in gender affirmation care.

Eyssell et al. (2017) reported participants' apprehension of specialized clinics becoming institutionalized, focusing on standardized diagnoses and processes rather than individualized treatment. In contrast, our study participants reported the desire to receive inclusive care from experienced providers at clinics specializing in gender affirmation care. Similar to results reported by Coleman et al. (2012), Hembree et al. (2017), and Shuster (2016) our participants embraced the idea of experienced providers looking at recommended treatment guidelines as a customizable care plan template rather than a rigid format and placing trust in the client to choose their course of treatment. For example, a few participants commented on having the option to choose the hormone therapy timeline they desired and to utilize treatments that were not widely studied. In addition, our results show inclusive and individualized healthcare helps mitigate mental health concerns that often arise when people seek gender affirmation care.

Several of our study participants reported a sense of anxiety surrounding their gender affirmation, extensive wait times to get an appointment at a clinic specializing in transgender care, and general experiences with healthcare. Through an art-based photograph, one participant highlighted that no one is immune to mental health challenges, including people with inherent physical strength or perceived power. The report of anxiety is congruent with results reported by Beagan and Hattie (2015), Christian et al. (2018), and Reisner, Vetters, et al. (2015), who state that transgender individuals experience high rates of anxiety and depression. One of our participants specifically commented on feeling at ease at their clinic, emphasizing the importance of an inclusive approach as it helps dissipate feelings of anxiety. The majority of participants who reported anxiety also reported a sense of relief provided by the positive interactions with healthcare staff. These statements affirm results reported by Christian et al. (2018), who highlight the positive effect inclusive providers have on the physical and mental health of transgender clients. Physiological and psychological health are part of the triad of holistic care. Spiritual health, often forgotten in transgender healthcare, is the third equally important component of holistic care.

Bockting and Cesaretti (2001) report transgender people experience a disassociation between mind and body leading to a divide from spirit when first exploring feelings of disconnect between the felt gender identity and birth assigned gender. Furthering this unease, religion may foster feelings of shame, guilt, and a detachment from felt gender identity (Beagan & Hattie, 2015). Rosenkrantz et al. (2016) assert that religion may contribute to damaging experiences among transgender people but thinking of positive religious or spiritual experiences can help heal and reconnect the mind, body, and spirit. This is echoed by a participant in our study who struggled with gender identity while raised in a home that practiced the catholic faith. Despite a departure from previous religious beliefs, the participant still appreciated a trip to Rome and Vatican City, perhaps placing some value in their religious upbringing. Rosenkrantz et al. (2016) further report that religious and spiritual practices help transgender people find a true sense of self-identity. Halkitis et al. (2009) expand on this idea of faith but suggest a spiritual belief, not a religious practice, is imperative to the well-being of transgender people.

Unanticipated Findings

With a phenomenological approach to our research question looking for the lived experiences of transgender individuals, we anticipated our participants' responses to focus on experiences with providers and staff. However, a sizable number of responses mentioned clinic operations. Many of our respondents included information about patient portals, dead names, online databases and support systems, inclusive paperwork, and access to the clinic itself.

A single participant voiced the belief that GD is not essential to transgender experiences. As the research literature generally regards a GD diagnosis as a necessity for gender affirmation care (Castañeda, 2015; Newsome et al., 2018; Roberts & Fantz, 2014), we did not anticipate a participant vocalizing this aspect of their experience. In contrast, the expedited informed consent model for transgender health does not view the presence of GD as necessary in order to commence treatment (Schulz, 2017). Though the idea corroborated by the expedited informed consent model is less prevalent in the literature, the informed consent model supports this participant's response.

Implications

In this section, we first discuss general implications. Thereafter, we narrow our focus on healthcare providers and holistic health. Last, we discuss implications for future research.

General implications. Based on our study results, a preliminary step to support transgender people in receiving better healthcare is to create inclusive spaces that focus on gender affirming oral and written communications. We offer examples of inclusive language that we crafted based on our participants' lived experiences. To begin, we recommend using gender-inclusive language or language that is not gender specific (e.g., they/them/ze, friend, folks, a person's stated name, all, y'all). The use of inclusive language can be incorporated into word choices in both verbal and written formats. We also advocate for the use of a person’s stated pronoun (e.g., they/their, she/her, his/him, he/she/zie) as part of verbal introductions, name badges, door and desk tags, and e-signature blocks. The website MyPronouns.org offers suggestions and resources for pronoun use in verbal and written communications. Furthermore, offering interactive workshops to all members of a healthcare team regarding gender-neutral language and therapeutic communications will serve to support transgender-specific healthcare needs. The organization JustUs Health offers workshops for healthcare professionals. Additionally, inclusive spaces incorporate gender specific modifications on intake forms and patient portals.

