

IMPROVING HEALTHCARE FOR PEOPLE IN POSSESSION OF TRANSFORMATIVE
GENDER IDENTITY (PIPOTGI): IMPACT OF EDUCATION ON NURSES' KNOWLEDGE
AND AWARENESS

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Abstract

People in possession of transformative gender identity (PIPOTGI) are those who identify themselves as transgender, gender-neutral, gender-queer, gender-fluid, or gender non-conforming. PIPOTGI face multiple barriers when attempting to access healthcare and are often discriminated against during healthcare encounters, resulting in PIPOTGI avoiding or delaying healthcare and leading to higher morbidity and mortality. A lack of nursing and other healthcare provider knowledge and training is recognized as foundational to this problem. The purpose of this project was to educate nurses regarding the healthcare needs of PIPOTGI while exploring their attitudes and beliefs surrounding PIPOTGI. The overall aim of the project was to enhance culturally competent care for PIPOTGI.

The project used a mixed-method research design to provide an educational session on PIPOTGI healthcare issues based on transformational learning theory to licensed nurses in the state of Hawaii. Both cognitive and affective learning outcomes were measured pre and post the educational session using the Transgender Attitude Beliefs Scale and a post-session debriefing. Quantitative data were analyzed using paired *t*-tests and a constant comparison technique employed to explore qualitative data.

There is the potential to change the paradigm of healthcare for PIPOTGI by completing this DNP project. Educating nurses regarding the healthcare needs of PIPOTGI and allowing them the opportunity to explore any preconceived bias they may have toward PIPOTGI, may help decrease the incidence of transphobia and discrimination against PIPOTGI in healthcare settings. Once they had a deeper understanding of PIPOTGI, nurses who participated in this study were empowered to serve as positive examples for their co-workers and to advocate for culturally competent healthcare for PIPOTGI.

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Chapter 1

1.0 Introduction to the Project

1.1 Problem

Although much has been accomplished over the past decades to promote equal rights in regards to race and gender, there continues to be a group of individuals who struggle for equality, especially in the healthcare arena. They are those who defy the categories of traditionally accepted binary genders of male and female. Transgender is “an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth” (Kcomt, 2019, p. 201), and can be considered to be people in possession of transformative gender identity (PIPOTGI). For the purpose of this paper, we can consider PIPOTGI to include not only transgender individuals, but also those who choose to identify themselves as gender neutral, gender queer, gender fluid, or gender non-conforming. This population frequently experiences *institutional erasure* (Carabez, Eliason, & Martinson, 2016), which include issues faced by PIPOTGI when they are not referred to by their preferred pronoun or name due to the insensitivity of forms and documents that ask PIPOTGI to choose between male and female. When these forms do not acknowledge PIPOTGI, they are unable to identify themselves accurately. Also contributing to institutional erasure are policies and procedures dictating sex-segregated health services which are outlined by insurance companies and institutions based solely on binary gender categories. In addition, PIPOTGI face *informational erasure* (Carabez, Eliason, & Martinson, 2016) as a result of lack of education among healthcare providers, who, although well-meaning, may have misconceptions regarding PIPOTGI which can result in unintentional negative mindsets towards this population. These issues pose significant hurdles for PIPOTGI in accessing affirming, knowledgeable healthcare. As a result of feeling erased,

many PIPOTGI avoid or delay seeking medical care, making them vulnerable to increased morbidity and mortality. Addressing this gap in provider knowledge and awareness is of primary importance to a correction of this problem and the provision of culturally competent care for PIPOTGI.

1.2 Significance

According to the Williams Institute (2016), an estimated 1.4 million adults in the United States identify as transgender, with the state of Hawaii having the highest percentage at 0.8% (Flores, Herman, Gates, & Brown, 2016). PIPOTGI frequently report experiencing bias and discrimination from healthcare providers who are not well-informed about PIPOTGI or their unique healthcare needs. *The Report of the 2015 US Transgender Survey* contained responses from 27,715 transgender people in the United States (James et al., 2016). They reported that in the last year, 33% of respondents experienced a negative experience with a healthcare provider, and 23% of respondents chose to avoid necessary healthcare because of fear of being mistreated (James et al., 2016). In their report, *A National Epidemic: Fatal Anti-transgender Violence in America in 2018*, the National Human Rights Foundation reported that one in four transgender people report having avoided medical care in the past year out of fear of being disrespected or mistreated.

When an individual has an irrational hatred or fear of a transgender person, it is called transphobia (Kcomt, 2019). Transphobia is at the root of direct acts of discrimination and violence committed against PIPOTGI. As of September 27, 2019, at least 18 PIPOTGI in the United States have been killed in a wave of violence that the American Medical Association has declared an epidemic (Rojas & Swales, 2019, para.2). Since 2013, there have been more than

128 cases of anti-transgender fatal violence (Human Rights Campaign, 2018). Such discrimination and violence often lead to increased homelessness, substance abuse, poverty, and employment inequities for PIPOTGI. Discrimination and violence can also lead PIPOTGI to sex work for survival, increasing their likelihood of sexual assault, substance abuse, depression, and trauma (Halliwell, 2019). According to *The Report of the 2015 US Transgender Survey* PIPOTGI have a lifetime suicide attempt rate of 41%, and a suicide rate nine times greater than the general population (James et al., 2016, p. 10).

When it comes to defining human beings and their social categories, “medicine remains one of the most powerful and influential institutions shaping our cultural definitions of sex, gender, and sexuality” (Paine, 2019, p. 353). Yet, PIPOTGI frequently report needing to educate their doctors and nurses about PIPOTGI. Systemic changes in provider education and training are crucially needed to close the gap in quality healthcare access for PIPOTGI and get ahead of the long-term health implications PIPOTGI face (Jaffee, Shires, & Stroumsa, 2016). Such an effort can logically start with enhancement to the education of nurses who are frontline caregivers to PIPOTGI.

1.3 Purpose and Aim

The purpose of this Doctor of Nursing Practice (DNP) project was, therefore, to educate nurses about PIPOTGI and their healthcare issues. While participating in a continuing education session, providers were also able to explore their personal attitudes and beliefs regarding PIPOTGI. The overall aim of the project was to enhance provider PIPOTGI knowledge and improve their awareness of the potential impact of any previously held mindsets in an effort to provide culturally competent care for PIPOTGI.

1.4 Operational Definitions

The following terms were used throughout the project and operationally defined as follows:

1.4.1 Cisgender are individuals whose gender identity matches their biological sex assigned at birth based on their genitalia.

1.4.2 Gender expression is the external display of one's gender, through a combination of clothing, grooming, demeanor, social behavior, and other factors, generally made sense of on scales of masculinity and femininity. Also referred to as "gender presentation."

1.4.3 Gender identity is the internal perception of one's gender, and how a person labels themselves, based on how much they align or don't align with what they understand their options for gender to be. Often conflated with biological sex, or sex assigned at birth.

1.4.4 Gender fluid is best described as individuals who dynamically flow between male and female gender expression. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more male some days, and more female other days

1.4.5 Gender neutral are individuals who feel they are neither male nor female.

1.4.6 Gender non-conforming are individuals whose expressed gender behavior and attitudes consistently characterize the opposite sex, but who do not identify as transgender. Often abbreviated as GNC.

1.4.7 Genderqueer describes individuals whose gender identity does not sit within

binary genders of male and female, but between or outside those binaries. It is also an umbrella term for many gender non-conforming or non-binary identities (e.g., genderfluid, gender non-conforming, gender variant).

1.4.8 Gender variant is a term used to describe someone who either by nature or by choice does not conform to gender-based expectations of society (e.g. transgender, intersex, gender non-conforming, genderqueer).

1.4.9 Intersex are individuals born with biological characteristics of both male and female.

1.4.10 LGBTQIA is an acronym for lesbian, gay, bisexual, transgender, questioning, Intersex, and asexual.

1.4.11 PIPOTGI is an acronym for people in possession of transformative gender identity.

1.4.12 Questioning is an individual who or time when someone is unsure about or exploring their own sexual orientation or gender identity.

1.4.13 Transgender is an umbrella term for anyone whose sex assigned at birth and gender identity do not correspond in the expected way (e.g., someone who was assigned male at birth, but does not identify as a man).

1.4.14 Transphobia the irrational fear or hatred for transgender people.

1.5 Background

Although the concept of transgenderism and gender non-conformity are only recently making headlines, they are not new. PIPOTGI have been around throughout the ages. In years past, when PIPOTGI were not comfortable revealing their true gender identity, it was only those who sought transition-related services from specialists who were counted, which grossly

underestimated the transgender population. PIPOTGI face barriers trying to access knowledgeable, relevant, and supportive healthcare (Goldstein, Corneil, & Greene, 2017). These barriers may be rooted in a resistance to cultural acceptance, a history of psychiatric pathologizing, absent or weak anti-discrimination policies, and a lack of healthcare provider knowledge and awareness about PIPOTGI healthcare needs.

1.5.1 Cultural acceptance of PIPOTGI. In modern time, a majority of the world exhibit bias toward the binary gender definitions of male and female, and transphobia persists. Yet, history reveals an acceptance of more than two genders and that PIPOTGI have been present in many cultures around the world with different levels of acceptance. “From the earliest records, figures such as the Greek God Hermaphroditus and the Sumerian Gala Priests of ancient Mesopotamia, have represented individuals not easily identified as either male or female” (Thorne, Yip, Bouman, Marshall, & Arcelus, 2019, p. 2). In pre-Columbus America, many tribes held the belief that there were, in fact, four genders - *male*, *masculine*, *feminine*, and *female* (Thorne et al., 2019). *Two-spirit* people were referred to as a distinct gender presentation in pre-Columbia America, with differing levels of acceptance. In some tribes, two-spirit people were held in high esteem, while in others, two-spirit people assimilated into everyday life without discrimination (Thorne et al., 2019). There exist many other non-binary gender systems identified in world history. The list includes, but is not limited to: the *Mino* warrior women of Dahomey/Benin, the *Sekrata* in Madagascar, the *Kathoey* in Thailand, the *Waria* in Indonesia, and the *third gender* category *Māhū* in Hawaii and other Pacific Islands” (Dozono, 2017, p.428). Similar non-binary genders that are recognized are the *fa'afafine* of Samoa and the *fakaleiti* or *fakafefine* of Tonga (Ching et al., 2018). In their landmark judgment in April of 2014 recognizing the third gender status of *hijras*, the Supreme Court of India stated “recognition of

transgenders as a third gender is not a social or medical issue but a human rights issue.

Transgenders are also citizens of India. The spirit of the Constitution is to provide equal opportunity to every citizen to grow and attain their potential, irrespective of caste, religion or gender” (Diehl et al., 2017, p. 393).

In Native Hawaiian culture, māhū would describe a person having characteristics of both sexes. Māhū is defined as both a cultural role and term used to describe a third gender that Native Hawaiian people perceive as a gender other than male or female. In pre-colonial Hawaiian culture and society, māhū played an integral role in cultural practices and were respected as spiritual and cultural leaders, especially in the preservation of Hawaiian traditions such as hula chants (Ching et al., 2018). Today, one in five (20%) Native Hawaiian/Pacific Islander respondents to a nationwide survey of PIPOTGI identified themselves as māhū (Ching et al., 2018) yet, “Post-colonial acculturation has shifted the role of māhū (as well as other sexual and gender minorities) from one of respect and social value to one of stigma and shame” (Ching et al., 2018, p. 7). Providing an opportunity for reflection on this shift in current day mindsets and an exploration of the historical acceptance of transgenderism in Native Hawaiian/Pacific Islander culture helped to frame an educational session on PIPOTGI health issues with nurses of the Hawaiian Islands.

1.5.2 Psychiatric pathologizing of PIPOTGI. Medical institutions and practitioners have the social power to determine who is considered to be healthy, normal and sane, and, conversely, who is considered to be sick, pathological, or insane (Stryker, 2017). Professional and social advocates of PIPOTGI find themselves arguing against a common belief that transgender people are mentally disturbed. Until recently, possessing a gender identity incongruent with one's assigned birth sex was viewed as sexually deviant and listed as such in

the *Diagnostic and Statistical Manual of Mental Disorders* from 1968 to 2013 (White Hughto, Reisner, & Pachankis, 2015). During the preparation of the 11th version of the *International Statistical Classification of Diseases and Related Health Problems (ICD-11)* (World Health Organization, 2018) many parties put pressure on the World Health Organization (WHO) to remove the diagnosis of gender dysphoria from the mental health chapter (F. Beek, Cohen-Kettenis, & Kreukels, 2016). This effort was successful, and in the ICD-11 released May 25, 2019, there was a significant change in the placement of gender identity conditions. Gender incongruence was no longer categorized as a mental disorder and was instead reclassified within the chapter on conditions relating to sexual health (Reed et al., 2019).

Nevertheless, some remnants of the belief that PIPOTGI suffer from a mental disorder remain. This circuitous pathologizing of PIPOTGI for questioning their gender identity as a mental disorder by their healthcare provider places increased stressors on PIPOTGI. “Focusing too narrowly on mental health outcomes may, therefore, serve to over-pathologize a vulnerable population who are likely experiencing a normative response to discrimination, violence, and exclusion” (Valentine & Shipherd, 2018, p.35).

