TRANSGENDER EDUCATION IN NURSING: A QUALITATIVE STUDY INVESTIGATING FACULTY BELIEFS

BY

VANESSA POMARICO-DENINO

A Dissertation Submitted to the School of Graduate Studies
in Partial Fulfillment of the Requirements for
the Degree of EdD in Nursing

Southern Connecticut State University
New Haven, Connecticut
April 3, 2018

APPROVAL PAGE

TRANSGENDER EDUCATION IN NURSING: A QUALITATIVE STUDY INVESTIGATING FACULTY BELIEFS

BY

VANESSA POMARICO-DENINO

This dissertation was prepared under the direction of the candidate's dissertation sponsor, Dr. Mary Ellen Doherty, Department of Nursing, and it has been approved by the members of the candidate's dissertation committee. It was submitted to the School of Graduate Studies and was accepted in partial fulfillment of the requirements for the degree of Doctor of Education.
Committee Members:

Mary Ellen Doherty, PhD, RN, CNM
Dissertation Chairperson

Ellen Abate, EdD, RN
Second Committee Member

Jamison Green, PhD
Third Committee Member

Lisa Rebeschi, PhD, RN
Department Chairperson

Dean, School of Graduate Studies

Date

ABSTRACT

Lesbian, gay, bisexual and transgender (LGBT) is an acronym that groups together four populations under one umbrella term. Each of these populations has their own distinct and unique health care needs. Transgender persons may present their gender differently than what is considered the societal norm. As a result, they are more prone to discrimination, harassment and acts of violence than other marginalized populations. Prior experiences with health care professionals may cause transgender persons to avoid seeking health care when needed. As more persons identify as transgender, the need to educate health care providers on the appropriate and sensitive care of this population takes on greater importance. In an effort to address the disparities of sexual and gender minorities, learning to care for this population should begin early on in nursing education. However, if nurse educators are not familiar with or have bias towards this population, it is unlikely that appropriate content to address the specific needs of this population will be included in course content. Educators may not be well versed on this topic owing to the lack of inclusion in the literature which may be a barrier. Nurses must recognize the variances that exist among diverse populations in order to effectively treat and affect positive health care outcomes.

The purpose of this qualitative descriptive study was to explore the attitudes, perceptions, knowledge and biases of nursing faculty regarding care for transgender persons and inclusion in nursing courses. The participants were nursing faculty who were currently teaching part-time, full-time or adjunct in baccalaureate programs. This study was conducted to determine what factors influence inclusion or exclusion of this content in nursing education.

This study used a qualitative descriptive research design. After conducting a qualitative content analysis of interview data from twenty participants, seven themes emerged including:

experience with transgender persons; inclusion and exclusion of content in curriculum; teaching to the test; holistic care and diversity; lack of faculty knowledge; secular versus religious influence on teaching transgender content; and student preparation and readiness to care for transgender persons.

Nurse educators are in a strategic position to teach student nurses on the specific needs of the transgender patient during their didactic and clinical rotations. Educating faculty on the unique needs of this population and thereby increasing their own familiarity will enable them to impart valuable knowledge to their students who, after graduation, will be better prepared to care for transgender persons. Transgender patients will benefit from more comprehensive and affirming nursing care provided to them.

Key words: Gender binary, gender dysphoria, gender identity, gender expression, gender role or non-conformity, gender variant, heteronormativity, LGBT, transgender, transition.

ACKNOWLEDGEMENTS

It is with the deepest gratitude that I acknowledge the following people who gave so much of themselves during my doctoral education to help me succeed in the completion of this work. This dissertation signifies not just the countless hours spent at my computer but a true milestone in my professional career.

Mary Ellen Doherty, PhD, RN, CNM, who conveyed an enthusiastic spirit and willingness to teach me about qualitative research, igniting in me a passion that I did not know I possessed and for selflessly giving so much of her time in order to help me accomplish so much over the past three years. She is a true midwife who helped me to give birth to this dissertation.

Ellen Abate, EdD, RN: For her ever-present support, insight and guidance and always knowing how to make me laugh. Her true interest in this topic and wealth of knowledge in social justice was an added bonus.

Jamison Greene, PhD: Thank you for taking a chance on a complete stranger, act as my content expert and add such incredible dimension to my work. His expertise on this content and skillful editing is so greatly appreciated.

My Ed.D cohort, especially CB: A sisterhood whose friendships I deeply treasure. The constant support for one another, hands on my back, pulling each other up and over the obstacles we faced will never be forgotten. There is a void in my Saturday mornings without our weekly Vidyo meetings.

To my parents for always being a guiding force behind my education and for continually wanting more for me than they wanted for themselves. Thank you for instilling in me good work ethic and understanding the importance of a good education. My dad always says, “Anything

worth doing is worth doing well." I hope I have made you both proud.

To the endless angels called friends who lifted me in prayer whenever I needed it. Your gift of faith, friendship and prayers are so very valued.

To S.M: For introducing me to my very first transgender patient that started me on this journey of enlightenment, passion and knowledge. Thank you for having faith in me as a provider to treat those so close to your heart.

Last, but most importantly, my husband David: Ever patient, always supportive and someone who never stopped believing in me even when I stopped believing in myself. For the endless cups of coffee, jellybeans and on-the-spot counseling sessions, I can never convey the depth of my love for you. All that I am would not have been accomplished without you being there right beside me.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER ONE: INTRODUCTION

Introduction

Lesbian, gay, bisexual and transgender (LGBT) is an acronym that groups together four distinct marginalized populations under one umbrella term. While a growing body of literature is focused on the lesbian, gay, bisexual and transgender (LGBT) population, each of these individuals within the acronym has their own unique health care needs (IOM, 2011; Lim & Bernstein, 2012). Before one can appreciate discrimination of a particular population, marginalized groups must first be examined globally to understand their differences and similarities and the impact of the lack of knowledge by the health care community.