On comprehensive health intake forms, it would be beneficial to include space to record current name and gender identity along with name and gender assigned at birth. It is also important to know whether the current name and gender identity are private and should not be used in front of others. To maintain confidentiality, before calling to speak with a client, clinic personnel should confirm and document which name and pronouns to use when directly communicating with a client, family member, or leaving a voicemail. With the focus on patient portals, we also recommend clinics evaluate their systems to see if portals can be made more robust and user friendly. Patient portals should be able to accommodate gender identities and gender assigned at birth as well as information about clients’ care continuum and privacy concerns. Along with changes made to the patient portals and intake forms, clinics should also reexamine clinical processes.

We recommend that clinics specializing in transgender healthcare evaluate factors impacting access and wait times such as the number of available providers, insurance and cost, and an informed consent process to determine how they may affect clients’ ability to receive care. We also recommend consistency in provider-client appointments to support continuity of care. Using preferred pronouns, providing appropriate spaces on intake forms and patient portals, and restructuring clinic processes all help to provide an inclusive space. Inclusive spaces embody the essence of restorative interactions in healthcare between transgender people, clinic staff, and providers.

Implications for healthcare providers. Our research participants highlighted the importance of providers partnering with clients to achieve better health outcomes. Participants reported trans-affirmative providers facilitated an understanding of the interrelationship between the clients' lived experiences and gender identities. Fostering a client-provider partnership also allowed clients to have personal agency in their healthcare. Therefore, we recommend providers promote reciprocal relationships to support their clients' autonomy.

To help empower clients and promote a connection between the mind, body, and spirit, we recommend all providers support trans-affirmative mental health services and administer a religious or spiritual assessment upon intake, such as the *Spiritual Well-Being Scale*. As part of a holistic and inclusive approach to healthcare, providers should then work collaboratively with clients to design a care plan that encourages whole-person care.

Implications for holistic health. St. Catherine University is a historically women’s university. As such, the holistic health studies program at our university should reevaluate its curriculum to make sure that discussions of gender are inclusive of transgender people. In addition to a self-review, we recommend our program increase the number of transgender-related workshops or invite members from the transgender community to give lectures. The above can help educate the university community regarding transgender related health needs. Additionally, our university should incorporate pronouns on admission forms and encourage students and staff to include pronouns on class assignments, thesis and dissertation title pages, research presentations, posters, and publications such as articles and books.

To foster a sense of belonging, holistic practitioners should ensure that their practice spaces, whether community- or home-based, are friendly and welcoming for transgender people. The focus on client intake and medical records from the medical discussion above also pertains to holistic practitioners who may need to change their record-keeping to reflect the identities of transgender people. For example, practitioners should offer their pronouns upon introducing themselves to clients, ensure confidentiality of clients' gender identity and chosen name, and modify intake forms to include clients' gender identity and gender assigned at birth. Some holistic practitioners work outside of medical practices and often have different, less formal electronic medical record (EMR) systems.

Implications for future research. Having undertaken this study, we recommend moving research forward with the transgender community. Researchers should partner with the transgender community to develop research that moves the community's voice forward in a way trans people want to be seen and heard. Additionally, there is little research in the area of transgender health and connection to spirituality (Beagan & Hattie, 2015) and the potential importance in joining the mind and body, which are often in conflict for transgender people struggling with assigned versus felt gender. Due to the significance between the mind, body, and spirit connection, we recommend further research in the field of spiritual care and its potential to be a significant component of whole person care for transgender people. In addition to expanding research in mind, body, and spirit connections, further research opportunities exist in the area of clinical operations.