1.5.3 Policy and law surrounding PIPOTGI. In 2005, a time when only 6 states in the United States had laws prohibiting discrimination on the basis of gender identity (Schaffer, 2005), unnecessary exposure to transphobia and improper care led to debates about the lack of policies protecting PIPOTGI and their right to quality care (Rosa et al., 2019). For PIPOTGI, there were no health policies in place to protect and advocate on their behalf until the adoption in 2010 of the Patient Protection and Affordable Care Act (ACA). Before that, policies and laws recognized only a binary view of gender, making male and female the only accepted genders. Choosing between female or male, which comes naturally for cisgender people, served to

marginalize and possibly endanger those who did not fit into those binary categories (Hein & Cox, 2018).

However, in 2016, the Republican platform took a strong stance against interpreting sex discrimination as encompassing anti-LGBT discrimination and has since rescinded the previous administration's non-discrimination regulations that offered protection for LGBT people (Wang & Cahill, 2018). In October 2017, upon President Trump's executive order, the U.S. Department of Justice issued a memorandum on federal law protections for religious liberty (President Donald J., 2018) articulating the view that organizations and individuals that receive federal funding to provide healthcare and other services should be allowed to discriminate on the basis of religious beliefs in the provision of services and to hire (Wang & Cahill, 2018). This memorandum opened a formidable legal door to more widespread discrimination that exacerbated PIPOTGIs vulnerability to discrimination and harassment (Wang & Cahill, 2018).

More promising is a recent May 17, 2019 amendment to Title VII of the Civil Rights Act of 1964 (Title VII) entitled the Equality Act (H.R. 5) which was passed by the U.S. House of Representatives with a vote of 236 to 173 and bipartisan support. The Equality Act is a bill that prohibits discrimination based on sex, gender identity, and sexual orientation (Equality Act, 2019). LGBTQ people across key areas of life will have protection by this legislation, which provides consistent and explicit non-discrimination policies. As of November 24, 2019, the Senate has received the Equality Act, and it has moved towards being signed into law with its referral to the committee on the judiciary (Equality Act, 2019). There have also been other efforts across the nation to demarginalize PIPOTGI. As of November 19, 2019, the Human Rights Campaign (HRC) announced 88 cities were earning the highest possible score on the Municipality Equality Index (MEI), which examines the degree to which municipal laws,

services, and policies are PIPOTGI-inclusive (HRC releases, 2019). Eighty-eight cities was a dramatic increase from 2012 when only 11 cities were earning such a score.

1.5.4 Lack of provider knowledge about PIPOTGI. It is undeniable that PIPOTGI are experiencing discrimination in the healthcare system (Kcomt, 2019). In her semi-structured narrative interviews with 50 LGBTQ cis women and transmasculine individuals, Paine (2018) uncovered the impersonal process through which structural stigma, in the form of societal norms of sex, gender, and sexuality employed in medical settings, distresses PIPOTGI during healthcare encounters. Paine's study highlighted how the medicalization of gender and sexuality serves to stigmatize and disadvantage PIPOTGI through the attempts of providers to *make sense of or sort out* a healthcare participant's natal gender.

A lack of provider knowledge about PIPOTGI is foundational to this problem and closing the gap in healthcare provider formal education on the needs of PIPOTGI, a rational solution. In the United States, one-third of medical schools require no hours of transgender-related content for students during their clinical training years (Baldwin et al., 2018). Similarly, a study of nurse educators found that a median total of 2 hours of training in nursing education covers issues related to not only transgender patients, but also those that are lesbian, gay, and bisexual (Carabaz, Eliason, & Martinson, 2016). This lack of professional training leaves healthcare workers unprepared, as noted by Paradiso and Lally (2018), who performed structured interviews with nurse practitioners. These practitioners concluded that perceived gaps in their knowledge threatened their ability to deliver quality, patient-centered care to transgender patients, despite their best intentions. In their survey of 399 emergency room physicians who had treated PIPOTGI, Chisolm-Staker, and colleagues (2018) also noted that few had received training, and most had inaccurate knowledge about essential aspects of PIPOTGI care.

Research has also shown that PIPOTGI want their healthcare providers to be more knowledgeable about the critical aspects of their needs, stating that healthcare providers require some “Trans 101” (Baldwin et al., 2018, p.1309). Trans 101 was described as essential information about gender identity, sexual orientation, major health concerns, and the basics regarding the unique circumstances and health needs of PIPOTGI (Baldwin et al., 2018). PIPOTGI also want providers to understand that not all PIPOTGI desire hormone therapy or gender-confirming surgery, and to realize that not all of PIPOTGI’s healthcare needs are associated with their gender identity.

For the delivery of quality, patient-centered care of PIPOTGI, additional education of frontline patient care providers on the terminology and common health issues faced by PIPOTGI is needed. An awareness of any unconscious preconceived bias regarding gender identity and the impact it may have on their delivery of culturally competent care for PIPOTGI requires exploration as well. Such attention to both enhanced knowledge and reflective awareness may assist nurses to provide evidence-based, culturally competent care for PIPOTGI.

1.6 Clinical Questions

Based on this need for culturally-sensitive, patient-centered care for PIPOTGI, this project posed two clinical questions:

- 1) What is the effect of a continuing education session provided to nurses on their knowledge of PIPOTGI terminology and common health issues?
- 2) What is the effect of a continuing education session provided to nurses on their awareness of preconceived attitudes toward PIPOTGI?

1.7 Summary

It is clear that improvement to the treatment and delivery of healthcare to PIPOTGI is much needed and that addressing this disparity will require attention to the multifaceted elements of institutional and informational erasure that PIPOTGI currently face. These include exploration of cultural acceptance, reduction in psychological pathologizing, and attention to discriminatory institutional policies and laws. Most importantly, a gap in healthcare provider PIPOTGI knowledge must be addressed, in that a lack of PIPOTGI knowledge and awareness can place healthcare providers in situations where they unintentionally harm this vulnerable population. PIPOTGI, who experience negative encounters with uninformed healthcare providers, may feel discriminated against, misgendered, and misunderstood, prompting their postponement or complete avoidance of seeking healthcare. These negative encounters place the PIPOTGI population at risk for decreased quality of life and inadequate preventive healthcare, as well as increased morbidity and mortality. This inequity needs improvement through an educational program for nurses, which enhances their understanding of PIPOTGI terminology and health issues and investigates cultural attitudes and ideations that may negatively impact care. By doing so, this practice improvement project provided an opportunity to improve the provision of culturally competent healthcare for the PIPOTGI population in Hawaii.

Chapter 2

2.0 Literature Review

2.1 Introduction

The evidence surrounding PIPOTGI health issues, gaps in provider knowledge, and other barriers to culturally competent care for PIPOTGI were explored in a comprehensive literature review. Findings from this review revealed several PIPOTGI health and healthcare-related issues. These included multiple mental health vulnerabilities rooted in transphobia, psychopathologization, discrimination, and marginalization such as anxiety, social exclusion, embodied disruption, depression, and risk for suicide. Additional related health risks were PIPOTGI's increased exposure to violence, incidence of substance abuse, use of unlicensed street hormones, and unsafe sexual practices. Other barriers contributing to PIPOTGI health disparities were also uncovered such as mutual lack of trust in patient-provider interactions, and the cisgender policies and procedures of healthcare institutions that result in misgendering and inadequate or delayed care. Throughout the literature review, the need for provider education to increase the quality of life and the provision of culturally competent healthcare for PIPOTGI was evident, and desired learning outcomes were determined to be both cognitive and affective. Educational theories appropriate to both learning domains were also explored with transformational learning theory (Mezirow, 1978) selected as the framework for this project which delivered a PIPOTGI continuing education seminar to nurses.

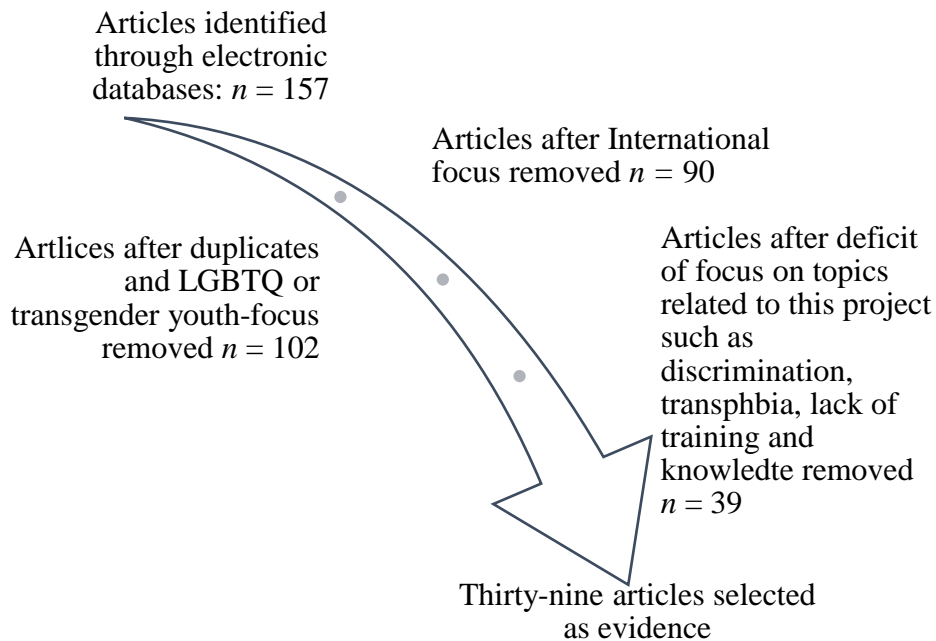
2.2 Methodology

Variables of interest were searched using a comprehensive computer-assisted search of the Cochrane systemic review registry, PubMed, CINAHL, and ERIC, as well as psychology and behavioral sciences collection databases. Articles found were subject to bibliographic mining for

other related articles. Keywords used were transgender, gender incongruence, gender nonconforming, knowledge, provider, nurse, nurse practitioner, physician, health, and healthcare in various Boolean combinations. Criteria for inclusion were articles related to PIPOTGI care published between 2015 and present. Other inclusion criteria were articles discussing gender nonconforming and transgender patients. Excluded were articles with a primary focus on transgender youth and those discussing LGBTQ people as a whole or in more general terms. A search was also conducted of the following professional organizations to discover laws, policies, and standards of care affecting PIPOTGI: World Professional Association of Transgender Health (WPATH); Human Rights Campaign Foundation (HRC); Lambda Legal; The Fenway Institute; National LGBT Health Education Center; Hawai'i State Department of Health; American College of Obstetricians and Gynecologists (ACOG); American College of Nurse Midwives (ACNM); Nurse Practitioners in Women's Health (NPWH); American Association of Family Physicians (AAFP); National Organization of Nurse Practitioner Faculties; Healthcare Equality Index (HEI); World Health Organization (WHO); and the United States Congressional records. As noted in Figure 2.1, a total of 157 articles were reviewed with 11 selected after duplicates were removed and exclusion criteria were applied. All of the available evidence was from non-experimental studies and rated either IIIA high or IIIB good when compared to the Johns Hopkins Nursing Evidence-based practice Research Evidence appraisal tool (Newhouse, Dearholt, Poe, Pugh, & White, 2007).

Figure 2.1

Summary of literature search



2.3 Findings

The literature revealed that PIPOTGI are marginalized, discriminated against, and victims of transphobia. Multiple studies reflected these findings and support the ideation that these factors increase health disparities experienced by PIPOTGI. Other studies confirmed additional barriers to culturally competent care of PIPOTGI such as institutional erasure, lack of trust, and health insurance coverage. The review of evidence also illustrated a significant gap in the education of healthcare providers on PIPOTGI healthcare issues and the likely existence of latent psychopathologizing mindsets about transgenderism in some clinicians. To facilitate culturally competent care for PIPOTGI, a professional development program for nurses required attention to both cognitive and affective domains of learning.

2.3.1 Mental health vulnerabilities. Societal definitions influence every aspect of being human. None are more pervasive than the binary genders of male and female. Interactions between underlying cultural norms related to the biological assignment of gender based on genitalia also influence the culture of gender norms. An individual demonstrating characteristics of the gender opposite of that assigned at birth goes against societal expectations. In so doing, they are often subjected to discrimination and are the victims of transphobia.

2.3.1.1 Marginalized. Research shows that many PIPOTGI are marginalized and face stigma as well as social exclusion, and psychopathologization (Winter et al., 2016; Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Ehrenfeld, Zimmerman, & Gonzales, 2018; Jacob & Cox, 2017; Halliwell, 2019; Scandurra, et al., 2019; White Hughto et al., 2015; Wang & Cahill, 2018; ACOG, 2019; A toolkit, 2019; Seelman, Miller, Fawcett, & Cline, 2018; Paine, 2018; Donald & Ehrenfeld, 2015; Rosa et al., 2019; Hoffkling, Obedin-Maliver, & Sevelius, 2017; Selix & Rowniak, 2016). The psychopathologization of gender incongruence confers a stigma that is particularly damaging, since it is the personal identities of PIPOTGI that are being pathologized (Winter et al., 2016). Throughout history, this pathologic view of transgenderism has greatly contributed to the marginalization of PIPOTGI. PIPOTGI were commonly sent to healthcare professionals to receive reparative therapy, also known as conversion therapy. This type of behavioral modification therapy attempted to change PIPOTGI's gender nonconforming ways to conform with traditional gender roles within society (Goldstein, Corneil, & Greene, 2017). Although most contemporary practitioners agree conversion therapy is not evidence-based and, therefore, not valid practice, some still perform it. Rooted in the notion that any non-heterosexual sexual orientation is a pathology in need of a cure, conversion therapy is currently still performed on adolescents in 32 states and four territories of the United States (Streed,

Anderson, Babits, & Ferguson, & Streed, 2019). This continued practice leads to the assumption that some practitioners may unwittingly contribute to the health disparities of PIPOTGI by harboring some pathologizing.