Vulnerable persons are described as "subgroups of the general population who are at greater risk for developing a wider range of social and health problems than the population as a whole" (Van Zandt, Sloand & Wilkins, 2008, p. 127). These groups include, but are not limited to, homeless persons, uninsured or underinsured, ethnic and racial minorities, immigrants, victims of domestic violence, gender and sexual minorities (Alegria, 2011; Flemmer, Doutrich, Dekker, & Rondeau, 2012; Kontunen et al., 2014; Murphy, Griffith, Mroz, & Jirikowic, 2017; Smedley, 2012; Van Zandt et al., 2008). There is a segment of marginalized populations who may be considered temporarily vulnerable such as homeless, uninsured or underinsured while others of this population who have several susceptibilities will live a lifetime in a vulnerable situation (Van Zandt et al., 2008). The underlying causes for these individual situations may change for some or may become a lifetime problem for others. These populations are more at risk for chronic health

diseases that are often untreated. As a result of their disparities, marginalized populations have less access to care, have poorer health care outcomes due to fragmented or non-existent health care or seeking health care only when in a crisis (Camann & Long, 2014; Kontunen, et al., 2014; Van Zandt et al., 2008).

Evidence-based research impacts public policy and social justice, generally based on the metrics of outcomes. However, policies may negatively affect marginalized populations if those persons who create public policy believe they have sufficient knowledge of those needs further diminishing the populations' existing challenges (Silva, Smith & Upshur, 2013). Public health policies are designed to promote or prevent disease among high risk populations thereby promoting social justice. Social justice is a concept that is accepted worldwide (Murphy et al., 2017). The Universal Declaration of Human Rights, Article 25, section 1 was proclaimed in 1948 by the United Nations as a way to ensure fundamental human rights including a standard of living promoting health, medical care and social services worldwide (United Nations, 1948). Health care has gone through a number of changes since 1948 but none so notably or as controversial as the changes that occurred during President Obama's second term in office. The passage of the Affordable Care Act (ACA) in 2010 has been touted as "Quality, Affordable Health Care for All Americans" and is a regulatory action providing all patients with access to health care, including preventative and mental health services (HHS.gov, 2017). The ACA allows those individuals, including marginalized persons, access to the same health care as privately insured individuals. Readily available primary care and preventative services have been well documented to decrease overall costs of care for underserved populations (Murphy et al., 2017). By offering affordable health care to those who are considered the working poor, homeless or otherwise vulnerable, these populations have an increased opportunity to

improve health care outcomes if they are able to access the health care system. The Institute of Medicine (IOM) published a report in 2002 indicating that lower quality of health care for minorities led to poorer health outcomes (Smedley, 2012). Discrimination among minorities and vulnerable populations is not just by way of health care, it also extends to housing, employment and mortgage lending. Discrimination may occur individually, institutionally, structurally within organizations and among social groups. The report concluded that "racial bias, discrimination, stereotyping, and clinical uncertainty" contributed to these health care disparities (Smedley, 2012, p. 933).

Gender minorities are considered a vulnerable population. The definition of gender has historically been viewed as only male or female, which is currently referred to as the gender binary. Little consideration has been given to those individuals who identify differently than just male or female. Transgender persons present their gender differently than what is considered the societal norm (Merryfeather & Bruce, 2014). While some individuals prefer traditional binary identification, others may not identify with any one particular description. The term transgender encompasses gender-variant identities and expressions (IOM, 2011, p. 26). As more persons identify as transgender, nursing as well as other health care disciplines are at greater risk for making assumptions based on heteronormative stereotypes. It is estimated that there are approximately 700,000 persons in the United States who identify as transgender but truly accurate data is deficient (Cornelius & Carrick, 2015; IOM, 2011; Selix & Rowniak, 2016). Others estimate approximately 1% of the U.S. population are transgender (Lim, Brown & Jones, 2014). It is difficult to obtain exact data on the number of transgender persons in the United States due to limitations of census questions that do not specifically identify someone as transgender. There may be reluctance on the part of those who have transitioned and who

may not be willing to disclose this information (Gates, 2011; Lim, Brown & Jones, 2013). A full census of the population of the United States occurs during the month of August every 10 years. This is to determine the number of seats in the House of Representatives based on individual populations. The 2010 U.S Census forms request an individual's gender data (i.e., male or female) but there is no place on the form reflecting transgender status for those who choose to identify as such (National Center for Transgender Equality, 2016). Future census forms reflecting current changes in the demographics of our populations may offer more precise information regarding actual gender status. However, any change to gender options on any on census forms requires approval from Congress (IOM, 2011).

There is also hesitancy on the part of the transgender person to reveal their gender identity due to fear of discrimination; therefore, the actual number of transgender persons is largely unknown (IOM, 2011). Furthermore, respondents to census inquiries may state that they are male or female and not necessarily transgender. This may be due to the fact that some transgender persons medically transition but do not choose to have surgical alterations performed and live their lives reflective of the gender with which they identify (Merryfeather & Bruce, 2014).

Transgender persons are more prone to discrimination, harassment and acts of violence throughout their lifetime from family and friends, employers, co-workers, healthcare professionals and society in general who are not well educated or accepting of a transgender person (Markwick, 2016; Parkhill, Mathews, Fearing & Gainsburg, 2014; Roller, Sedlak, & Draucker, 2015; Sedlak & Boyd, 2016; Selix & Rowniak, 2016; Shires & Jaffee, 2015). Prior experiences with the health care community may cause transgender persons to fear being stigmatized or marginalized due to the lack of attention to their