From the comparative statements of participants who went to more than one clinic, a further research project could expand to multiple recruitment sites in order to compare and contrast transgender clients' experiences. The focus participants placed on clinic operations at specialty clinics warrants further research. Medical systems are redesigning their EMR systems, transitioning from a binary paradigm to one that is inclusive of diverse gender identities. Further research could focus on the efficacy of new systems to meet the needs of all clients. Participants reported the informed consent model of receiving hormone therapy decreased their wait times. The expedited informed consent model stands apart from the WPATH guidelines and has a different understanding of GD (Schulz, 2017). Further research is necessary on the informed consent model. We also recommend further research to evaluate other means in which wait times could be decreased at specialized clinics.

Conclusion

There are a multitude of barriers transgender clients and healthcare providers face within the healthcare system (Kcomt, 2019). Clinics specializing in transgender healthcare exist to improve healthcare experiences and offer higher quality of care for transgender clients (Hudson, 2018). Our research contributes to the small but growing body of research on specialized clinics and the value they contribute to gender affirmation healthcare.

Our phenomenological digital questionnaire and art-based participatory photography methods gathered the lived experiences of 20 transgender adults who receive care at a midwestern clinic in the U that specializes in gender affirmation healthcare. Utilizing hermeneutic phenomenological analysis, while focusing on a critical inquiry paradigm and holding our lenses of holism and intersectionality at the forefront, six themes emerged: *Clinic Operational Experiences, A Sense of Belonging, Participants' Views of Providers, Anxiety and*

Relief, *Personal Agency,* and *Lens on Duality*. These themes honor the highlights and challenges transgender people encounter when seeking care at clinics specializing in gender affirmation healthcare.

The themes compliment and diverge from past research literature. Findings supporting the literature include: a marked prevalence of mental health concerns, particularly anxiety, among transgender people (Beagan & Hattie, 2015; Christian et al., 2018), long wait times (Blodgett et al., 2018; Eyssell et al., 2017), the informed consent model fast-tracking hormone therapy (Reisner, Bradford, et al., 2015), and a desire for reciprocal relationships with providers when deciding on treatment options (Blodgett et al., 2018; Romanelli & Hudson, 2017).

Deviating from results reported by Eyssell et al. (2017), our study participants support the need for inclusive healthcare, with some participants specifically asking to have all healthcare needs addressed by specialized clinics. Our participants largely focused on clinic operations such as satisfaction with EMR systems that include diverse gender identities, a desire for easier access to clinic patient portals, and an increase in the number of in-clinic secondary support systems. In an effort to carry forward the voice of our participants, we recommend: using preferred pronouns; reassessing clinic intake forms and EMR systems to ensure inclusion of diverse gender options for clinics who have not already done so; expanding and improving secondary support systems within clinic settings; creating inclusive spaces; and offering holistic care options that comprehensively care for all transgender clients' healthcare needs. Addressing these needs is a small step to increase the presence and acceptance of transgender clients in healthcare settings. Understanding transgender individuals' lived experiences offers a collective voice to transform the political, healthcare, and academic landscapes of society. We hope our study advances social solidarity.

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Appendix A
Digital Questionnaire Instructions

Hello, thank you for participating in our digital questionnaire. The purpose of this study is to describe the lived experiences of transgender adults receiving gender affirmation care at a clinic specializing in transgender healthcare. Our questionnaire begins with a few demographic questions and next there are two open-ended questions we would like you to answer to help us understand your lived experiences receiving gender affirmation care at a clinic specializing in transgender healthcare. You can take as much time as you need to answer the questionnaire, though we estimate it may take one hour. You may only take the survey once. You must click "Submit" for your response to be recorded. By clicking "Submit," you may no longer withdraw from the study. There are no right or wrong answers. We are interested in your experience.

Before you begin the questionnaire, we would like to remind you that:

- The purpose of this study is to describe the lived experiences of transgender adults receiving gender affirmation care at a clinic specializing in transgender healthcare.
- By clinics specializing in transgender healthcare, we mean clinics with a multidisciplinary team with a specialty practice that focuses on the healthcare of gender non-conforming people.

We appreciate your time and input.

Appendix B
Digital Questionnaire

There is a lot of research regarding the experiences of transgender adults at nonspecialized clinics. However, there is a lack of research on the experiences of transgender adults at clinics specializing in transgender healthcare.

Clinics specializing in transgender healthcare are clinics that focus on healthcare for transgender individuals. One example is [Clinic Recruitment Site], however you may write about other clinics specializing in transgender healthcare.