2.3.1.2 Discrimination. As a marginalized group, PIPOTGI face discrimination in multiple areas of their lives. There was an overwhelming amount of literature to support discrimination in the workplace, educational settings, and healthcare settings (Winter et al., 2016; Jacob & Cox, 2017; Halliwell, 2019; Kcomt, 2019; Lagos, 2018; McCann & Brown, 2018; White Hughto, Reisner, & Pachankis, 2015; Baldwin et al., 2018; Carabez et al., 2016; Selix & Rowniak, 2016; Gonzales & Henning-Smith, 2017; Valenta, Shade, & Lieggi, 2018; Weir & Piquette, 2018; Ehrenfeld, Zimmerman, & Gonzales, 2018; Jaffee, Shires, & Stroumsa, 2016; Kattari & Hasche, 2016; Chisolm-Straker et al., 2018; Paradiso & Lally, 2018; Stroumsa, Shires, Richardson, Jafee, & Woodford, 2019; Goldstein, Corneil, & Greene, 2017; ACOG, 2019). To some PIPOTGI, providers may even appear to be hostile (Winter et al., 2016; Seelman, Colón, LeCroix, Xavier-Brier, & Kattari et al., 2017; Carabez et al., 2016). Research confirms that reports of discrimination are associated with later poor health. Discrimination is one of the many factors significantly associated with PIPOTGI's delayed care, which is costly for the US healthcare system, resulting in overutilization of emergency rooms as well as contributing to high levels of morbidity and mortality for PIPOTGI (Jaffee et al., 2016).

2.3.1.3 Transphobia. While not all PIPOTGI experience profound distress regarding their gender identity, they overwhelmingly report some degree of transphobia (Bauer et al., 2015; Kcomt, 2019; Miller & Grollman, 2015; Weir & Piquette, 2018; Seelman et al., 2017; Baldwin et al., 2018; Hoffkling et al., 2017; Stroumsa et al., 2019; Valenta et al., 2018). Interventions to reduce transphobia have the potential to contribute to improved care for PIPOTGI including

substantial reductions in the high prevalence of suicide ideation and attempts. Increased efforts to address transphobia in society in general, and in healthcare education in particular, is essential to improve the quality of care for PIPOTGI (Stroumsa et al., 2019).

2.3.2 Additional Related Health Risks. Due to a lack of exposure to PIPOTGI, many healthcare providers are under the false assumption that all of their patients are cisgender. This mindset creates coming into contact with a PIPOTGI an anomaly, or in other words, something pathologic. The view that PIPOTGI is a mental disorder can then translate into or support discriminatory behavior (Winter et al., 2016; Paine, 2018). This heightens the risk of PIPOTGI seeking care from unlicensed professionals, engaging in unsafe sexual practices and substance abuse, increased suicide risk, and poor health outcomes (White Hughto et al., 2015; McCann & Brown, 2018; Jacob & Cox, 2017; Winter et al., 2016; Seelman et al., 2018; Rosa et al, 2019; Selix & Rowniak, 2018).

2.3.2.1 Seeking care from unlicensed professionals. After experiencing negative encounters with healthcare providers, some PIPOTGI choose to seek hormone treatment from unlicensed providers. Street hormones can pose health risks if PIPOTGI take more than the recommended doses or if the syringes used harbor HIV or other blood-borne pathogens. Due to the unregulated nature of street hormones, they can pose increased health risks if the hormones contain a dangerous substance, which is common (White Hughto et al., 2015; McCann & Brown, 2018; Jacob & Cox, 2017; Winter et al., 2016; Seelman et al., 2018; Rosa et al, 2019; Selix & Rowniak, 2018).

2.3.2.2 Unsafe sexual practices and substance abuse. Living on the margins of society, often unable to benefit from opportunities available to cisgender people they interact with, and with health and well-being compromised, many PIPOTGI find themselves involved in unsafe

sexual practices and substance abuse that leave them at risk of poor health and well-being (Winter et al., 2016; McCann & Brown, 2018; Weir & Piquette, 2018; Miller & Grollman, 2015; Scandurra et al., 2019; Carabez et al., 2016; Wylie et al., 2016; Stroumsa et al., 2019; Selix & Rowniak, 2016). Living on the margins of society also leads some PIPOTGI to sex work (Jacob & Cox, 2017; Halliwell, 2019; McCann & Brown, 2018; Weir & Piquette, 2018; Wylie et al., 2016). In addition, many PIPOTGI live with a constant threat of violence (Winter et al., 2016; Bauer et al., 2015; Hein & Cox, 2017; Halliwell, 2019; Kcomt, 2019; Weir & Piquette, 2018).

2.3.2.3 Increased suicide risk. As a result of constant threat of violence, substance abuse, unsafe sexual practices, discrimination in the workplace, in healthcare and educational settings, verbal and physical abuse, unemployment, poverty, and an absence of social support, PIPOTGI experienced a higher burden of poor mental health than cisgender people (Downing & Przedworski, 2018). Because of their poor mental health, suicidal ideation and suicide attempts are much higher for PIPOTGI with a range of 22-43% of PIPOTGI people in the US and Canada reporting attempting suicide compared to 0.6 to 6% of the cisgender population (Winter et al., Bauer et al., Jacob & Cox, 2017; Halliwell, 2019; Miller & Grollman, 2015; Weir & Piquette, 2018; White Hughto, Reisner, & Pachankis, 2016; Seelman, Colón, et al., 2017; Carabez, Eliason, & Martinson, 2016; Wylie et al., 2016; Stroumsa et al., 2019; Selix & Rowniak, 2016).

2.3.2.4 Socioeconomic impact of poor health outcomes. Providing the opportunity for PIPOTGI to obtain healthcare from appropriately trained providers will increase their access to care and impact their overall health. Increasing the quality of life for PIPOTGI will result in long term socioeconomic consequences for the rest of society. “When marginalized groups are subjugated through systemic oppression, their opportunities to make a social contribution are suppressed” (Kcomt, 2019, p.215).

2.3.3 Other Barriers. PIPOTGI face barriers related to institutional and individual erasure. This erasure is evidenced by whether or not their choices of gender on forms is limited to only the binary choices of male and female and is one indication as to whether or not PIPOTGI would be safe to reveal their gender identity when presenting to a healthcare office for an initial visit. Insurance coverage has an impact on PIPOTGI as well. One study (Kattari & Hasche, 2016) found that PIPOTGI who carried private insurance were less likely to be discriminated against and that having public insurance carried an increased likelihood of reporting experiences of harassment. When their identification does not accurately reflect their pronoun and name associated with their gender identity, PIPOTGI insurance providers may choose to deny gender related claims.

2.3.3.1 Erasure. Several research articles mention the concept of erasure to explain how the inability to express their gender overlaps social, cultural, institutional, and political systems which effectively erase the existence of PIPOTGI (Kcomt, 2019; Scandurra et al., 2019; White Hughto et al., 2015; Restar & Reisner, 2017; Carabez et al., 2016; Hoffkling et al., 2017; Goldstein et al., 2017). An informational and institutional erasure of PIPOTGI exists in healthcare institutions and professional training. This erasure creates an uncertain environment for PIPOTGI. When given only male and female to choose from, PIPOTGI are associated with whichever gender they chose from the moment they complete an intake form. Once the form is complete, based on the box they checked, the staff will assume which pronoun to use and what to anticipate under their gown. According to Carabez and colleagues (2016) “Healthcare institutions are rigidly locked into this gender binary, and therefore, those who exist outside of it create discomfort and uncertainty in the providers” (p.269).

Policymakers and service providers must address discrimination and social exclusion in employment, education, and healthcare (McCann & Brown, 2018; Wang & Cahill, 2018). One place to start would be with the policies impacting the collection and recording of sexual orientation and gender identity (SOGI) information within electronic health records (EHR). Most electronic health records do not accurately capture gender identity data, and, when forced to choose the gender matching their identification documents instead of their gender identity, PIPOTGI will be misgendered or addressed inappropriately upon arrival (Ehrenfeld et al., 2018; Scandurra et al., 2019; Donald, & Ehrenfeld, 2015).

2.3.3.2 Lack of trust. Some providers who aren't up to date with the reclassification of gender incongruence continue to assume PIPOTGI have a mental disorder. Due to their misinformation, providers may lack trust in what patients are telling them about their gender perception and identity. Being misinformed undermines the willingness of providers to trust PIPOTGI's mental capacity to make decisions about their own care (Winter et al., 2016). Conversely, PIPOTGI lack trust in healthcare providers. When seeking healthcare, PIPOTGI report healthcare providers refusing to provide needed care, using excessive precautions, using harsh or abusive language, or being physically rough or abusive (Healthcare equality index, 2019). When providers are unable to 'figure out' their patients' gender, their reaction ranges from disciplining to disengaging from their PIPOTGI patient. Paine (2018) describes *embodied disruption* as the phenomenon when PIPOTGI are mis/recognized by providers who assumed them to embody a normative binary identity during an encounter in a medical setting (p 354). At the moment they realize their provider is experiencing this dilemma, PIPOTGI must balance their need for appropriate care with their healthcare providers' discomfort. These moments of mistrust cause anxiety, confusion, panic, fear, and distress in PIPOTGI.

2.3.3.3 Impact of insurance. It is important to consider the role of insurance on discrimination and disparities as well. Among PIPOTGI, insurance status is a significant predictor of postponing the use of healthcare. Some PIPOTGI choose to travel out of state to a PIPOTGI friendly provider who isn't covered by their insurance knowing they will have to pay out of pocket for the visit. Due to unstable housing and employment, PIPOTGI with insurance coverage may need to move away from a trusted healthcare provider (Kattari & Hasche, 2016; White Hughto et al., 2015; Ehrenfeld et al., 2018). Insurance companies can deny transition-related surgeries under the guise that the procedures are cosmetic and not medically necessary (Halliwell, 2019). “Once insurance companies begin to cover transition-related procedures, it will have a legitimizing effect in the medical field” (Kattari & Hasche, 2016, p. 300).

2.3.4 Lack of Provider Knowledge. Knowledge is obtained through both cognitive and affective learning, and it is clear from the literature that healthcare providers have a deficit in both domains as it relates to PIPOTGI (Chisolm Straker et al., 2018; Paradiso & Lally, 2018). “Cognitive learning occurs as a function of the brain and is created when information is received, processed, and stored in either long-term or short-term memory” (Fressola & Patterson, 2017, p.71). “Learning in the affective, or “feeling,” domain involves shaping one’s feelings expressed as emotions, interests, beliefs, attitudes, values, and appreciations” (Bastable, 2017, p.358). It is imperative for providers to not merely have the cognitive knowledge of PIPOTGI issues and healthcare needs, they must also have an ability to access their emotions, beliefs, and attitudes towards PIPOTGI for learning to take place.

2.3.4.1 Lack of provider training and curriculum in health programs. Most medical and nursing training programs are still not teaching about transgender healthcare, and trainees often do not get exposure to transgender patients (Ehrenfeld et al., 2018; White Hughto et al., 2015;

Nurse Practitioners, 2018; Seelman et al., 2018; Seelman et al., 2017; Baldwin et al., 2018; Chisolm Straker et al., 2018; Paradiso & Lally, 2018; Stroumsa et al., 2019; Gonzales & Henning-Smith, 2017; Valenta et al., 2018; Bauer et al., 2015; Paradiso & Lally, 2018).

Healthcare providers report that they do not have exposure to information about transgender patients and, therefore, lack confidence in their capacity to care for PIPOTGI (Jaffee et al., 2016; Nurse Practitioners, 2018; Baldwin et al., 2018; Mehta et al., 2018). Educational curricula in medical and nursing programs can provide the most significant benefit in improving PIPOTGI health by increasing the knowledge and cultural competency of health professionals working with this population (Jacob & Cox, 2017; White Hughto, Reisner, & Pachankis, 2015; Mehta et al., 2018; Wylie et al., 2016). This lack of healthcare provider confidence is evidenced by PIPOTGI participants who, in a national transgender discrimination survey, stated they had encountered gaps in provider knowledge and found themselves "teaching their provider" (James et al., 2016, p. 96). In other studies, PIPOTGI reported similarly about the need to teach their providers about PIPOTGI care (Halliwell, 2019; Jacob & Cox, 2017; Seelman et al., 2018; Baldwin et al., 2018; Chisolm et al., 2018; Paradiso & Lally, 2018; Stroumsa et al., 2019). Due to their lack of knowledge regarding the healthcare needs of PIPOTGI, healthcare providers are likely to be uncertain about their ability to provide adequate care. This uncertainty can unintentionally create an atmosphere of disapproval for transgender patients due to unconscious bias (Jaffee et al., 2016; Seelman et al., 2018). This unconscious bias among healthcare providers can shape attitudes, beliefs, and behaviors and can influence whether and when PIPOTGI feel safe to disclose their gender identity to healthcare providers (Kattari & Hasche, 2016; Seelman, et al., 2017; Valenta, Shade, Lieggi, 2018). While there is substantial evidence that points to the lack of provider training and curriculum on PIPOTGI healthcare issues,

questions still exist on how to integrate PIPOTGI health into academic programs best to increase the ease in which of both medical and nursing professionals care for PIPOTGI patients (Ehrenfeld et al., 2018). Yet, professional development in the form of a continuing education session for nurses could help to increase both gaps in knowledge and culturally competent care.

Based on this literature review and the evidence highlighting the disparity in PIPOTGI healthcare and treatment, it's negative consequences, and a notable lack of healthcare provider knowledge and awareness, the need for an educative training session is apparent. The type of learning needed must have the ability to disrupt providers' transphobic beliefs regarding PIPOTGI to allow for transformation to occur.