unique health care needs. This may largely be attributed to interpersonal or institutional policies (Buttaro, Trybulski, Polgar-Bailey, & Sandberg-Cook, 2017; IOM, 2011). Transgender persons may also avoid health care due to a past negative experience and fear of discrimination. According to the National Center for Transgender Equality (2016), there are unmet healthcare needs, including high rates of depression, risky behaviors, substance abuse, higher rates of HIV and sexually-transmitted infections, victimization, smoking and mental health disorders among transgender persons. The National LGBT Task Force (2018) published the results of their survey of transgender persons revealing that 33% of the respondents, who saw a health care provider in the previous year, reported having a negative experience related to being transgender, including being refused treatment, verbal harassment, physical or sexual assault or having to teach the provider about transgender people in order to get appropriate care" (p. 10). This number was even higher among persons of color. Identifying as transgender was one reason for refusal of treatment by a medical provider or facility. Transgender and gender non-conforming patients were subject to harassment and violence in a medical setting. Lack of provider knowledge accounted for 50% of the respondents answers on the survey (National Center for Transgender Equality, 2016). Fortunately, there has been some incremental improvement in access to care for transgender persons. According to the IOM (2011), health care institutions and medical systems available have "evolved within a society that has historically stigmatized these populations and this has important implications for their ability to address the needs of sexual and gender minorities" (p. 32). Improving access to care for this population has been identified as a priority but the implementation process has been slow. The societal norm for institutions have well-rooted socialization of barriers and beliefs that perpetuate stigmatization of gender and sexual minorities, further implicating their inability to

adequately provide fair, equitable health care to transgender persons (IOM, 2011). Those who are uninsured typically do not seek health care unless it is an emergency or life-threatening situation due to the cost or fear of being turned away. The transgender population is less likely to have health care insurance (Buttaro et al., 2017; Lim et al., 2013; Markwick, 2016; Roller et al., 2015). There are healthcare disparities related to aging LGBT persons with respect to chronic diseases that are left untreated due to lack of access to care, insurance and discrimination by health care providers who are not educated in the provision of care for this population. As our society ages, the likelihood of nurses providing care for an LGBT elder will increase (Lim & Bernstein, 2012). Open bias towards transgender persons and discrimination among health care providers create barriers to access to care for this population of patients. Without adequate education on caring for transgender patients, nurses will perpetuate the lack of appropriate care for this population (Alegria, 2011).

Merryfeather and Bruce (2014) state that nursing did not generally include human sexuality content within their course offerings until the 1980's. There may be some persistent discomfort among nurse educators regarding the place sexuality has in nursing education. The implications of their study reveal a greater need for more education regarding gender diversity to decrease stigma and misconceptions of the LGBT population. These authors further suggest there is greater need for nursing to understand gender diversity and especially transgender persons. Nurse educators need to develop cultural competence as it relates to transgender and gender affirming procedures through the acknowledgement of the unique needs of this population.

Heteronormativity is a term used to describe heterosexuality as the social norm (Rondahl, 2009). There is an identifiable gap in nursing literature related to the care of

transgender individuals despite all-inclusive courses devoted to underserved populations that typically do not include information specifically on transgender care. LGBT-related content in nursing curriculum is largely unknown (Lim et al., 2014). Faculty knowledge and their own comfort level in the inclusion of this content in their curriculum influences whether or not content on this specific population will be taught in the classroom (Lim, Johnson & Eliason, 2015).

The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary professional association that promotes evidence-based care, education, research and policy for transsexual and transgender care (WPATH, 2011; Wylie et al., 2016). As an international organization, they dedicate their work to focusing on best practices and policies that will improve healthcare outcomes for transgender patients. Using an interdisciplinary approach, all branches of healthcare including medicine, mental health, law, family studies, sociology, speech and voice therapists work to increase and improve gender dysphoria and treatment (WPATH, 2011). As a result, WPATH publishes the "Standards of Care" and "Ethical Guidelines" to assist health care professionals in appropriately treating this segment of an underserved population.

Due to the unique needs of this population, nurses must recognize the variances that exist among diverse populations in an effort to effectively treat the patient and positively impact healthcare outcomes and eliminate healthcare disparities (Carabez et al., 2015). It is difficult to effectively change nursing practice when there is so little current evidence-based research to reflect new trends in health care. Most studies are several years old and their relevance and accuracy are no longer deemed current especially since social attitudes towards this population change over time (Lim & Hsu, 2016). The lack of new research impedes the ability of health care providers to effectively change their practice. As the

healthcare profession adopts the patient-centered care model, and as more patients emerge and identify as transgender, it will become increasingly important for all healthcare disciplines to become educated and trained on the delivery of culturally competent care in order to eliminate barriers to care for these individuals (Sedlak & Boyd, 2016; Wylie et al., 2016).

Rationale for the Study

It is evident in the literature that nursing has trailed behind other health care disciplines in terms of changing policies and practice guidelines, developing new theoretical frameworks and publishing research on LGBT issues (Carabez et al., 2015; Eliason, Dibble, & DeJoseph, 2010; Lim & Bernstein, 2012). Nurses will care for transgender persons at some point in their career and without the appropriate education to prepare them to care for this population there will be repercussions on the health care needs of these patients. Faculty must be willing and open to understand and explore their own personal values and beliefs in order to create the appropriate environment for learning about this population (Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012).

A chasm has been identified between what health care professionals perceive they know and what they actually know regarding LGBT healthcare needs which ultimately impacts on patient care in the form of inadequate understanding in caring for this population (Lim et al., 2014). As a result, nurses will be unable to provide culturally competent and compassionate care to patients about whose distinctive needs they have little knowledge. There is a limited availability of trained or transgender-educated providers who can adequately care for the LGBT population (Lim & Bernstein, 2012). Additionally, there are few nursing textbooks that include information on LGBT health and among those that do include any information; it is frequently just a brief mention.

In a five-year impact review of the top ten nursing journals, only three journals out of 10 contained articles pertaining to LGBT health (Lim & Bernstein, 2012). Nursing curriculum contains little information on this population and nurse educators are not adequately prepared to teach LGBT health issues (Carabez et al., 2015). The reasons for the disproportion of information are unclear and may be due to a myriad of factors. For example, nurse educators may not include this content in their courses due to their own personal bias. Educators have not been properly taught themselves on this topic owing to lack of inclusion in the literature which would preclude them from teaching it to students. They are deficient in the awareness and familiarity of language to appropriately address the transgender population and risk alienation of the nurse/patient relationship. Human sexuality was not included in nursing curricula until the 1980's and as a result, there may be some residual discomfort on the part of educators regarding the place this has in nursing education (Merryfeather & Bruce, 2014).