1) Please describe your experience with gender affirmation healthcare (also known as trans healthcare) at clinics specializing in transgender healthcare.

2) Is there anything else you would like to share with us related to your gender affirmation healthcare experiences at clinics specializing in transgender healthcare? For example, describe experiences you consider ideal or not ideal, and describe what these experiences mean to you.

Appendix C
Optional Photograph Submission

Hello, thank you for participating in our optional photograph submission. We ask that you submit one original meaningful photograph representing your experience receiving gender affirmation care at clinics specializing in transgender healthcare. A photograph will provide a more in-depth view of your experience and offers another way to share your voice.

- By an original photograph, we mean your own artistic work. For example, you could take a photograph of an art piece you created, a photograph of nature, or use your creativity. Keep in mind the following:
    - We ask that you do not submit photos with human subjects or identifiable characteristics such as tattoos, birthmarks, or scars.
    - Photos with human subjects or characteristics will be deleted and not used in the final study.
- Please include a one to three sentence description of your photograph. You may write more if you wish.
- To keep your identity confidential, do not add any names of the clinics you attend or any person’s names within the written part of your photograph (ex. the name of your doctor, nurse, or any friends).
- It may take up to twenty minutes to finish, but you can take more time if you need.
- You must click “Submit” for your response to be recorded.

We appreciate your time and input.

Appendix D
Demographic Information

The data collected on the participant demographics form will assist the team of researchers to compare and contrast the lived experiences you share in your questionnaire with published research in the area of transgender healthcare. Please select the answer that best reflects your personal information.

1. Age
   a. 18-25
   b. 26-35
   c. 36-45
   d. 46-65
   e. 65+
   f. Prefer not to say

2. Ethnic background
   a. American Indian
   b. Asian
   c. Black
   d. Latino/a
   e. White
   f. Multiracial
   g. Other
   h. Prefer not to say

3. Housing
   a. Renter
   b. Owner
   c. Transient / homeless
   d. Prefer not to say

4. Is the area you live:
   a. Urban
   b. Suburban
   c. Rural
   d. Prefer not to say

5. Highest education completed
   a. Elementary School
   b. Some High School
   c. High School or General Education Diploma (GED)
   d. Community / Technical College
   e. Bachelor's Degree
   f. Master’s Degree
   g. Doctoral Degree

  h. Prefer not to say

6. Employment status
  a. Full-time
  b. Part-time
  c. Unemployed
  d. Disability / Medical Leave
  e. Student
  f. Prefer not to say

Appendix E
Recruitment Email

Subject: Research Participation Opportunity

January 09, 2019

You are receiving this email as an invitation to participate in a research study by students in the Master of Arts in Holistic Health Studies program at St. Catherine University. The purpose of this study is to describe the lived experiences of transgender adults receiving gender affirmation care (also known as trans healthcare) at clinics specializing in transgender healthcare.

This study includes an online questionnaire with two open-ended questions and the choice to upload one photograph with a written description. The photograph should be an artistic expression, and not include any human subjects or identifiable characteristics. To keep your identity confidential, do not add any names of the clinics you attend or any person's names within the written part of your photograph (ex. the name of your doctor, nurse, or any friends). We estimate this will take 1 hour and 35 minutes to complete, but you are welcome to spend more time. You will not be paid for your time. Choosing to participate or not participate in this study will have no impact on the care you receive at [Clinic Recruitment Site].

The study opens January 9th, 2020 and will end on January 30th, 2020, or when the maximum number of participants have submitted responses. The researchers do not know or have access to your email address. Therefore, [Clinic Recruitment Site] will send a reminder email. A reminder email will be sent even if you have already participated.