2.4 Theoretical Framework

Given the likelihood that negative mindsets, elements of transphobia, or psychopathologizing may persist with some healthcare providers, a disruption of those ideas is needed for affective learning to take place, and cognitive learning to be successful. For this reason, the educational theory of transformational learning (Mezirow, 1978), was selected as the theoretical framework for a PIPOTGI-centered continuing education session. The goal of using Mezirow's theory was for nurses to form a more developed frame of reference surrounding PIPOTGI. For this to occur, it was necessary to disrupt their existing frame of reference to make space for reflection and a new understanding of PIPOTGI.

Mezirow recognized that individuals traverse through distinct phases during transformational learning. These phases include 1) a disorienting dilemma 2) self-examination and critical assessment of assumptions with feelings of inner conflict 3) recognition 4) realization 5) acquisition of knowledge 6) exploration of options for new roles 7) planning course of action 8) provisional trying of new roles 9) building self-confidence in new roles and

10) a reintegration into one's life based on one's new perspective (Mezirow, 1991). Any significant challenge for an established perspective that questions deeply held beliefs can result in a transformation by threatening one's very sense of self.

The goal of using transformational learning was to allow nurses an opportunity to open their minds by being provided a disorienting dilemma concerning cisgender privilege that began their process of transformation. Other steps in Mezirow's transformational learning theory that follow the disorienting dilemma allowed nurses to critically reflect and self-examine their beliefs and feelings surrounding PIPOTGI, acquire PIPOTGI-centered knowledge, become confident with their new knowledge and reintegrate into their practice armed with a progressive perspective of PIPOTGI. Achieving a change in perspective was paramount in the process of transformational learning. Mezirow (1991) speaks to the importance of perspective transformation describing it as a way to become "critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world" (p.167). Providing continuing education using Mezirow's transformational learning allowed nurses the opportunity to develop a new perspective surrounding gender identity. This new and integrative perspective empowered nurses to provide unbiased healthcare and increase social justice for PIPOTGI.

2.5 Summary

It is clear that PIPOTGI are at risk for mental health vulnerabilities, which include marginalization, discrimination, and transphobia. Living on the margins of society also place PIPOTGI at risk for unsafe sex practices, substance abuse, and increased risk of suicide, which are a result of both institutional and informational erasure. Their lack of access to culturally competent care, as well as their lack of trust in healthcare providers, results in PIPOTGI

reluctance to seek medical care and in some cases obtaining care from unlicensed professionals and use of illicit and unsafe street hormones. This increases PIPOTGI's risk of poor health outcomes. It is also clear there is a deficit in appropriate training for healthcare providers. Continuing professional education for nurses embedded in transformation theory provided an opportunity for personal growth. Transformational learning tested their foundation of beliefs regarding PIPOTGI by giving them space to explore the roots of their assumptions and preconceptions and, as a result, changed the way they construed the meaning of gender identity.

Chapter 3

3.0 Methods

3.1 Introduction

This chapter outlines the methods and procedures that were employed in this practice change project aimed at improving the healthcare of PIPOTGI. The goal of this project was to answer the interconnected qualitative and quantitative questions posed in chapter one regarding the effect of educating nurses on PIPOTGI terminology and health issues as well as their awareness of any preconceived bias towards PIPOTGI they may have had. The results of this study support the idea that providing cognitive, affective, and PIPOTGI-centered education for nurses, through transformational learning contribute to PIPOTGI having access to enhanced culturally competent healthcare.

3.2 Project Design

The proposed project used a mixed-method research design to evaluate the PIPOTGI knowledge and awareness of participants before and after the delivery of a three-hour educative session. Due to the complexity and depth of issues surrounding PIPOTGI, a QUAL + QUAN (Morse, 1991) design was selected to address the mix of project research questions that investigated both the cognitive effects of the educational intervention as well as possible affective outcomes of shifts in participant perceptions. This type of design has been proven to facilitate healthcare providers in providing “conceptually sound, holistic knowledge to guide practice, policy, and research” (Hall & Roussel, 2017, p. 63). Quantitative data were obtained by pre-post intervention measurements of knowledge of PIPOTGI terminology and healthcare issues. Measurements of attitudes toward PIPOTGI were acquired before and after the intervention. Qualitative data was obtained in small group debriefing discussions following the

educational sessions. The reason for separating into smaller, more intimate groups, was to be to encourage quality discussion. To encourage free responses during debriefing, the facilitator provided open-ended prompts for the participants.

The data collection procedures, order, and time spent delivering the education sessions were designed to remain the same to enhance internal validity. However, due to participants' questions and tangential conversations that occurred among the group as a result of these questions, it was not possible to provide absolute consistent timing for delivery of each education session. This prompted a small threat to internal validity. As the educational sessions recruited only nurses, the study findings are generalizable to that limited population for external validity.

3.3 Sample and Setting

The goal was to have a minimum of 60 participants for this research project. Participants were licensed nurses (LPNs, RNs, and APRNs) working in any area of healthcare. Inclusion criteria were an active Hawaii nurse licensure regardless of the state in which they practice. The collection of all data occurred before the participants' departure; therefore, there was no need to account for attrition.

The project conducted two educational sessions held in classroom settings on university campuses. The classrooms had the necessary audio-visual equipment, desks/tables, and chairs. There were refreshments available to the participants as provided by the primary researcher. On the island of Maui, the educational session took place within the nursing department on the University of Hawaii campus. On the island of Oahu, the pedagogical setting took place at Hawaii Pacific University (HPU). Each session had a physical limit of 30 participants due to room size and the need to facilitate post-session debriefing groups. Privacy was enhanced in the

classrooms on both campuses' by closing the door during the educational session and signage posted on classroom doors.

Recruitment took place through convenience and purposive sampling. Nurses who attended the educational session were eligible to receive three credit hours of continuing education (CEU) towards the renewal of their Hawaii nursing license. After engaging with the administrators of the nursing departments at the University of Hawaii (UH)-Maui and Hawaii Pacific University (HPU), recruitment methods included signage at both campuses to recruit LPN and RN students as well as RN faculty members as potential participants (Appendix A). The primary investigator also visited graduate nursing classrooms at HPU to invite students to participate.

3.3.1 Protection of human subjects. Potential volunteers for the project were informed that participation in this project was voluntary. For those nurses who were also faculty or students at either UH or HPU, it was made clear to them that whether they chose to participate or not it did not affect their employment, grades, or progression in their university programs. Informed consent (Appendix B) was obtained on the day of the educational session before the start. Prior to starting, the project was submitted for expedited review and approved by the Institutional Review Board (IRB) of Hawaii Pacific University (Appendix C). Confidentiality was maintained as the names and identities of the participants were not made public. All information is being stored with the primary researcher on a password-protected computer and in a lock-secured cabinet.

3.4 Data Collection Instruments

A combination of quantitative and qualitative measurements was used to carry out this project. The tools included an evidence-based instrument for the measurement of transgender

attitudes and beliefs, as well as an investigator-developed demographics questionnaire and pre-post knowledge tests. In addition, open-ended interview questions were used to collect qualitative data.

3.4.1 Demographic survey. The demographic survey collected the following information: level of nursing education, years of practice, area of practice, age, gender, number of years living in Hawaii, and relationship with a PIPOTGI. Gathering information regarding education, years of nursing experience, areas of practice, age, gender, and prior relationships with PIPOTGI was used to examine possible correlates to the project outcome variables. Exploring linkages between the number of years in Hawaii, where 20% of Native Hawaiians identify as a third gender, was used to investigate any possible relationship of this variable and acceptance of PIPOTGI. A copy of the demographic survey is available in Appendix D.

3.4.2 Knowledge of PIPOTGI test. A 10-item multiple-choice test developed by the primary investigator was used to measure participant knowledge about PIPOTGI terminology and healthcare issues before and after the educational session. A copy of this tool is available in Appendix E.

3.4.3 The transgender attitudes and beliefs scale (TABS). The TABS (Kanamori, Cornelius-White, Pegors, Daniel, & Hulgus, 2017) was used to collect data on participant's outcome variables of knowledge and awareness and is available in Appendix F. Permission was requested and granted by the author to use the TABS, which is a 29-question Likert scale with contextual relevance and capacity to assess multiple dimensions of beliefs and attitudes. The TABS measured three factors; interpersonal comfort, sex/gender beliefs, and human value and was therefore selected for this DNP project as it focuses on both cognitive and affective outcomes. Targeting cognitive learning, the TABS assesses underlying beliefs regarding gender

and sex as dichotomous. The affective responses were designed to capture interpersonal comfort moving along the spectrum of affective states of antipathy, ambivalence, and acceptance. Higher scores on the TABS tool equated to more positive attitudes toward transgender persons. (Kanamori et al., 2017).

The TABS has a high degree of reliability with the overall scale demonstrating a Cronbach alpha of .98 and each factor a high internal consistency with alpha coefficients =.97 for interpersonal comfort, .95 for sex/gender beliefs, and .93 for human value. Construct validity of TABS has also been satisfactorily confirmed with psychometric testing of convergent and discriminate validity (Kanamori et al., 2017).

3.5 Procedures

After introductions and greetings, all participants signed an informed consent form, all of which took 20 minutes. After they were comfortably seated, participants were given another 20 minutes to complete the knowledge pre-test and demographic survey. Once all of the participants completed the necessary forms, the educational session began. The primary investigator started by providing a ten-minute *disorienting dilemma*, in the form of a ‘Privileges for Sale’ activity created by Sam Killerman (n.d.) (Appendix G). This activity involved the participants being told to imagine they no longer had any privilege. As a group, they decided which of the thirty-three listed privileges they would purchase with the artificial money provided. Examples of privileges for sale included: using public restrooms without fear of threat or punishment, adopting your children, and being able to go to a doctor and getting treatment that doesn’t conflict with your identity. According to the transformational learning theory, participating in this type of activity allowed participants the time to investigate the meaning of privilege and began the process of critical self-reflection, making space for the learning to come.

It was an essential component of transformational learning when attempting to remove any preconceived bias towards PIPOTGI.

For the next hour, a learning module based on *Improving healthcare for transgender people* developed by the National LGBT Health Education Center: A program of the Fenway Institute was presented. This learning module was the best choice to educate nurses, as it is relevant to their role in caring for PIPOTGI.

After the presentation, participants were provided a 20-minute break before their 30-minute debriefing session took place. Then, the debrief session was conducted by the primary investigator. Participants were given time to write answers to several open-ended questions that explored participant attitudes and perceptions toward PIPOTGI. Prior to departing, the participants completed both the knowledge and TABS post-tests. They were thanked for their participation, and each received a CEU certificate. An outline of this procedural flow is available in Table 3.1.

Table 3.1

Project Procedural Flow

Activity	Allotted time
Greetings and introductions	5 minutes
Informed consent	15 minutes
Completing pre-tests and demographic survey	20 minutes
Disorienting dilemma	10 minutes
Power point presentation	60 minutes
Intermission/refreshments	20 minutes
Debriefing	30 minutes
Completing post-test measurements	20 minutes

Potential problems with these procedures were audio/visual difficulties, unanticipated needs of participants resulting in additional time added to the presentation, or unforeseeable

weather or traffic conditions delaying participant's ability to attend. When requesting classroom space for the educational sessions, an additional 30 minutes above the expected session requirements was requested to account for this possibility.

3.6 Data Analysis

Data analysis involved an integration of quantitative and qualitative data arriving at meta-inferences about the impact of an educational session on nurse participant's knowledge and awareness of PIPOTGI terminology and healthcare issues and the concurrent impact it had on their attitudes and perceptions of PIPOTGI. IBM SPSS was used to analyze quantitative data with a level of significance set at 0.05. Descriptive statistics were analyzed for indicators of central tendency and variability as well as correlations to outcome measurements of knowledge and awareness. To test the difference in mean scores on the Knowledge of PIPOTGI and TABS pre-tests and posttests, paired *t*-tests were calculated with confidence intervals (*CI*s) constructed around differences in means. In addition, measures of central tendencies were reviewed, and correlation coefficients calculated to analyze the test-retest reliability of the Knowledge of PIPOTGI and TABS instruments.

The analysis of qualitative data gained from participants' answers to open-ended questions was transcribed and evaluated by the primary researcher and a research assistant using a constant comparison technique (Creswell, 2008) to identify common themes. A triangulation technique was applied to enhance the trustworthiness of qualitative data. The two researchers compared and refined the themes to ensure interrater reliability.

3.7 Resources and Budget Considerations

The educational sessions occurred between January and April of 2020 and were personally financed on the islands of Maui and Oahu by the primary investigator. The goal was

to have two sessions with 30 participants. Smaller sessions were offered with a minimum attendance of five.

3.8 Project Timeline

Component	Projected Completion Date
Project Proposal Defense	December 2019
Institutional Review Board Approval	January 2020
Recruitment	February 2020
Delivery of Educational Sessions	March-April 2020
Data Analysis	May 2020
Write-up of results and discussions	May-August 2020
Project Presentation/Defense	August 2020

3.9 Summary

The potential to change the paradigm of healthcare for PIPOTGI was evident in the completion of this DNP project. Educating nurses regarding the healthcare needs of PIPOTGI and allowing them the opportunity to explore any preconceived bias toward PIPOTGI may help to decrease the incidence of transphobia and discrimination against PIPOTGI in healthcare settings. Once they had a deeper understanding of PIPOTGI, nurses verbalized how they would act as positive examples for their co-workers and were empowered to advocate for culturally competent healthcare for PIPOTGI.