Governmental agencies and stakeholders acknowledge the need to prioritize LGBT health needs (Lim et al., 2013). Yet, as the literature review in Chapter Two demonstrates, there is a definitive dearth in publications regarding inclusion of transgender education in all healthcare profession curricula. Despite the recommendations from professional organizations and governmental agencies, the literature is sparse in terms of valid nursing research in this area. Much of the literature review contains findings that propose the need for further research. There are few substantive research articles and dissertations specifically focusing on why nursing faculty do not include this population in the content of their courses. Additionally, an integrative review revealed that across the interdisciplinary spectrum of healthcare, students lack adequate knowledge of this population (Brennan et al., 2012; Eliason et al., 2010; Rondahl, 2009). Faculty knowledge

in this area plays an important role in whether or not students will learn this content during their nursing education. Another article suggests that nurse educators play a key role in the education and training process of nurses to help eliminate health care disparities (Lim et al., 2012). However, if nurse educators are not well-versed on this content, it appears unlikely they will include this information in their courses. Lim and Hsu (2016) state "the challenge for nursing education is to synthesize the growing evidence of LGBT health issues into meaningful curricular integration that will result in positive health outcomes for patients, for their families, and for society" (p. 144).

Significance

As stated previously, nursing has been identified as being deficient in the publication of research, development of new frameworks and practice guidelines regarding LGBT health (Lim & Bernstein, 2012). The American Association of Colleges of Nursing (AACN) Essentials of Doctoral Education acknowledged the need for elimination of health disparities, promotion of patient safety and excellence in practice and providing implementation of clinical prevention and population health activities to achieve the goal of improving the health status of the population of the United States (AACN, 2006). It is not just baccalaureate programs that are recognizing this need for change in practice. The National Organization of Nurse Practitioner Faculties (NONPF) (2013) includes transgender education as part of the population-focused nurse practitioner (NP) competencies. In an effort to guide curriculum development, a collaborative effort between NONPF and AACN resulted in establishing core competencies in primary care across the lifespan for NP education. Task force sub-groups identified competencies for population-focused care, including "acceptance and embracement of cultural diversity and individual differences" and gender-unique disease presentations (NONPF, 2013, p. 10). There are

nine core competencies that delineate essential behaviors of all nurse practitioners. It is expected that entry-level NPs will meet these core competencies during their educational preparation.

Policies

Recent events in this country have placed transgender rights on the forefront of political discussions, gaining national attention on issues that many non-transgender persons take for granted. Some examples include, the use of restrooms based on the person's identified gender and not based on birth gender, marriage equality, participation in the Boy Scouts and Girl Scouts of America and ongoing insurance battles regarding coverage of transition-related healthcare. In Connecticut, a transgender female was placed in a male juvenile detention center based on her birth gender and not her gender identity until transgender advocates stepped in to help advocate for more appropriate care of this female youth (*The New York Daily News*, 2014).

The Joint Commission (2001) now requires that all accredited healthcare facilities are now prohibited to discriminate against any sexual orientation, gender identity, and gender expression (American Geriatrics Society Ethics Committee, 2015; The Joint Commission, 2001). The care of this population is hindered by the lack of knowledge and understanding on the part of the healthcare professional regarding the nuances of the individual needs of transgender persons. Inclusion of transgender content in curriculum will help decrease students' fear of not knowing how to treat transgender patients (Faught, 2016). Transgender patients could suffer negative consequences because of inadequate and non-gender affirming care given to them by nurses who are unfamiliar with the specific nuances of their needs. The lack of education among health care providers and institutions may contribute to the persistence of discrimination towards transgender patients in the

health care setting (Shires & Jaffee, 2015). The needs of transgender persons are poorly understood despite the fact that this population will seek care related to their gender dysphoria, gender identity, issues related to transition with social implications as well as other healthcare needs (Winter et al., 2016).

National health care policies and the Affordable Care Act (ACA) increased access to care for many people, including transgender persons. This act prohibits discrimination based on gender identity or sexual orientation (Selix & Rowniak, 2016). The American College of Nurse-Midwives (ACNM) published a position statement acknowledging the need for further education, training and cultural competency on caring for these individuals. They recommended increasing awareness and education on this topic until midwifery education begins to routinely include this population as part of their curriculum (Selix & Rowniak, 2016).

A goal of Healthy People 2020 is to be inclusive of understanding LGBT disparities and efforts to improve the overall health of this population. There is a well-documented scarcity of transgender-educated providers; therefore, it is reasonable to adopt the process of educating future providers of health care early on and throughout their training (Stroumsa, 2014; Walker, Arbour, & Waryold, 2016; Zuzelo, 2014). As more persons identify as transgender, incorporation of this content into curriculum takes on greater importance. There are societal and medical community discriminatory practices against transgender (TG) persons due to lack of education and understanding that can ultimately delay medical care (Stroumsa, 2014). Any interruption in the timely treatment of medical problems can have a deleterious effect on a patient. The IOM provides evidence-based research and recommendations for public policy and practice. Inclusion of transgender healthcare in nursing curriculum aligns with the IOM recommendations that more

evidence-based practice guidelines for this population need to be studied and established (IOM, 2011). Additionally, numerous articles identify the lack of information in nursing education, for students, nurses and faculty (Carabez et al., 2015; Eliason et al., 2010; Merryfeather & Bruce, 2014). Nursing curriculum is designed to prepare students for generalist practice. Transgender health care, while not commonly encountered, is generally not included in nursing curriculum. Inadequate understanding and knowledge of the specific needs of this population prevents nurses from providing "competent, compassionate, and ethical care" (Merryfeather & Bruce, 2014, p. 111). Further research is needed to help identify the causative factors influencing the lack of inclusion of this population in nursing curriculum. A transgender person can feel alienated in the nurse-patient relationship when the nurse is unfamiliar with appropriate language and terminology while interacting with the patient (Merryfeather & Bruce, 2014). The review of the literature distinctly recognized lack of knowledge among nursing faculty. This proposed research study specifically focused on the reasons why this content is not routinely included in curriculum and attempted to help increase awareness among nursing faculty as a means to ensure that the content is threaded throughout all levels of nursing education. However, if nursing educators are not well-versed on this content, it is unlikely they will include this information in their courses.