Here is a link to the study: [INSERT LINK TO STUDY]

We appreciate your time,

[Clinic Recruitment Site]

Elizabeth Crandall, B.S., Rebecca DeBaker, B.S., BSN, PHN, RN, Brandon Lorge, B.A., M.A.C.T., Ellen Schneider, BSN, RN, CMS, PCCN, and Kendra-Ann I. Seenandan-Sookdeo, MN, BN, RN, CEIM

Appendix F
Crisis Resource List

Minnesota County Mental Health Numbers
https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/adult-mental-health/resources/crisis-contacts.jsp

National Suicide Prevention
Hotline: (800) 273-8255
https://suicidepreventionlifeline.org/

Trans Lifeline Peer Support Lifeline
(877) 565-8860

Crisis Text Line
Text "HELLO" to 741-741

The Lesbian, Gay, Bisexual, and Transgender National Hotline
(888) 843-4564

Appendix G
Invitation to Research Day

Dear Research Participant,

Thank you for sharing your experience with us. We value the time you committed to our research efforts. The information you gave us will contribute to our research. We invite you to learn about our research findings during our public presentation at the Master of Arts in Holistic Health Studies Research Day. Research Day will be on May 16, 2020 at 9:00am at the Coeur de Catherine, St. Catherine University, 2004 Randolph Ave., St. Paul, MN, 55105.

Our thesis detailing our research findings will be published in Summer 2020 on Sophia, a public access repository of master's and doctoral thesis at St. Catherine University, St. Paul, MN. We welcome you to review our findings in their entirety. We will also make a summary of our research available to the recruitment clinic so you can access it there.

Once again, please accept our sincere thanks for so generously sharing the details of your experience.

Kind regards,

Elizabeth Crandall, Rebecca DeBaker, Brandon Lorge, Ellen Schneider, and Kendra-Ann I. Seenandan-Sookdeo

Appendix H
Eligibility Criteria Screening

Do you self-identify as transgender?
 __Yes
 __No

Are you 18 years of age or older?
 __Yes
 __No

Do you currently receive gender affirmation related care from a clinic specializing in transgender healthcare?
 __Yes
 __No

Can you read and write in English?
 __Yes
 __No

Are you your own Legal Guardian? (Do you make your own legal decisions?)
 __Yes
 __No

If you chose to participate in the optional photograph portion of the study, you will need to have access to a device capable of taking a photograph and the ability to upload the image.

Appendix I
Online Consent Form

ST. CATHERINE UNIVERSITY

Informed Consent for a Research Study

Study Title: A Phenomenological Study of Adults Receiving Gender Affirmation Care at Clinics Specializing in Transgender Healthcare.

You are invited to take part in a research study. This study is called, *A Phenomenological Study of Adults Receiving Gender Affirmation Care at Clinics Specializing in Transgender Healthcare*. The study is being done by Elizabeth Crandall, B.S., Rebecca DeBaker, B.S, BSN, PHN, RN, Brandon Lorge, B.A., M.A.C.T., Ellen Schneider, BSN, RN, CMS, PCCN, and Kendra-Ann I. Seenandan-Sookdeo, MN, BN, RN, CIMI, masters' candidates in the Master of Arts in Holistic Health Studies at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Carol Geisler, PhD, Associate Professor in the Master of Arts in Holistic Health Studies. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document carefully before you agree to be in the study.

Why are the researchers doing this study?

The purpose of this study is to describe the lived experiences of transgender adults receiving gender affirmation care at clinics specializing in transgender healthcare.

This study is important because it will add to the scientific literature on gender affirmation care for transgender adults. About 300 people are expected to take part in this research.

Why have I been asked to be in this study?

You have been asked to be in this study because you are an adult who self-identifies as transgender and presently receiving gender affirmation related healthcare at [Clinic Recruitment Site].

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, you will be asked to do the following:

- Read this consent form which will take about 15 minutes to read

- Complete an online written questionnaire consisting of two open-ended questions, which will take about one hour to complete

- An optional part of the study is to upload an original photograph for the purposes of data analysis. Please include a brief written description (one to three sentences, though you may write more if you wish) of your photograph. The photograph should be an artistic expression, and not include any human subjects or identifiable characteristics. To keep your identity confidential, do not add any names of the clinics you attend or any person's names within the written part of your photograph (ex. the name of your doctor, nurse, or any friends). This step will take about 20 minutes to complete.

In total, this study will take approximately1 hour and 35 minutes to complete over one session.

What if I decide I don’t want to be in this study?