Chapter 4

4.0 Results

4.1 Introduction

The project was conducted over 10 weeks beginning on March 16, 2020. A total of eleven PIPOTGI-centered educational sessions were delivered on 3/16/20, 3/17/20, 4/12/20, 4/29/20, 5/5/20, 5/14/20, 5/15/20, 5/17/20, 5/21/20, and 5/26/20. Data analysis of the quantitative outcome measures of the PIPOTGI knowledge test and the TABS was conducted using Microsoft Excel and confirmed with IBM SPSS version 26. Exploratory qualitative analysis of a transcript containing participant's written responses to three open-ended questions was conducted by two reviewers using a constant comparison approach to identify categories and themes. Results were examined to determine if a PIPOTGI-centered educational session based on transformational learning theory delivered to licensed nurses would improve their knowledge of PIPOTGI terminology and common health issues and increase their awareness of preconceived attitudes toward PIPOTGI.

4.2 Nurses Demographics

A convenience sample of 21 licensed nurses participated as volunteers in this project. The majority of the participants were female (95%) registered nurses (57%), followed by APRNs (33%), with LPNs composing ten percent of the participants. The majority of the participants were over the age of 40 years old (86%), nurse educators (67%), and educated at the master's level (52%). Most had worked in nursing for 2-10 years (48%). Sixty-seven percent of the participants had cared for a PIPOTGI patient and 62% knew someone identifying as PIPOTGI. Nurses who were born and raised in Hawaii represented 14.3% of participants. The number of years living in Hawaii was varied with 24% living in the state for 2-10 years and the bulk of

participants (76%) having lived in Hawaii for more than 10 years. The majority of participant demographics did not correlate with outcome measures. However, being a nurse educator was positively associated with higher post knowledge scores.

4.3 Findings: Assessment of PIPOTGI Knowledge

A ten-question test measuring PIPOTGI knowledge was administered before and after the educational session. It was scored using a 5-point Likert scale. For questions 1-8 the desired response, disagree, earned 5-points, and somewhat disagree earned 4-points. Neutral earned 3-points, somewhat agree earned 2-points and agree earned 1-point. Questions 9-10 were similarly scored with the desired response being agree.

After confirming assumptions of normality, a paired samples *t*-test was used to analyze differences of scores on pre/post-PIPOTGI knowledge tests. A pre-test mean score = 41.86 (SD 5.02) and post-test mean score = 46.95 (SD 3.80) resulted in a mean increase in scores following the educational session of 5.095 (SD = 3.65). This difference in scores was normally distributed as confirmed by a non-significant Wilks $p > .05$. The *t*-test revealed a statistically significant difference in the total scores on pre-tests versus post-tests, with knowledge improving for the post-test $t(20) = 6.405, p = .000$ (95% CI = 3.436 – 6.755). This difference was representative of large effect size with a Cohen's $d = 1.4$. The Cronbach's alpha of the *Assessment of PIPOTGI Knowledge Test* was .738, indicating good item-reliability.

Participants improved their scores on each of the ten PIPOTGI knowledge test items as outlined in Table 4.1. Responses with statistically significant changes post-intervention included statements whose context dealt with PIPOTGI's access to care and their feelings of safety when seeking healthcare. The nurses also increased their awareness of specialty physicians' lack of specialized education necessary to care for PIPOTGI. The statement with the most significant

change was ‘sex and gender are the same.’ On the pre-test, only 36% of the nurse educators disagreed with this statement. After the educational session was delivered, 100% of the nurse educators disagreed that sex and gender are the same. Three statements that did not result in statistically significant improvement were related to PIPOTGI suicide risk, surgical choices, and the conflation of PIPOTGI and mental illness. A fourth item without significant improvement was about the emergency room physician training. There was a decrease in scores between pre and post-tests for question number six which most likely was an anomaly due to the negative phrasing of that question.

Table 4.1
Means (SD) of PIPOTGI Knowledge Test Items (n = 21)

Test Item	Mean (SD) Pre-Test	Mean (SD) Post-Test	Mean Change (SD) in Nurse’s PIPOTGI Knowledge	Significance of Change Post-Intervention <i>p</i>
1. Sex and gender are the same.	3.71(1.4)	4.71(.90)	1.00	.001*
2. If someone tells me they are transgender, I understand that it means they have had surgery to change their gender.	4.19(1.0)	4.86(.48)	.667	.007*
3. Transgender individuals have equal access to care.	3.48(1.6)	4.52(1.2)	1.05	.004*
4. When seeking healthcare, transgender individuals feel safe.	4.14(1.1)	4.76(.44)	.619	.006*
5. Specialists such as emergency room physicians have specialized training regarding caring for transgender people.	4.48(.87)	4.71(.72)	.238	.348
6. Transgender people are not at higher risk for suicide than the rest of society.	4.76(.89)	4.52(1.2)	-.238	.234

7. When taking care of transgender people, I know it is okay to ask them why they chose that lifestyle.	4.24(1.1)	4.86(.48)	.619	.009*
8. Not identifying with the gender you were born with (based on genitalia) is a mental illness.	4.76(.77)	4.95(.22)	.190	.214
9. Some transgender individuals choose not to have surgery to change their gender.	4.62(.80)	4.81(.68)	.190	.428
10. I know where to find the information I need to care for transgender individuals.	3.29(1.3)	4.33(1.1)	1.05	.002*

*Significance level < .01

4.4 Findings: Transgender Attitude and Beliefs Scale (TABS)

A 29-question TABS questionnaire was completed by participants before and after the educational session. TABS is comprised of three factors measuring interpersonal comfort (14-items), sex/gender beliefs (10-items), and human value (5-items). Interpersonal comfort items specifically measured nurses' level of ease being in social situations with transgender individuals. Previous mindsets held by nurses surrounding gender and sex was measured by the sex/gender beliefs items. Finally, human value questions gauged nurses' beliefs about the inherent merit and virtue of transgender people. The responses ranged from 1 = *strongly disagree* to 7 = *strongly agree* with the responses for fourteen of the statements being reverse-scored 1 = *strongly agree* and 7 = *strongly disagree*.

After confirming assumptions of normality, a paired samples *t*-test was used to analyze differences of scores on pre/post TABS tests both overall and on each of the three factors of interpersonal comfort, sex/gender beliefs, and human value. A total TABS pre-test mean score = 182.57 (SD 16.93) and post-test mean score = 190.00 (SD 15.93) resulted in a mean increase in

scores following the educational session of 7.429 (SD =8.89). This difference in scores was normally distributed as confirmed by a non-significant Wilks $p > .05$. The t -test revealed a statistically significant difference in scores for pre-test versus post-test, with TABS improving for the post-test $t(20) = 3.829, p = .001$ (95% CI = 3.381 – 11.476). This difference was representative of a large effect size with a Cohen’s $d = .83$. The Cronbach’s alpha of the *Transgender Attitudes and Beliefs Survey* was .921, indicating excellent item-reliability.

Participants improved their scores on each of the three factors of the TABS as outlined in Table 4.2. Factor one, measuring interpersonal comfort, resulted in increased scores following the educational session nearing statistical significance ($p = 0.068$). Factor two, measuring sex/gender beliefs, had a statistically significant change ($p = 0.02$). Factor three, measuring human value, did not show a significant change ($p = 0.54$).

Table 4.2
Means (SD) of Transgender Attitudes and Beliefs Scale (TABS) Factors 1-3 (n = 21)

Factors	Mean (SD) Pre-Test	Mean (SD) Post-Test	Mean (SD) Change in Nurses Transgender Attitudes and Beliefs	Significance of Change (p)* Post-Intervention
1: Interpersonal Comfort	87.67 (9.6)	89.90 (9.2)	2.23 (5.3)	.062
2: Sex/Gender Beliefs	60.38 (9.0)	65.38 (7.2)	5.00 (6.4)	.001*
3: Human Value	34.52 (1.5)	34.71(1.3)	.19 (1.4)	.54

*Significance level $< .01$

4.5 Findings: Qualitative Themes

Following the educational session and debriefing, participants were asked to respond in writing to the following open-ended questions:

- 1) Prior to attending this educational session what were your beliefs about PIPOTGI?

- 2) After attending this educational session, in what ways have your beliefs surrounding PIPOTGI been transformed (or not)?
- 3) What changes (if any) do you plan to make based on the information you have learned today?

Using a constant comparison technique, the reviewers independently analyzed transcribed notes containing the participant's written responses which were transcribed by the primary investigator into a word document. The following process was implemented to promote inter-coder reliability and reduce bias. Each reviewer read through transcribed notes in their entirety to promote immersion into the data. Perusing the entire transcript allowed the reviewers to gain a general understanding of the context and key concepts. Then, to identify segments belonging to particular categories, each reviewer re-read the transcribed notes. After noting general categories from the transcribed notes, the reviewers then discussed their analyses, and consensus was reached on evolving themes recognized by both reviewers. The transcribed notes were then re-conceptualized to ensure they supported the themes. The following themes were then finalized:

- Theme 1: Realization and inner conflict
- Theme 2: Increased knowledge and awareness
- Theme 3: Transformation of thoughts
- Theme 4: Advocacy

4.5.1 Theme 1: Realization and inner conflict. The majority of the participants expressed the desire to treat PIPOTGI in accordance with their core nursing values, but it was clear they were struggling with their professional identity as caregivers. The nurses seemed to question if they could uphold the tenets of nursing if they lacked adequate knowledge about or had possessed unconscious bias toward PIPOTGI. This conflict was evidenced by statements of realization such as: “I thought it was okay to have binary questionnaires and that it was OK if people had to select M or F” and “I am probably saying things that make PIPOTGI feel dehumanized without meaning to” and “I realized I did not always know the right thing to say or

do.” The International Council of Nurses (ICN) Code of Ethics (2012) states “Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect” (p.1). Seemingly influenced by this ethical code, participants frequently used the terms “respect” (16), “human” (13), “treat” (9), and “rights” (4) in their responses to the open-ended questions. This struggle with the desire to uphold core nursing values of treating individuals with dignity, kindness, and respect seemed to fuel an inner conflict in the nurses as evidenced by written statements such as “My hope is that 2 [*sic*] create a feeling of respect + [*sic*] value in how I interact with them [PIPOTGI]” and “They are human and deserve basic human rights however in society they[PIPOTGI] are often severely judged and poorly treated” and “I believed they [PIPOTGI] deserved the same healthcare as everyone else.” The nurses frequently recognized their lack of understanding with statements of: “I recognized there was much I did not know” and “Professionals need to [have] more education to better provide care to everyone” and “They [PIPOTGI] are an at-risk group due to both ignorance and lack of knowledge and discrimination in the healthcare arena” and simply, “I still have a lot to understand.” These statements of realization demonstrates a sincere desire for an increased understanding of PIPOTGI.

4.5.2 Theme 2: Knowledge and awareness. The nurses often questioned the terminology related to PIPOTGI as if to make sure they “got it right”. Many participants seemed to be caught up in the differences between expressed gender identities and verbalized the usefulness of the acronym PIPOTGI as a way to simplify gender identity. The majority of nurses expressed an increase in knowledge with statements such as: “My understanding has been broadened” and “I will feel somewhat knowledgeable on the subject”, and reporting that they had “...more clarification on gender identity versus sexual orientation”. It was not only the

terminology that the nurses focused on, but also the application of their knowledge. The participants connected their increase in knowledge with ways in which they would use it to infuse caring into their interactions with PIPOTGI saying: “[This educational session] informed my ability to support and love them [PIPOTGI]”, and “I definitely have a better understanding of PIPOTGI and the struggles they face” and “I have an awareness of terminology, what is the least non-offensive, or accepting thing to say.”

The transcripts also revealed a positive impact on affective learning following the educational session. Several participants acknowledged increased awareness and perspective saying “Times have changed and it is no longer a binary gender world” another noted “You cannot tell a book by its cover” and, “I learned that they’re humans like everyone else and it doesn’t matter if they’re male or female”. The nurses also recognized how their attitudes could impact their interactions with PIPOTGI, and how a more positive attitude could lead to a better experience for PIPOTGI. This was evidenced by the statements: “I would want to be more aware of how someone identifies and not put my issues with that on them” and “This talk [*sic*] has created an awareness in me [*in*] how to be more sensitive in my interactions”.

4.5.3 Theme 3: Transformation of thoughts. Intertwined with increasing awareness was a transformation of nurses’ mindset toward PIPOTGI as they questioned their assumptions. They expressed wanting to be able to establish trust with PIPOTGI and recognized the value of changing their mindset towards PIPOTGI. Examples included participants writing: “I will be more intentional about how I approach others to prevent the “shut down” of [the] relationship” and “I hope to be accepting and allowing the patient feel comfortable in expressing their wants and needs.” The importance of continuing the transformation of nurses’ thoughts was evidenced when a participant wrote “This is/has to be an ongoing dialog for all”.

4.5.4 Theme 4: Advocacy. Nurses also expressed their readiness to create change for PIPOTGI following the educational session, with the majority of them indicating ways they would advocate for PIPOTGI. Examples of such statements were: “As a medical community, we need to embrace PIPOTGI, changing ways we approach people and our processes” and that nurses should: “...help be part of the change” and “ ...speak out against discrimination”. Poignantly, one participant was empowered to: “...speak up to help my colleagues transform” and another committed to: “...continue to explore my own feelings and actions so that I can become an advocate for [PIPOTGI] patients and the community as a whole.” Another succinctly responded that she would: “...work on being a better advocate”.