Problem Statement

There is definitive evidence of the lack of inclusion of transgender education in nursing curricula. As more persons identify as transgender, nursing as well as other health care disciplines are at greater risk for making assumptions based on heteronormative stereotypes. While there are entire courses devoted to multicultural and underserved populations, the healthcare needs of the transgender population are largely excluded from

them. Despite some course content on cultural competence, the exposure to transgender persons does not necessarily segue into any proficiency pertaining to cultural competency (Fulbright-Sumpter & Brooks-Carthon, 2011). Diversity among gender minorities exists yet without proper education on this content, nursing care for these patients may be compromised. The lack of culturally-competent health care providers for this population results in diminished access for routine and transgender-specific care (Unger, 2015). With the recognition that health care disparities exist for this population as well as the efforts of nurses to provide culturally competent care, it would be beneficial to both nurses and patients to include this content in nursing education. Cultural competence is imperative to further develop an awareness of the differences and specific needs of this population (Merryfeather & Bruce, 2014). Nurses who do not have adequate knowledge on this subject will be ill-prepared to address and identify the unique healthcare needs of this population. An increased awareness of the healthcare disparities of transgender persons by members of any healthcare discipline is one essential step in assisting them to provide care that will positively affect healthcare outcomes for this population. Faculty, students and future patients will all benefit from the addition of transgender health care content in nursing curricula which will positively affect healthcare outcomes for this population**.**

Purpose Statement

The purpose of this study was to examine the reasons why nurse educators choose to include or exclude content on caring for transgender patients in their respective courses. The discovery of nurse educators' attitudes, knowledge, perceptions and biases towards transgender persons may influence inclusion or exclusion of this material in nursing curriculum. The knowledge gained from this study may impact nursing education and help make the necessary changes in course content to benefit both educators and nurses which

will ultimately result in culturally competent and compassionate care for transgender persons.

Research Questions

1. What factors contribute to the inclusion or exclusion of transgender education in undergraduate and graduate nursing education?
2. What are nurse educators' attitudes, beliefs, knowledge and biases regarding transgender persons?

Definitions

Gender binary: societal expectation that gender is simply male or female, masculine or feminine; that there are only two genders and nothing in between or beyond them.

Gender dysphoria: a condition that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association (APA), 2017).

Gender identity: Someone's' internal sense of themselves as male, female, a blend of both or neither. One's gender identity can be the same or different from their birth gender.

Gender expression: refers to **"**Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees" (WPATH, 2011, pg. 96).

Gender role or non-conformity: gender expression from their assigned birth sex differs from conventional or normative expectations of masculinity and femininity (WPATH, 2011).

Gender variant: Behaviors and interests that may lie outside of societal norms (WPATH, 2011).

Heteronormativity: a term used to describe heterosexuality as a social norm (Rondahl, 2009).

LGBT: acronym representing lesbian, gay, bisexual, and transgender populations (may also be expressed as LGBTQIA to include queer, intersex and ally).

Transgender (TG): a term used to describe those individuals whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth (GLAAD.org).

Transition: a period of time when an individual changes the gender role assigned at birth to one that expresses the gender they identify with. This period may or may not include hormonal or surgical interventions and can occur over an extended period of time.

Introduction to Conceptual Framework

Josepha Campinha-Bacote's Model of Transcultural Care is a theory that is both applicable as well as important for this topic as it is based on the assumption that cultural competence is an evolving process in the care of patients (Campinha-Bacote, 2002). Dr. Campinha-Bacote lists the five constructs of cultural competence which include: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. Cultural competence involves recognition of one's own biases, prejudices and assumptions about those persons who are considered different than one's own culture and values (Campinha-Bacote, 2002). Of the five constructs, cultural desire involves the concept of

caring and aspiration to genuinely engage in becoming more culturally knowledgeable and acceptable of people's differences. It requires acceptance of differences, flexibility and openness to be willing to learn from others. This construct is most applicable to faculty in changing their own personal attitudes and perceptions about transgender patients thereby sharing this knowledge with future nurses during the education process. This model applies to healthcare providers in all areas of practice and includes nurse educators. It serves as a foundation for nurse faculty learning and also as a model for teaching.

Campinha-Bacote (2002) states that comprehension of one's beliefs about health and values will help understand how one interprets illness and how that impacts on their own actions (Campinha-Bacote, 2002, p. 182). Recognition of these beliefs and values is an essential process in appreciating the patient's view of their illness. The literature supports that students may struggle with the overlap of their own beliefs and attitudes and their professional responsibility to provide care to LGBT persons (Lim & Hsu, 2016). Appreciating this, the same may apply to educators' beliefs and values concerning transgender persons. The purpose of this study was to provide an answer as to how we can best close the gap between inclusion and exclusion of this content in nursing curricula.

Assumptions/Limitations

The sample consisted of nurse educators currently teaching in baccalaureate nursing programs. There is little information and research on this topic in the literature as previously identified. Lack of knowledge pertaining to the transgender population in nursing curriculum has been acknowledged. The assumption was made that participants in the study honestly answered questions regarding their personal beliefs, knowledge, and attitudes regarding transgender persons. It is hoped that the data gathered in this study will help add to knowledge development in this area and encourage nurse educators to infuse

information on this population into their courses. The study was limited to participants in this geographical area. Additionally, there were some differences in willingness among faculty members to participate who were from public and private institutions.