Participation in this study is completely voluntary. If you decide you do not want to participate in this study, please do not sign this form and do not complete the questionnaire. If you decide to participate in this study but want to withdraw before you have finished submitting your digital questionnaire or optional photograph with a description, you may do so by not clicking “Submit.” However, by clicking "Submit" after the digital questionnaire and/or after the optional photograph submission, you are no longer able to withdraw from this research study. Your decision of whether or not to participate will have no negative or positive impact on your relationship with [Clinic Recruitment Site], St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

While participating in this study, you may remember an experience related to gender affirmation that is upsetting to you. You may stop this study at any time. A list of mental health crisis resources is available to you on the study welcome page and upon completion of the study.

We ask you not to use any names or identifiers for yourself or others. Your written answers in the questionnaire may in error identify yourself as a research participant in this study. In our analysis, and prior to sharing research data, we will do our best to remove any identifying information that is shared within your responses.

If you choose to upload a photo and it has information that could identify you or another person, you risk revealing yourself as a research participant in this study.

The researchers will store all responses and photographs in a secure online location, however there is always a risk of electronic data being hacked.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits to you for participating in this research. An indirect benefit to participating in this research is your contribution to the collection of ongoing research in the area of gender affirmation healthcare.

Will I receive any compensation for participating in this study?

We will not be collecting any identifying or contact information in order to keep your identity private. As a result, you will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in this study will be combined with other participants' information. A qualified research aide or aides will remove (de-identify) potential information such as names that could identify you or a healthcare provider Only the de-identified data will be given to the research team to study. We may use specific quotes and photos in reporting our research results. In data analysis, we will be specifically looking for themes.

The researchers will keep your questionnaire responses, photos, and photo descriptions in Box, an online, password protected, cloud based, data management tool. Only the researchers, their advisor, and a qualified research aide or aides will have access to the records.

Data analysis will be completed by July 1, 2020. Once data analysis is complete, the research aide or aides will destroy all original reports and identifying information. De-identified data will be kept indefinitely.

The study results, including optional photos and accompanying descriptions, will be presented to the public during the Master of Arts in Holistic Health Studies Research Day presentations held on Saturday, May 16th, 2020 at the St. Catherine University campus in St. Paul, MN. The study results and photos will also be published within the researchers' thesis that will be available on Sophia, an online public access repository for master's and doctoral theses completed by students at St. Catherine University.

Any information that you provide will be kept confidential. You will not be individually identified in any way and we will work to protect your identity in any written reports or publications.

Could my information be used for future research?

It is possible that your data will be used for future research studies. All data collected will be de-identified, and data may be used for future research by individuals on this research team or be given to another investigator for future research without gaining additional informed consent.

How can I get more information?

If you have any questions before you sign this form, please feel free to contact the research team at (651) 356-8122. If you have other questions or concerns regarding the study and would like to talk to someone other than the researchers, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

If you choose to contact the IRB or the researchers, you will no longer be anonymous. We will keep your information confidential by not recording any identifying information.

You may keep a copy of this form for your records.

Statement of Consent:

By clicking on the statement "I have read and understand the consent form and agree to participate in this study" participants have given informed consent.

If you do not want to participate in this study, please do not sign this form and do not complete the questionnaire. Participation in this study is voluntary and you can withdraw from this study by not clicking “submit.”

Appendix J
Informed Consent Clarification Form

The purpose of this form is to make sure you understand the informed consent.

You may retake this form until you have answered all five questions correctly.

1. By choosing to participate in this study, the care I receive at the recruitment clinic
    a. Will not be affected
    b. Will be affected
    c. I’m uncertain

2. Including the time I have already spent, about how long will it take for me to complete this study?
    a. 1 hour and 35 minutes
    b. 4 hours
    c. 6 hours

3. Am I being compensated for this study?
    a. I am not being compensated for this study
    b. I am being compensated with a gift card
    c. I am being compensated with money

4. Will specific quotations I write and photos I upload be used by the researchers in publications and presentations?
    a. De-identified quotations and photos will be used in future publications and presentations
    b. De-identified quotations and photos will not be used in future publications
    c. Identifiable quotations and photos will be used in future publications and presentations

5. In order to be included in the research, the optional photograph cannot have:
    a. Landscapes
    b. Physical spaces
    c. People or identifiable characteristics

Appendix K
Reminder Email

Subject: Research Participation Opportunity Reminder

January 23, 2019

In case you have not yet participated, this is a reminder email about a research study conducted by students in the Master of Arts in Holistic Health Studies program at St. Catherine University. The purpose of this study is to describe the lived experiences of transgender adults receiving gender affirmation care (also known as trans healthcare) at clinics specializing in transgender healthcare. If you have already participated, please disregard this email.