Several nurses offered specific examples of what they would personally do to advocate for PIPOTGI such as to: “...remember to include extra categories beyond M/F on forms” and “...change some of our forms to reflect gender identity”. Other participants planned to ask patients about specifics related to their gender identity as demonstrated by their plans of: “...being more mindful of asking individuals what pronoun they prefer” and to: “...identify what their [patients] gender identity is”. One of the nurse educators planned to advocate for PIPOTGI by stating that she would: “...consider a way to give the topic more time in the curriculum” and another plans to bring PIPOTGI education to their hospital, stating: “When we do our annual feedback at work, I can suggest that we all have PIPOTGI training”.

4.6 Summary

There were several positive results from the PIPOTGI-centered education session. First, there was an improvement in nurses’ knowledge surrounding PIPOTGI as noted by an increase in means scores from the pre-test compared to the post-test. Secondly, there was a change in sex/gender beliefs, interpersonal comfort, with PIPOTGI, and human valuing as evidenced by an

increase in the mean scores on all three factors from the pre-test TABS compared to the post-test TABS. Themes from the qualitative data were consistent with the transformational learning theory as nurses struggled with the inner conflict of wanting to treat PIPOTGI with dignity, honor, and respect but lacking the knowledge to do so. During this educational session, nurses were able to realize whether or not they held any preconceived bias toward PIPOTGI, and demonstrated a transformation of thoughts post-intervention. Importantly, the educational session contributed to nurses desiring to become advocates for PIPOTGI.

Chapter 5

5.0 Discussion

5.1 Introduction

By using the transformational learning theory of Mezirow (1978) as a method of delivery for a 3-hour PIPOTGI-centered educational session, nurses were given the opportunity to learn about PIPOTGI healthcare needs and for critical reflection into their own personal belief systems and questioning of any preconceived bias toward PIPOTGI. Owing to the scarcity of culturally competent PIPOTGI education within nursing curriculum, well-meaning nurses participating in this research project had misconceptions surrounding gender identity which, admittedly for some, resulted in unintentional negative mindsets towards PIPOTGI. After participation in the PIPOTGI educational session, nurses demonstrated an improvement in their knowledge as well as an increased awareness surrounding sex/gender beliefs. An additional key finding was an increase in nurses' interpersonal comfort with PIPOTGI. With gained knowledge and awareness, the nurses also expressed plans to be advocates for PIPOTGI. The outcomes of this project support the presumption that educating nurses through transformational learning is an effective way to enhance PIPOTGI-centered cultural competency in healthcare frontline workers. The ways in which nurses' cognitive and affective domains of learning were transformed will be further explored in this chapter.

5.2 Implication of Findings

The qualitative and quantitative findings from this project provide insight into the effectiveness of utilizing transformational learning for the delivery of PIPOTGI-centered education to nurses. This type of learning led to an increase in nurses' knowledge and a deeper understanding of the distinction between sexual orientation and gender identity. Nurses also

experienced a transformation of their thoughts and became empowered to be advocates for PIPOTGI.

5.2.1 Effectiveness of transformational learning. Nurses participating in this study experienced the modification in perception necessary to alter their perspective of gender identity. Presupposing nurses, by virtue of their humanness, may have had some unconscious bias toward PIPOTGI; it was imperative to disrupt such mindsets by providing them with a disorienting dilemma. Even those nurses who said “you are preaching to the choir, let’s see what you’ve got” upon entering the educational session admitted to a change in thought prior to departing. Transformational learning proved to impact nurses in a positive and substantial way that helped change their perception of PIPOTGI.

During the educational session, the nurses naturally traversed through phases of transformational learning. The steps participants experienced during the educational session were very similar to the phases of transformational learning as explained by Mezirow (1978). Figure 5.1 shows the phases of Mezirow’s transformational learning as experienced by the participants of this study. Interweaving quotes from participants, this figure depicts the ways in which nurses began their transformation with a disruption of their old meaning of gender identity. The quotes illustrate the nurses moving through the phases of recognition and realization and illumination of their inner conflict. By reading their comments, one can see how the nurses’ opened up to accept a new meaning of gender identity. After their acquisition of knowledge, nurses were encouraged to explore what they could do with their new understanding. Armed with their new perspectives on gender identity, nurses verbalized specific actions they planned to take and advocacy roles they would fill within their work settings.

Figure 5.1

Transformative Learning Experienced by Study Participants



Note: This figure is a schematic view of participants’ walk through transformational learning

5.2.2 Increase in nurses’ knowledge and understanding of gender identity. Several participants recognized they had a need for more information prior to attending, saying “I believed I wanted/needed to know more about PIPOTGI and how to be respectful” and “...with changing terminology, I needed further education.” The need to understand the terminology related to the LGBTQIA acronym was universal among the participants. Nurses were confused regarding the meaning of the letters LGBTQIA, and most were surprised to learn the Q was for ‘questioning’ not ‘queer.’ Yet, the investigator-developed term PIPOTGI[®] was embraced by the

nurses' participating in this study as evidenced by remarks such as "I love the word PIPOTGI – the transformative part of it." Once the acronym PIPOTGI was introduced, nurses were better able to comprehend the fundamental differences between sexual orientation and gender identity. Using the acronym PIPOTGI as an umbrella term to describe the multitude of ways in which individuals describe their gender identity added a bonus of providing clarity and made a positive impact on the understanding of participants.

The difficulties experienced by participants in understanding acronyms and terminology in the context of gender identity versus sexual orientation is also reflected in the literature. A preponderance of recent articles has recognized the importance of separating sexual orientation and gender identity in order to understand the needs of non-binary people (Bradford, 2019; Fiani & Han, 2019; Frei et al., 2019; Johnson, Hill, Beach-Ferrara, Rogers, & Bradford, 2020), and Motmans and colleagues (2019) importantly recognized that the diversity of how PIPOTGI choose to describe their gender and the lack of an umbrella term for gender non-binary descriptors is problematic. There is an opportunity to remedy this lack of an umbrella term recognizing the multiplicity of gender identities with the acronym PIPOTGI.

To the best of our knowledge, there are no other published interventional studies that have measured nurses' knowledge and awareness surrounding PIPOTGI before and after a PIPOTGI-centered educational session. Previous studies seeking information about nurses from interviews or questionnaires have revealed a lack of nurses' knowledge (Carabez, Elizason, & Martinson, 2016), and others measuring nurses' knowledge, attitudes, and beliefs (Paradiso & Lally, 2018; Kanamori & Cornelius-White, 2016) have noted that nurses recognize that a lack of knowledge impedes their ability to provide culturally competent care. Although these studies have provided much-needed information on the current gap in nurse's knowledge, attitudes, and

beliefs surrounding PIPOTGI, this study's findings advance our understanding of effective interventional methods to address these barriers. There are also no previous reports of the effects of gender identity-based teachings in nursing which speaks to the obvious need for more education. As reported by Ding, Ehrenfeld, Edmiston, Eckstrand, and Beach (2020) in *The Joint Commission Journal on Quality and Patient Safety*, PIPOTGI are discriminated against and 'comprehensive approaches to improve the quality of healthcare of transgender and gender non-conforming (TGNC) patient populations are currently lacking' (p. 37). PIPOTGI education that is based on transformational learning theory is a proven and novel approach that can bridge this gap.

5.2.3 Transformation of thoughts. Previous studies have recognized the need for the transformation of providers' thoughts surrounding PIPOTGI in order to create a more welcoming environment for PIPOTGI in healthcare. Stroumsa et al. (2019) prioritized the need to address transphobia rather than merely increasing hours of transgender-related education in order to improve access to culturally competent care for PIPOTGI. Paine (2018) concluded that, for such education to be effective, it must '...deconstruct provider assumption about binary gender' (p. 357) and Mehta et al. (2018) recognized that provider experiences have a profound impact on their comfort with PIPOTGI. In this project, nurses were able to question their interpretation of gender identity, allowing for the necessary deconstruction of preconceived ideas of gender.

This study's findings demonstrate that it is possible to change nurses' mindsets surrounding PIPOTGI and gender identity through cognitive and affective learning. The power of the affective aspect of learning was evident with the change in nurses' awareness even though some participants may have initially found the information on gender identity discordant with what they believed to be true. After nurses' knowledge was increased, their awareness

enhanced, and thoughts transformed, they were more willing to accept PIPOTGI for who they inherently were, versus questioning the reasoning behind why a particular individual identifies outside of binary genders. Interestingly, an internal pressure to do what is right after being empowered with more knowledge was evidenced in the participants of this study. During the debriefing of one session, several participants vocalized internal discomfort and an increased ethical-pressure to do the right thing now that they had an enhanced understanding of the life experiences of PIPOTGI. This increased sense of ethical responsibility sheds light on the depth of transformation experienced by nurses in this study and demonstrated a foundational shift in their perspectives that empowered them to become PIPOTGI advocates.

5.3 Limitations

Due to the 2020 COVID-19 pandemic, some adjustments to the original implementation plan were necessary. Instead of carrying out two education sessions of approximately 30 participants in classroom settings on university campuses, a total of 11 smaller sessions were held. Two sessions were delivered on the University of Hawaii-Maui campus on March 16 and 17, 2020 before the campus closed due to the pandemic. These two sessions yielded a total of 6 participants. After that, nine additional educational sessions were delivered in various settings (the investigators home, participant's home, or participant's office) between April 12 and May 26, 2020, with the number of participants in each session ranging from 1-4. Overall, the result was smaller than the planned sample size, which limits the generalizability of findings. The intimacy of the small group sizes, some being one-on-one sessions, may also have impacted the findings by increasing participants' comfort, leading to increased disclosure, and when combined with a possible Hawthorne effect, may have inflated the study's positive outcomes. Favorable outcome findings mirroring nursing ethics may have also been influenced by the unique

characteristics of the participants as nurses. The International Council of Nurses (ICN) Code of Ethics (2012, p.1) states “Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect.” Participants may have held back on sharing negative attitudes that were counter-intuitive to these core nursing values. In addition, the study used convenience sampling to recruit participants and those who attended were intrinsically motivated to learn more about PIPOTGI. This may have prompted some selection bias and inflation of positive outcome findings. Test/retest bias may also have impacted participants' performance on outcome measures.

5.4 Recommendations for Implementation

In considering future implementation of this project within healthcare settings, concepts from the integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) were selected as a framework (Kitson & Harvey, 2016). Briefly, the i-PARIHS model understands that the successful implementation of innovative knowledge requires an understanding of recipients, context, and the prevailing culture of settings into which the knowledge will be translated. The philosophy of i-PARIHS is considered to be harmonious with transformative learning in that it recognizes that the facilitator functions as the active ingredient in the translation of knowledge (Harvey & Kitson, 2015).

5.4.1 Introducing a novel and innovative idea into practice. The i-PARIHS framework recognizes that facilitators must carefully assess the unique characteristics of the innovation they will be implementing. Facilitators of PIPOTGI educational sessions must acknowledge that, for some, the concept of non-binary gender identities may be a novel idea. Due to this novelty, introducing the innovative theme regarding diversity of gender identities to nurses requires a creative method of presenting this psychosocial issue. Facilitators must

recognize that this subject may have disruptive undercurrents within the minds of the participants. The preparation surrounding introduction of this innovation differs greatly from preparing to introduce a new piece of equipment to the same group of participants. Unlike learning to use a novel piece of equipment, participants may have emotional reactions to the subject of gender identity. These emotions could run the gamut of being compatible and accepted, to being contested and causing angst within participants.

As evidenced by the positive outcomes of this project, transformative facilitation was a successful way to transfer PIPOTGI knowledge to nurses. Mezirow recognized that facilitators offer points of view that some participants may initially find threatening, dissonant, and unsavory, but subsequently come to recognize them as requisite to reckoning unconscious bias (Mezirow, 1991). Nurses participating in this study felt the dilemma between wanting to treat PIPOTGI with respect and their personal beliefs. One participant expressed “the lack of clarification in gender identity is confusing to me personally this I relate to as a mental health illness to some degree.” The facilitator providing educational content on PIPOTGI must be enlivened, adaptable, and approachable. Facilitators must take caution to not react to participants verbalizing their discomfort with the subject of gender identity. They must assess the baseline understanding of gender identity as well as continuously assess participants’ contestability to this subject and adapt their way of delivering the educational content accordingly.

Most importantly, facilitators must create a trusting and safe environment. Without trust, the participants will lack the comfort and vulnerability necessary to ask questions during the educational session and when expressing their thoughts. During the debriefing of one session, a participant explained her belief that asking patients what pronoun they prefer is extremely rude and vehemently declared that she would never do that. Because the facilitator established a

trusting and safe environment for transformation to take place, comments such as this were allowed to be spoken without judgment.

5.4.2 Participants as recipients of novel innovation. Applying the i-PARIHS framework for the implementation of PIPOTGI educational sessions requires careful evaluation of the receptivity of participants to the novel innovation. Facilitators must recognize that nurses are unique recipients. Due to their core nursing values and the ethics guiding their practice, nurses innately feel internalized pressure to do the right thing. Facilitators must also take into account that nurses are confident and well-educated participants and may have some resistance as their boundaries expand. Some may realize that they hold some unconscious bias toward PIPOTGI. Facilitators must help to normalize this realization for participants as it can be a source of shame for nurses.

At the start of the educational session delivered in this study, nurses were challenged to open their minds by a learning activity in which participants experienced losing privilege through a disorienting dilemma (see Appendix G). Lively discussions were surrounding this exercise in privilege with one participant boldly saying, ‘I don’t see these as privileges, I see them as my rights.’ Setting the stage for transformation by disrupting their assumptions challenged nurses to acknowledge and alter any negative frames of reference they may have had surrounding PIPOTGI. For some nurses, this process created resistance. When answering the open-ended question asking in what ways their beliefs surrounding PIPOTGI were transformed, some nurses were reluctant to admit to their change in mindset. They wrote “I do not believe my beliefs have changed however, my understanding has been broadened” and “...not necessarily transformed, more aware and more knowledge” and “they have not except being more aware...”