Summary of Chapter One

The definition of gender has historically been viewed as only male or female and is now commonly referred to as the gender binary. Little consideration has been given to those individuals who identify or may be perceived differently than simply male or female. While a growing body of the literature is focused on the lesbian, gay, bisexual and transgender (LGBT) population, each of these individuals within the acronym has their own unique health care needs (Lim & Bernstein, 2012). Transgender persons have distinctive health care needs that should be understood in an effort for nursing to appropriately care for them. Transgender persons present and experience their gender differently than what is considered the societal norm (Merryfeather & Bruce, 2014).

Nursing curriculum contains little information on this population and nurse educators are not adequately prepared to teach LGBT healthcare much less focus on transgender health issues (Carabez et al., 2015). The reasons for this disparity are unclear and may be due to multiple factors. Some nurse educators may omit this content in their courses due to their own personal bias or because they have not been adequately educated about this content (Carabez et al., 2015). Until more research is conducted and published, faculty may continue to exclude this information from their courses leading to further health care discrepancies for this growing population of patients.

CHAPTER TWO: REVIEW OF THE LITERATURE

Overview of the Literature Review

A comprehensive review of relevant professional literature was performed on the subject of transgender education in nursing as well as other healthcare disciplines. A university librarian with expertise in nursing electronic database searches was enlisted to help develop a clear search strategy as well as provide direction for this search as incomplete literature searches can result in inadequate database as well as inaccurate results (Whittemore & Knafl, 2005). A focused search on transgender and LGBT in all healthcare disciplines was performed with the use of computerized database searches in an effort to identify the phenomenon of inclusion of transgender content in curriculum. Additionally, reference lists from published dissertations on LGBT were reviewed and some relevant articles were gleaned. Ancestry articles on the subject were also reviewed. Networking with professional associations devoted strictly to transgender care also provided further direction towards more information on the topic.

A review of available articles published between the years 1995-2017 that addressed transgender education in all health care disciplines was conducted. Electronic database searches included the Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, EBSCO Host, ERIC, and Google Scholar databases. Publications prior to 1995 contained limited, outdated information and terminology therefore these were excluded from the search. The initial, cursory search yielded 1458 articles, the majority of which were devoted to how to care for the LGBT patient. Fewer than 100 articles across the spectrum of healthcare disciplines focused on transgender education. Of the less than 100 articles, the majority were summative review articles with few research articles. Only seven of the 100 articles were on transgender education in nursing. Another cross-reference

search using the term “cultural competency” yielded 110 articles, many of which were duplications of previous searches. A search using the term cultural competency and transgender resulted in 46 research articles, of which only eight focused on education. The term “transgender education in nursing” yielded just 10 articles while “transgender education” resulted in 158 articles but were articles on LGBT and not exclusively transgender. The review of the literature revealed few relevant and usable research articles that were devoted strictly to transgender education. Key word searches included transgender, nursing education, nursing faculty, transgender care, transgender education in nursing, transgender education, and transgender healthcare education, transgender education in healthcare, LGBT health care, transgendered persons, heteronormative, and cultural competency. Articles with strict focus on surgical procedures and homosexuality were excluded**.** The entire collection of journal articles used for this study is from national and international peer-reviewed journals that are considered dependable (Roberts, 2010).

A matrix was developed to help organize the various articles and to assist with identification of themes. This was set up in chronological order with the date of publication, type of research, frameworks used and findings in an effort to recognize commonalities among the articles for the year that it was published as well as help identify current trends and changes that developed over the years. Persons with what we now term as transgender characteristics are not new, but the terminology of transgender is relatively recent since the early 1990s. The educational aspect of including this content in curriculum is fairly new. Little research has been published and what was published as recently as 10 years ago has been replaced with more appropriate terminology and updated information that is considered acceptable among both the transgender and health care communities. Few studies on LGBT have been performed by nursing scholars (Lim et al., 2013).

Some of the articles were not usable but were reviewed nonetheless to capture ancestry articles from the references for use in this study. It is unfortunate that there was little in the literature for this particular topic and many of the articles reviewed were summative review articles. Hays and Singh (2012) echo the difficulty qualitative researchers have with the limited number of studies available on a particular topic. Of note, during the George W. Bush administration, LGBTQI health and research support was temporarily suspended. It was not until the Obama administration in 2010 when the United States Department of Health and Human Services released Healthy People 2020 that included LGBTQI disparities (Eckstrand & Ehrenfeld, 2016).

Merryfeather and Bruce (2014) published a literature review that identified key discourses in the literature of transgender issues in nursing. They highlighted prevailing issues of discussion and deficiency in the importance of understanding of gender diversity in nursing (Merryfeather & Bruce, 2014). This type of insufficiency in nursing care breaches the ethical and equitable care of transgender patients. Their concept was based on the assumption that nursing accepts multi-culturalism and diversity but does not recognize the LGBT community as a diverse population (Merryfeather & Bruce, 2014).

Overarching themes that emerged in the review of the literature included knowledge and attitudes, the need for diversity training, barriers to care for transgender patients, cultural competence and LGBT content in education. The overwhelming majority of articles recommended the necessity of culturally competent training and education to prepare tomorrow's providers which would effectively decrease barriers to care for transgender patients and increase access to care from educated providers if content across curriculum included this content. Additionally, the research articles endorsed the need for further research to be performed in this area.

Review of Research Literature

Due to the unique needs of this population, nurses must recognize the variances that exist among diverse populations in an effort to effectively treat the patient and positively impact healthcare outcomes and eliminate healthcare disparities (Carabez et al., 2015). Nurses play a principal role that can positively or negatively impact the care a transgender patient may receive. Most studies are several years old and their relevance and accuracy are no longer deemed current especially since social attitudes towards this population change over time (Lim & Hsu, 2016). As the healthcare profession adopts the patient-centered care model, and as more patients emerge and identify as transgender, it will become increasingly important for all healthcare disciplines to become educated and trained on the delivery of culturally competent care in order to eliminate barriers to care for these individuals (Sedlak & Boyd, 2016; Wylie et al., 2016).