This study includes an online questionnaire with two open-ended questions and the choice to upload one photograph with a written description. The photograph should be an artistic expression, and not include any human subjects or identifiable characteristics. To keep your identity confidential, do not add any names of the clinics you attend or any person's names within the written part of your photograph (ex. the name of your doctor, nurse, or any friends).We estimate this will take one hour and 35 minutes to complete, but you are welcome to spend more time. You will not be paid for your time. Choosing to participate or not participate in this study will have no impact on the care you receive at [Clinic Recruitment Site]. This study will end on January 30th, 2020, or when the maximum number of participants have submitted responses.

Here is a link to the study: [INSERT LINK TO STUDY]

We appreciate your time,

[Clinic Recruitment Site]

Elizabeth Crandall, B.S., Rebecca DeBaker, B.S, BSN, PHN, RN, Brandon Lorge, B.A., M.A.C.T., Ellen Schneider, BSN, RN, CMS, PCCN, and Kendra-Ann I. Seenandan-Sookdeo, MN, BN, RN, CEIM

Appendix L
Research Aide Job Description

Greetings,

We are a group of five researchers in the Master of Arts in Holistic Health Studies program at St. Catherine University seeking a research aide. The purpose of our study is to describe the lived experiences of transgender adults receiving gender affirmation care at clinics specializing in transgender healthcare. Our research study will be conducted using Qualtrics and will have participants answer two open ended questions. There is also an option for participants to upload a photo and add a description of one to three sentences, though participants may write more if they wish.

We are requesting a research aide to go through the writings before the research team reviews the data and ensure that no personal or clinic names are present. Although study participants are requested not to use names, the purpose of hiring a research aide is to ensure identifiable information is not present in the data we will analyze. The research aide will also review all photos to ensure no identifiable human subjects are present. If so, they will not be given to the researchers to analyze.

As a research aide you will read through the participants' answers and replace specific names with generic ones. For instance, "I was at [Clinic Recruitment Site]" would be changed to "I was at [Clinic A]" or "I was with my friend Sam" with "I was with my friend [Person C]."

We will open the digital questionnaire on January 9th and close it once we have a maximum of 300 participant responses or on January 30th. We request that the research aide provide us the de-identified data on a rolling basis as it comes in rather than all at once after the questionnaire closes. We are open to discussion on timing and logistics.

Additional requirements:

Work must be done in a secure, confidential location so that outsiders and the researchers cannot see your screen. For example, do not work at a location like Starbucks. You could work in the privacy of your own home or in a private study room in the library.

You may not keep any of the data for yourself.

You will destroy all identifiable data collected in this study by July 1st

You will replace all identifying information with Clinic A, Clinic B, etc., Person A, Person B, etc. Do not label the same clinic with the same label across all responses, e.g. [Clinic Recruitment Site] cannot always be labeled Clinic A.

You will sign a confidentiality agreement.

The stipend of $400 will be divided equally between multiple aides or given in full to a single aide.

Appendix M
Confidentiality Agreement

Confidentiality Agreement for Research Aide

Title of Research Project: A Phenomenological Study of Adults Receiving Gender Affirmation Care at Clinics Specializing in Transgender Healthcare.

Local Principal Investigators: Elizabeth Crandall B.S., Rebecca DeBaker B.S., BSN, PHN, RN, Brandon Lorge MA, Ellen Schneider BSN, RN, and Kendra-Ann Seenandan-Sookdeo MN, BN, RN, CEIM

As a member of this research team, I understand that I may have access to confidential information about study sites and participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study sites or participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information, unless specifically authorized to do so by approved protocol or by the local principal investigator acting in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to read information about study sites or participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I agree to notify the local principal investigators immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this be on my part or on the part of another person.

______________________________	________________	_____________________
Signature of Research Aide	Date	Printed name
______________________________	________________	_____________________
Signature of Local Investigator	Date	Printed name

Signature of Local Investigator	Date	Printed name
Signature of Local Investigator	Date	Printed name
Signature of Local Investigator	Date	Printed name
Signature of Local Investigator	Date	Printed name