This is contrasted by one participant who emphatically declared, “Yes it [my beliefs surrounding PIPOTGI] has been transformed”.

Participants, as recipients of a novel innovation, must also have the chance to refute, question, challenge, and hear others do the same. Especially important is the provision of adequate time and space for internal reflection. Mezirow put it well, saying “The more reflective and open to the perspectives of others we are, the richer our imagination of alternative contexts for understanding will be.” (Mezirow, 1991, p. 83) Anecdotal evidence supporting the need for reflection occurred during a debriefing session when one participant disclosed that her child is non-binary and prefers the pronouns “they/them/theirs.” Prior to her making this disclosure, the other participants were having difficulty understanding how to use a plural pronoun to describe one person. Being able to imagine their co-worker having a non-binary child who identifies themselves with plural pronouns shifted the other participants’ frame of reference. This openness by one participant to communicate her experience as a mother of a child identifying as “they” enabled her fellow participants to transform. It can be said that, in order to understand the unknown, one must allow themselves to imagine. The presence of an open-minded facilitator creating a safe space for such imagining allowed this participant to share her extremely private and personal experience for others to benefit from her revelation.

5.4.3 Nurse advocacy influencing contexts to incorporate PIPOTGI into practice.

Within the i-PARIHS framework, context is identified as local and organizational practice settings (Dryden-Palmer, Parshuram, & Berta, 2020). It is recognized that these contexts and their environments influence the ease of incorporating a novel innovation, such as the acronym PIPOTGI delivered through transformative learning modality, into practice. In this study, after the delivery of PIPOTGI education by a self-aware, expert facilitator, nurses became advocates

and described concrete ways in which they would adjust their individual practice to support PIPOTGI. They also verbalized plans to help their co-workers transform. This was an exciting outcome in that making the change in one nurse held the possibility of helping multiple others to also transform. This sharing of knowledge among nurses could help shift the nursing culture to be more inclusive for PIPOTGI.

Nurses, acting on their own, may not have the influence required to fully incorporate change into local and organizational contexts. To support nurses' efforts in advocating for PIPOTGI, there must be a buy-in from the local and organizational healthcare systems where they are employed. DNP leaders can act as PIPOTGI subject matter experts and champions for nurse advocates and work with stakeholders to develop appropriate strategies to further the nurses' efforts towards advocacy for PIPOTGI.

To ease this transition, mandatory PIPOTGI education should be required for healthcare administrators and healthcare policymakers. Facilitators of these sessions must be aware that healthcare organizations are believed to be among the most complex of environments for knowledge translation (Dryden-Palmer et al., 2020). Partnerships between expert facilitators, nurses, and stakeholders will help deepen the understanding of the systems that must be in place for the full integration of this novel innovation. After all, the goal of using i-PARIHS as the framework for introducing PIPOTGI-centered education into healthcare is singular. If the teaching is carried out efficiently throughout a healthcare organization, a person in possession of transformative gender identity will not be an outlier. They will have the ability to make an appointment and be seen for their healthcare problem just as any other stakeholder would, without ever needing to explain their gender identity to the support staff, their nurse, or their provider.

5.5 Recommendations for Future Practice, Education, Policy, and/or Research

In order to incorporate the results of this research project into practice and improve healthcare for PIPOTGI, there needs to be continued offerings of PIPOTGI-centered educational sessions. In the area of practice, the DNP leader can raise awareness surrounding discrimination and transphobia towards genders beyond the institutionally accepted binaries of male and female. In order to promote both cognitive and affective learning, transformative teaching methods should be considered. Encouraging stakeholders to support institutional policy changes to include non-binary genders on intake forms and within electronic medical records of institutions will help reduce erasure of PIPOTGI.

5.5.1 Practice. Given that PIPOTGI delay or avoid going into healthcare settings due to a history of being mistreated (Frei et al., 2019), and their mistrust in and sometimes fear of providers has been identified as a barrier to obtaining culturally-competent healthcare (Johnson et al., 2020, Winter et al., 2016; Paine, 2018), a fundamental practice change is clearly needed. DNP leaders can help create PIPOTGI-friendly and trusting healthcare environments by opening the dialogue regarding gender identity with administrators, nurses, and support staff of healthcare organizations. Once dialogue surrounding gender identity is initiated within an organization and facilitators are in place to promote comprehension of PIPOTGI information, there will be a higher likelihood of successfully integrating PIPOTGI language into healthcare settings. DNP leaders can then continue the dialogue until gender identities outside of male and female are normalized, and barriers to accepting PIPOTGI within healthcare organizations can be overcome.

5.5.2 Education. Systemic changes should reflect the implementation of PIPOTGI education into new employee orientation schedules. Having nurses within healthcare

organizations who are cognizant of the broad spectrum of gender identities that PIPOTGI possess, will allow for trust between nurse and patient. This trust will enable a change in the paradigm of healthcare for PIPOTGI and help to improve their quality of life.

This project tested the feasibility of using transformational learning as a theoretical framework to deliver PIPOTGI-centered education to nurses and found this method to be an effective approach to improving nurses' knowledge and awareness. There were rich discussions among participants, with all agreeing there was an egregious lack of PIPOTGI-centered education within their nursing education. Participants were appreciative of the opportunity to participate in this project that addressed their educational needs and filled a knowledge gap with gender identity information. Adding PIPOTGI-centered curriculum as a requirement within nursing education will foster increased understanding and, perhaps, an increased acceptance of PIPOTGI in the next generation of healthcare providers. In order for the paradigm to shift toward acceptance of PIPOTGI within health care settings, it is imperative that healthcare providers who lack exposure to variations of gender identities beyond male and female have access to PIPOTGI continuing education.

5.5.3 Policy. DNP leaders can work with local and state governmental organizations to advocate for policy changes to help increase access to care for PIPOTGI in healthcare settings. Interesting to note is the paradoxical change that is happening across the nation. While the state of Hawaii is progressing forward, other states are retracting policies protecting PIPOTGI. Starting July 1, 2020, residents of Hawaii can choose between 'male', 'female', and 'x' when applying for, or renewing, their drivers' license (Acheta, 2020). Changing the policies which require people to choose between male and female and allowing for a non-binary option will allow PIPOTGI to feel accepted. While we are celebrating the acknowledgment of non-binary

genders in Hawaii, PIPOTGI and their advocates in other states and across the nation are experiencing increased negative pressures from recent changes in legislation. As an example, in Idaho, HB 509 was recently passed which forbids PIPOTGI from changing their gender marker on their birth certificates (Morrow, 2020). The past four years have been devastating to the PIPOTGI community due to decisions made by the current Trump-Pence administration such as the Department of Housing and Urban Development who, on July 23, 2020, proposed a regulation listing ways emergency shelters can turn away marginalized individuals, especially transgender people (Tran, 2020). In this election year, there is a cry from the PIPOTGI community and their advocates for change. As nurses become empowered with more knowledge and awareness, they can serve as powerful advocates for policy changes to protect PIPOTGI.

5.5.4. Research. There is an urgent need for more research into the underlying roots of transphobia and how we can work to shed harmful mindsets that underly the discrimination faced by PIPOTGI. Currently, there is a preponderance of evidence indicating that PIPOTGI are avoiding healthcare due to being discriminated against in healthcare settings. There is also an abundance of research claiming that healthcare providers lack the necessary training to care for PIPOTGI. What is missing are facilitators, acting as researchers, who are willing to forge ahead with the uncomfortable task of changing providers' mindsets, shifting their boundaries, and undoing negative attitudes towards PIPOTGI through education. More research on the effects of educational interventions is needed and researchers facilitating such sessions must be self-aware and comfortable with being vulnerable. In essence, researchers engaging in replicating this type of study must be courageous. They must understand that while they are providing much-needed knowledge, they are also asking participants to dig deep and disrupt any existing bias that may be present towards PIPOTGI. It is also recommended that DNP leaders also orchestrate

interprofessional collaboration at local and state levels. By working with policymakers and professionals representing the educational, healthcare, and social science professions, DNP advocates will improve the likelihood of successful integration of research findings into healthcare settings.

5.6 Summary

In this project, the delivery of a PIPOTGI-centered educational session successfully enhanced nurses' sex/gender beliefs and increased their knowledge and acceptance of PIPOTGI. These findings on the effectiveness of PIPOTGI-centered education demonstrate a promising potential to change the paradigm of healthcare by creating nurses who advocate for PIPOTGI. It is important to note that such education should be approached from both the cognitive and affective domains, and a framework such as Mezirow's transformational learning theory is useful toward that end. The DNP nurse leader is in the ideal position to be an advocate for such educational opportunities as well as by leading organizational initiatives that will enhance access to culturally competent care for PIPOTGI.

As a nurse researcher and DNP leader, I have continued the dialogue regarding gender identity using the acronym PIPOTGI. For example, an abstract from this project was selected for presentation at the Health Advocacy and Policy Conference in Chiang Mai, Thailand, June 16-18, 2020. Unfortunately, this conference was canceled due to the 2020 COVID-19 pandemic. Findings from this project were presented at the *Virtual* Sigma Theta Tau International (STTI) Nursing Congress July 22-24, 2020 and a copy of this poster presentation has been published in the STTI repository. My future plans include presenting a half-day workshop entitled "Transgender 101" during the American College of Nurse-Midwives 2020 Inclusion Conference: Dare to Think Different on September 12, 2020. In addition, I now routinely include PIPOTGI

lectures in the curriculum of the nursing courses I am teaching at the University of Hawaii-Maui College. Maui Memorial Medical Center has also invited me to present my PIPOTGI education at their Nurse Residency Program when they reconvene their education sessions. I am also in the process of creating a program called the PIPOTGI Project which will include an online community that will help PIPOTGI and their families connect with culturally competent healthcare providers.

This DNP project and its correlations to the AACN DNP essentials can be found in Appendix H. As a DNP scholar, I am committed to continuing PIPOTGI-centered research and have applied for the Doris Bloch Research Grant offered by STTI. With the monies from this grant, I will travel throughout the Hawaiian Islands delivering PIPOTGI educational sessions and obtaining additional data on its effectiveness. I am confident that with my continued efforts I can propel this project to larger initiatives that can shape new practices. Through scholarship, I can influence healthcare policy to create needed changes within healthcare settings that will improve access to culturally competent care for PIPOTGI.

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Appendix A

Recruitment Flyer



Attention Nurses

VOLUNTEERS NEEDED FOR RESEARCH

THE PURPOSE of this study is to enhance your knowledge of the health care needs of transgender and gender non-conforming people after attending a 3-hour educational session.

Benefits of participation:

- 3 hours of continuing education (CEU)

- Improvement in the ability to care for transgender and gender non-conforming patients.
- Increased awareness.

Requirements:

- Participants must be a licensed LPN, RN, or APRN.
- Must be able to read and understand English.

This training will consist of a three-hour educational session on transgender and gender non-conforming healthcare needs. You will be asked to complete

a demographic survey, pre-post tests regarding your knowledge and beliefs regarding transgender and gender non-conforming people. You will also be asked to write your answers to three open-ended questions after attending the educational session.

If interested please email

jbaumstark1@my.hpu.edu

This research has been reviewed and approved by the Hawai'i Pacific University Institutional Review Board.

Appendix B

Informed Consent Document

Project Title: Improving Healthcare for People in Possession of Transformative Gender Identity

(PIPOTGI): Impact of Education on Nurses' Knowledge and Awareness

Investigator(s): Jennifer Baumstark, MSN, APRN, CNM-BC

PURPOSE

This study involves research. The purpose of the research is to determine if a three-hour educational session provided to licensed nurses will increase their knowledge and awareness of PIPOTGI's health care needs.

We are inviting people to participate in this research because they: 1. Are a licensed nurse. 2. Are interested in increasing their knowledge of PIPOTGI. The goal is to educate at least 60 participants.

This project will last for approximately two months, from March 2020 to April 2020. The educational session will last for approximately 3 hours.

PROCEDURES

Those agreeing to participate can expect the following to occur:

- You will be taken to a conference room by the investigator.
- You will be asked to complete a pre-test regarding your knowledge of PIPOTGI and a Transgender Attitude and Beliefs scale pre-test prior to listening to a three-hour educational session given by the primary investigator.
- You will be asked to answer open-ended questions immediately following the education session.

RISKS

Participation in this study poses no foreseeable risks to you.

BENEFITS

There may be personal benefit for participating in this study. It is hoped that the educational session will increase both your knowledge and awareness of PIPOTGI health needs. In the future, society could benefit from this study by serving to improve the understanding of PIPOGI by healthcare providers.

COSTS AND COMPENSATION

There will not be any costs to you for participating in this research project.

Participants will be compensated for their time and inconvenience for participating in this research project by receiving three credit hours of continuing education (CEU) for renewal for their Hawaii nursing licenses.

CONFIDENTIALITY

Records of participation in this research project will be maintained and kept confidential to the extent permitted by law. However, federal government regulatory agencies and the Hawai'i Pacific University IRB may inspect and copy a subject's records pertaining to the research, and these records may contain personal identifiers. Names and identifying data will not be used. All surveys will be kept in a secure location, within the investigators computer, which is double password protected. Interviews will not be recorded in any way. In the event of any report or publication from this study, the identity of subjects will not be disclosed. Results will be reported in a summarized manner in such a way that subjects cannot be identified.