Through the process of analyzing data from a multi-disciplinary approach to the review of the literature, a clear identification of a phenomenological deficit has emerged in student learning as it pertains to transgender individuals across the healthcare spectrum. There is also a void in faculty knowledge and readiness for teaching LGBT content in the respective interdisciplinary healthcare programs. Non-nursing disciplines such as speech pathology, medicine, dental hygiene, childbirth education, social work, counseling, psychology and public health have also identified inconsistencies in their educational offerings that impact on competencies (Aguilar, El, & Fried, 2015; Bidell, 2013; Hancock & Haskin, 2015; Khalili, Leung, & Diamant, 2015; McNair & Hegarty, 2010; Moll et al., 2014; Rutherford, McIntyre, Daley, & Ross, 2012; Shires & Jaffee, 2015; Singer, 2015). Academic and community-based researchers as well as LGBTQ activists and organizations recognize and endorse the need for healthcare provider education and training to address

the unique healthcare needs of sexual and gender minorities (Daley & MacDonnell, 2015). As previously stated, if educators are not well-versed on this content, it appears to be unlikely they will include it in their curriculum.

In a study by Eliason et al. (2010), the authors identified the need for new theoretical frameworks that will generate new ways to make LGBT persons more visible among healthcare workers and assist in identifying the distinctive needs of these patients. Using Queer theory as the basis of their study, their findings suggest that nurse educators begin to infuse their curriculum with LGBT content. Queer theory has its' roots in women's studies, feminist theory, and gay and lesbian studies suggesting fluidity regarding gender identity beyond the societal norm of gender binary (Gieseking, 2008).

Additionally, Eliason et al. (2010) suggested that authors of new nursing textbooks integrate issues of diversity and LGBT concerns. They encouraged educators to include this content in their course offerings and avoid discouraging research on LGBT that others might be interested in performing. The authors further proposed developing a system in which to mentor new nurses in performing future research in this area. Other recommendations include suggesting that journal editors consider special issues devoted to just LGBT issues and care. Of importance, the authors also suggest that professional nursing organizations endorse changes in nursing curricula to be more gender-inclusive.

Knowledge and attitudes and familiarity

Current research has revealed that LGBT patients feel uncomfortable with the lack of knowledge demonstrated by health care providers on caring for the individual needs of this population (O'Brien & Ellis, 2016; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006; Sedlak et al., 2016; Winter et al., 2016). Some authors found that those medical students who participated in their study and had previous experience or exposure to LGBT

patients tended to obtain more pertinent information thorough patient histories. Those students also possessed more positive attitudes and greater knowledge of the health care concerns for this patient population of patients than those students who had little or no clinical exposure.

Rondahl (2009) states health care providers do not receive any education in the different types of personal relationships that influence a person's health. The author also states that the health care system incorrectly endorses heteronormativity and that many providers are not comfortable discussing issues that may reveal their bias or lack of knowledge. The Accreditation Council on Graduate Medical Education emergency medicine residency does not include LGBT-specific education. Additionally, there is nothing current in the emergency medicine literature. In her study of 135 nursing and medical students, using a non-experimental descriptive correlational design to describe relationships among variables, Rondahl (2009) revealed that students' knowledge of issues related to LGBT was inadequate. An oral informational session was held where participants then completed the questionnaires. The modified instrument used was the Knowledge about Homo- and Bisexual and Transgender Persons Questionnaire (KHBT) containing 22 statements with answers of "True," "False," or "Don't know." Three separate knowledge areas were identified: care knowledge, psychological knowledge, and public knowledge. The findings revealed that the students' knowledge on LGBT was inadequate as was care and psychological knowledge. Nursing students scored lower than the medical students in the areas of care knowledge. She suggested that the education system should address the knowledge deficit currently existing regarding LGBT among nursing and medical students and also suggested that specific LGBT education including

historical attitudes in medical care, social psychology, legal implications and specific health related issues to this population is included in future courses (Rondahl, 2009).

Inadequate knowledge and negative attitudes towards LGBT people have been closely related to students' gender, ethnicity, religious beliefs, level of education and political views (Chapman, Watkins, Zapia, Nicol, & Shields, 2011). These authors conducted a descriptive, comparative study using a self-administered questionnaire to a convenience sample of 100 third year nursing and 161 fifth year medical students to assess and investigate students' attitudes, knowledge and beliefs regarding LGBT parents seeking healthcare for their children. Three published scales were used to evaluate the respondents' knowledge, attitude and beliefs, including The Knowledge about Homosexuality Scale (Harris, 1995), The Attitude toward Lesbians and Gay Men Scale (Herek, 1998), and The Gay Affirmative Practice Scale (Crisp, 2006). There were three open ended questions, 20 true false statements and a 20-item, four-point Likert scale that assessed overall attitudes of respondents towards LGBT families. The authors concluded that it is important to develop new ways to address those students who may be prejudiced against providing health care or who display discriminatory or other discouraging behaviors toward LGBT parents seeking care for their children. The results of this study also found pervasive homophobia and emphasized the need to prevent discrimination against diverse families.

Diversity training

Much of the literature suggests that diversity training has a direct effect on behaviors and that this type of training needs to be further explored. The invisibility of gender diversity impacts the ethical behaviors of nurses (Merryfeather & Bruce, 2014). Expanding knowledge of gender diversity decreases stigma and misconceptions about transgender and transsexual individuals. Nurse educators and individual academic

institutions need to develop cultural competence and awareness through recruitment of transgender individuals willing to participate in the educational process of future nurses.

A needs assessment was performed by Carabez et al. (2015) to explore the effectiveness of having students perform structured interviews as a means to educate themselves about the health care needs of LGBT patients in order to help improve the quality of health care. Highly structured key informant interviews were done through the use of a 16-item script based on the Healthcare Equality Index (HEI) which is an instrument that assesses institutional policies to ensure quality healthcare is available to LGBT persons. One hundred nineteen nursing students recruited a convenience sample of 268 registered nurses (RNs). The results revealed that 79% of the participants reported the absence of LGBT patient-centered care training in their respective organizations. The majority of participants stated they felt comfortable providing care to LGBT patients but 20% stated a need for further training in this area. The authors went on to suggest that LGBT health care education needs to start in nursing schools, but that educators are not prepared to include this in their courses (Carabez et al., 2015).