VOLUNTARY PARTICIPATION

All participation is voluntary. There is no penalty to anyone who decides not to participate. Nor will anyone be penalized if he or she decides to stop participation at any time during the research project. Each interview with a client will be prefaced with a statement indicating that they may terminate the interview at any time, or rescind their participation. Participation in this study and any data gathered during the study will not affect the treatment provided to the participant by the clinic.

QUESTIONS

Questions are encouraged. Questions about this research project and questions about the rights of research subjects or research related injury may be addressed to the IRB Chair (Dr. Trish Ellerson at 566-2467 or irbchair@hpu.edu)

Subject's name (printed): _____

(Signature of Subject)

(Date)

INVESTIGATOR STATEMENT

I have discussed the above points with the subject or the legally authorized representative, using a translator when necessary. It is my opinion that the subject understands the risks, benefits, and obligations involved in participation in this project.

(Signature of Investigator) (Date)

CERTIFICATE OF CONFIDENTIALITY

A. Certificate of Confidentiality has been issued for this project by the Department of Health and Human Services (DHHS). This Certificate will protect the investigator(s) from being forced, even under a court order or subpoena, to release any research data in which subjects are identified. Subjects may receive a copy of this certificate upon request.

Appendix C

Hawai'i Pacific University Institutional Review Board Project Application

Please complete and submit the form to the IRB chair via email: to irbchair@hpu.edu

Study title: Improving healthcare for people in possession of transformative gender identity (PIPOTGI): Impact of education on nurses' knowledge and awareness

Investigator:

Name: Jennifer Baumstark
(Please check one)

· Faculty x Student · Outside Investigator

Phone: 808-212-4538

Email: jbaumstark1@my.hpu.edu

Sponsoring HPU Faculty Member: Dr. Kathleen Burger

(if Investigator is not an HPU faculty member)

Please attach a brief summary of the project. This should include an explicit statement of methods, data collection, and how confidentiality of subjects/data will be protected including consent form.

Category for Review:

Check one level of review (Exempt, Expedited, Full) for which you believe the project qualifies, and each criterion that your project meets.

___ **Exempt from review (nil or minimal risk study, or already reviewed by an IRB)**

___ Research involves ONLY investigation into or comparison of normal instructional strategies.

___ Tests, interviews, and surveys are unlikely to elicit emotion or place subjects at risk of civil/criminal liability or damage to their reputation, financial standing, employability, etc. AND information will not be recorded in such a way that subjects can be identified.

___ Research involves only the study or analysis of existing data, documents, records, or specimens that are publicly available or recorded in such a way that subjects cannot be identified.

___ If study involves ingestion of food: only wholesome food without additives in excess of USDA recommended levels is consumed.

___ Brief informed consent will be done (except in the case of existing data, etc.).

___ No use of vulnerable subjects (children, prisoners, pregnant women, mentally ill, etc.).

____ Has already been approved by IRB at _____.
(Include copy of signed IRB approval form.)

Expedited review (minor risk study)

Research and data collection methods are unlikely to elicit strong emotion and deception is not involved.

____ Research involves only noninvasive, painless, and non-disfiguring collection of physical samples, such as hair, sweat, excreta.

____ No use of vulnerable subjects (children, prisoners, pregnant women, mentally ill, disabled, etc.).

____ Data are recorded using noninvasive, painless, and non-disfiguring sensors or equipment, such as EKG, weighing scales, voice/video recording.

____ Research involves only moderate levels of exercise in healthy volunteers.

Research does not involve ingestion of drugs or use of hazardous devices.

If existing data, documents, records, or specimens with identifiers are used, procedures are in place to ensure confidentiality.

Informed consent process will be done (attach copy of informed consent form).

Data will be kept confidential and not reported in identifiable fashion.

____ **Full review required (more than minor risk)**

Attach a statement that describes the use of vulnerable subjects or the study procedures and conditions that place subjects at risk. Describe the precautions that will be taken to minimize these risks. Attach a copy of the informed consent form that will be used.

Certification by Principal Investigator: The above represents a fair estimate of risks to human subjects.

Name/ Title/ Date

-

FOR IRB USE ONLY

Certification by IRB Chair: I have read this application and believe this research qualifies as:

____ Exempt from IRB review

____ Appropriate for expedited review, and
____ approved

____ disapproved

____ Appropriate for review by the full IRB

IRB Chair Date

Appendix D

Demographic Survey

1. What is your age (circle one)? • < 25 years • 26-30 • 31-35 • 36-40 • > 40 years
2. What is your gender? • Male • Female • MTF • FTM • Other _____
3. What is your job title? • LPN • RN • APRN • Other _____
4. What area of nursing are you currently working in?
• Hospital • Outpatient setting • Other _____
5. Are you a nurse educator?
• Yes • No
6. What is your highest level of education?
• ADN • BSN • MSN • PhD • DNP
7. How long have you worked in your current job?
• < 2years • 2-10 years • 10-20 years • >20 years
8. How long have you lived in Hawaii?
• < 2years • 2-10 years • 10-20 years • >20 years
9. Were you born in Hawaii? • Yes • No
10. Have you taken care of a transgender or gender non-conforming patient?
• Yes • No • Unsure
11. Do you know anyone who identifies as transgender or gender non-conforming?
• Yes • No • Unsure
12. Do you belong to a religious organization? If so, please provide denomination.
• No • Yes _____

Appendix E

Assessment of PIPOTGI Knowledge

Participant name _____

1. Sex and gender are the same.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
2. If someone tells me they are transgender, I understand that it means they have had surgery to change their gender.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
3. Transgender individuals have equal access to healthcare.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
4. When seeking healthcare, transgender individuals feel safe.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
5. Specialists such as emergency room physicians have specialized training regarding caring for transgender people.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
6. Transgender people are not at higher risk of suicide than the rest of society.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
7. When taking care of transgender people, it is okay to ask them why they chose that lifestyle.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree
8. Not identifying with the gender you were born with (based on genitalia) is a mental illness.
 - Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree

9. Some transgender individuals choose not to have surgery to change their gender.

• Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree

10. I know where to find the information I need to care for transgender individuals.

• Agree • Somewhat agree • Neutral • Somewhat disagree • Disagree

Appendix F

Transgender Attitudes and Beliefs Scale (TABS)

This questionnaire is designed to measure your beliefs and attitudes toward transgender persons. It is not a test, so there are no right or wrong answers. Please answer each question as carefully and honestly as you can, using the 7-point scale described below. For this questionnaire, a transgender person is defined as a person whose biological sex at birth does not match their felt sense of self as male or female.

Strongly Disagree	Disagree	Somewhat Disagree	Neither	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

FACTOR 1 (Interpersonal Comfort)

- Q1.1 I would feel comfortable having a transgender person into my home for a meal.
- Q1.2 I would be comfortable being in a group of transgender individuals.
- Q1.3 I would be uncomfortable if my boss was transgender.
- Q1.4 I would feel uncomfortable working closely with a transgender person in my workplace.
- Q1.5 If I knew someone was transgender, I would still be open to forming a friendship with that person.
- Q1.6 I would feel comfortable if my next-door neighbor was transgender.
- Q1.7 If my child brought home a transgender friend, I would be comfortable having that person into my home.
- Q1.8 I would be upset if someone I'd known for a long time revealed that they used to be another gender.
- Q1.9 If I knew someone was transgender, I would tend to avoid that person.
- Q1.10 If a transgender person asked to be my housemate, I would want to decline.
- Q1.11 I would feel uncomfortable finding out that I was alone with a transgender person.
- Q1.12 I would be comfortable working for a company that welcomes transgender individuals.

Q1.13 If someone I knew revealed to me that they were transgender, I would probably no longer be as close to that person.

Q1.14 If I found out my doctor was transgender, I would want to seek another doctor.

FACTOR 2 (Sex/Gender Beliefs)

Q2.1 A person who is not sure about being male or female is mentally ill.

Q2.2 Whether a person is male or female depends upon whether they feel male or female.

Q2.3 If you are born male, nothing you do will change that.

Q2.4 Whether a person is male or female depends strictly on their external sex-parts.

Q2.5 Humanity is only male or female; there is nothing in between.

Q2.6 If a transgender person identifies as female, she should have the right to marry a man.

Q2.7 Although most of humanity is male or female, there are also identities in between.

Q2.8 All adults should identify as either male or female.

Q2.9 A child born with ambiguous sex-parts should be assigned to be either male or female.

Q2.10 A person does not have to be clearly male or female to be normal and healthy.

FACTOR 3 (Human Value)

Q3.1 Transgender individuals are valuable human beings regardless of how I feel about transgenderism.

Q3.2 Transgender individuals should be treated with the same respect and dignity as any other person.

Q3.3 I would find it highly objectionable to see a transgender person being teased or mistreated.

Q3.4 Transgender individuals are human beings with their own struggles, just like the rest of us.

Q3.5 Transgender individuals should have the same access to housing as any other person.

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Appendix G

Privilege For Sale

Please look at the following list of privileges. Each privilege costs \$100 to purchase. As a group, please purchase as many privileges as your money allows.

1. Celebrating your marriage(s) with your family, friends, and coworkers.
2. Paid leave from your job when grieving the death of your partner(s).
3. Inheriting from your partner(s)/lover(s)/companion(s) automatically after their death.
4. Having multiple positive TV role models.
5. Sharing health insurance with your partner(s).
6. Being able to find role models of the same sexual orientation.
7. Being able to see your partner(s) immediately if in an accident or emergency.
8. Being able to be promoted in your job without your sexuality playing a factor.
9. Adopting your children.
10. Filing joint tax returns.
11. Able to obtain child custody.
12. Being able to complete forms and paperwork with the information you feel most accurately communicates who you are.
13. Being able to feel safe in your interactions with police officers.
14. Being able to travel, or show ID in restaurants or bars, without fear you'll be rejected.
15. Kissing/hugging/being affectionate in public without threat or punishment.
16. Being able to discuss and have access to multiple family planning options.
17. Not questioning normalcy both sexually and culturally.
18. Reading books or seeing movies about a relationship you wish you could have.
19. Receiving discounted homeowner insurance rates with your recognized partner(s).
20. Raising children without worrying about state intervention.
21. Having others comfort and support you when a relationship ends.
22. Being a foster parent.
23. Using public restrooms without fear of threat or punishment.
24. Being employed as a preschool or elementary school teacher without people assuming you will "corrupt" the children.
25. Dating the person you desired in your teens.
26. Raising children without worrying about people rejecting your children because of your sexuality.
27. Living openly with your partner(s).
28. Receiving validation from your religious community.
29. Being accepted by your neighbors, colleagues, and new friends.
30. Being able to go to a doctor and getting treatment that doesn't conflict with your identity.
31. Being able to access social services without fear of discrimination, or being turned away.
32. Sponsoring your partner(s) for citizenship.
33. Being open and having your partner(s) accepted by your family.

Killerman, S. (n.d.) Privilege for sale activity. Retrieved from <https://thesafezoneproject.com/?s=privilege+for+sale>

Appendix H

DNP Essentials and Relationship to DNP Project

Essential Number	Description of AACN DNP Essential	Relationship to DNP Project
I	Scientific Underpinnings for Practice	<ul style="list-style-type: none"> • Knowledge of scientific foundation of nursing and care of people in possession of transformative gender identity (PIPOTGI) was used to identify and enhance the understanding of the problem PIPOTGI face accessing culturally competent care and its significance to health care outcomes. • An education session was developed based on empirical knowledge of nursing care of PIPOTGI.
II	Organizational & Systems Leadership for QI & Economics	<ul style="list-style-type: none"> • Collaboration with key stakeholders such as nursing and education in developing research grant proposal to promote continuing education opportunities for nurses.
III	EBP/Translational Science	<ul style="list-style-type: none"> • Development and acceptance of DNP proposal. • Achieving HPU IRB approval for DNP project. • Analysis of quantitative and qualitative data • The Johns Hopkins Nursing Evidence-Based Practice Rating Scale was used for this project to evaluate the quality and strength of the evidence in the literature review. Refer to page 22. • The integrated Promoting Action on Research Implementation in Health Services Model of EBP proposed to drive the implementation of the findings of this study
IV	Information Systems/Technology	<ul style="list-style-type: none"> • Use of IBM-SPSS to assess quantitative data. • Use of HPU Doctor of Nursing Practice research guide to search databases for relevant research related to PIPOTGI and nursing care.
V	Health Care Policy & Ethics	<ul style="list-style-type: none"> • Became a member of World Professional Organization of Transgender Health (WPATH) for networking and communication on an international level about research on PIPOTGI.

		<ul style="list-style-type: none"> • Advocate for social justice of PIPOTGI within nursing practice by educating nurses in the community.
VI	Interprofessional Collaboration	<ul style="list-style-type: none"> • Collaborated with administrators of nursing programs at the University of Hawaii and Hawaii Pacific University to evaluate the viability of delivering educational sessions on their campus’. • Discussions with Maui Memorial Medical Center’s Director of Nursing for permission to incorporate PIPOTGI educational sessions into their Nurse Residency Program.
VII	Prevention & Population Health	<ul style="list-style-type: none"> • Population health data was used to create the learning module for this project.
VIII	Advanced Nursing Practice & Education	<ul style="list-style-type: none"> • Disseminated results from the project with a poster presentation at the Virtual Sigma Theta Tau 31th International Research Congress on July 22-24, 2020 • Scheduled to present a half-day workshop entitled “Transgender 101” during the American College of Nurse-Midwives 2020 Inclusion Conference: Dare to Think Different on September 12, 2020