In a related study, a panel discussion consisting of both transgender male and females was offered as part of a diversity course in a pharmacy program (Parkhill et al., 2014). The course was comprised of the use of videos, interactive exercises, guest speakers and group discussions. Volunteers were recruited from a local gay alliance agency who served as panel members. The study had 79 participants who completed a 1-hour introductory presentation on LGBT terminology, a 2-hour panel discussion and completion of two surveys after the presentations along with a written reflective journal of the experience. The authors used qualitative analysis of the open-ended reflections that revealed the following: lack of knowledge regarding transgender patients, limited

educational content regarding the appropriate use of hormones for transgender patients and the applicability of diversity training on personal knowledge, empathy and understanding of this population. The authors recognized the limitations of their study and plan to implement more panel discussions and diversity trainings in future cohorts (Parkhill et al., 2014).

Professional development programs focus on LGBT content are an avenue to help increase educators' knowledge in an effort to stop LGBT bias in schools. Greytak, Kosciw and Boesen (2012) conducted two-hour training workshops designed to understand and deal with LGBT harassment and bullying. It was also an opportunity for participants to learn how to create a safer environment for this population of students. Attendees were mandated to participate in these workshops, including teachers, mental health providers, school building and district administrators. The trainer was from a local affiliate of a national LGBT organization. A pre- and post-test questionnaire was administered. The findings of this study revealed that professional development programs focusing on LGBT issues can increase awareness, knowledge and safety impacting LGBT students (Greytak et al., 2012).

Barriers to care

An integrated review of the literature overwhelmingly revealed a lack of knowledge across the spectrum of healthcare providers regarding transgender patients. The inability of transgender patients to find a knowledgeable health care provider who understands their unique needs was considered a common barrier to care (Levitt, 2015). In addition to the lack of knowledge on the part of health care providers, there is evidence to suggest that some providers refuse to treat a transgender patient based on their own biases. A subset of the transgender population may fall victim to prejudice and/or bias in the workplace which

may lead to unemployment or underemployment then to unsafe or high risk sexual behaviors and substance abuse further impacting on health and well-being due to poverty, homelessness and self-harm (Winter et al., 2016). These barriers often lead to delay of initiation of services and ultimately impact on health disparities. A survey performed by the National Center for Transgender Equality (NCTE) and the National LGBTQ Task Force reported that 24% of the 27,715 participants had to teach their health care providers about transgender care (National Center for Transgender Equality, 2016). This survey showed that transgender individuals are less likely to disclose their gender identity due to fear of discrimination or refusal to be treated by a health care provider and will seek care only in emergent or urgent situations. Transgender persons are less likely to undergo routine surveillance screenings for breast, cervical and colon cancers.

The inclusion of LGBT health was added to the Healthy People 2020 initiative that addresses the persistent stigma and discrimination towards LGBT individuals (Parkhill et al., 2014). It is definitively acknowledged throughout the literature that it is not unusual for transgender persons to experience discrimination and be refused care by the medical community (Alegria, 2011; Chapman et al., 2011; Cornelius & Carrick, 2015; Faught, 2016; Khalili et al., 2015; Levitt, 2015; Lim & Bernstein, 2012; Lim et al., 2014; Lim et al., 2015; Moll et al., 2014; Obedin-Maliver, 2015; Peate, 2008; Roller et al., 2015; Rutherford et al., 2012; Sedlak & Boyd, 2016; Shires & Jaffee, 2015; Smith, 2016; Stroumsa, 2014; Unger, 2015; Winter et al., 2016). Lesbian, gay, and bisexual individuals may choose to withhold disclosure of their sexual orientation without penalty. Transgender individuals must disclose their gender identity in order to receive appropriate care but are more likely to be subject to the use of non-inclusive terminology, improper pronoun use and inadequate demographic forms.

Without appropriate evidence-based knowledge for transgender persons, healthcare professionals lack the education necessary to provide culturally competent, accepting care to transgender individuals (O'Brien & Ellis, 2016). Patients are in their most vulnerable state when they are ill and simply being accepting of one's gender identity is not enough to adequately care for LGBT persons. The need for inclusive, equitable and non-discriminatory practice without harassment or marginalization should be the impetus behind increasing health care provider education in this area. Health care providers receive little to no training in this area due to the lack of research about how best to educate them in caring for this population (Shires & Jaffee, 2015).

LGBT content in education

LGBT concerns are not focused on just individuals but impact families when a provider assumes heteronormativity among patients and families. Questioning or identifying sexual orientation and gender identity may not be asked during an office visit which may lead to patients who are not comfortable offering this information or withholding this information (Singer, 2015). There remains a division between perceptions of providers of healthcare and what they actually need to know to effectively care for LGBTQ families. It is incorrectly presumed that heteronormativity is the societal norm; yet, this is what is being taught and practiced (Singer, 2015). There is insufficient LGBTQ-inclusive information being taught at the university level to provide student nurses with the knowledge and skill they will need to practice culturally-competent care of transgender patients (Singer, 2015, p. 18).

Current faculty may need significant educational preparation to be able to appropriately answer students' questions (Singer, 2015). The author also states that there is a further need for faculty development in the area of LGBTQ and suggests a full semester

course of human sexuality within healthcare. Faculty must be adequately prepared to teach this information on the various aspects of human sexuality and gender diversity. Those practicing with childbearing families should attend LGBTQ focused education (Singer, 2015).

An analogous study by Unger (2014) confirmed that medical school and residency curricula lack inclusion of transgender care content resulting in inexperienced providers that perpetuates lack of access to care for transgender persons. A cross-sectional survey of 141 OB/GYNs was designed to understand provider experience and individual practice environments, personal and professional experiences with transgender persons and knowledge regarding care of the transgender patient. The survey consisted of 34 non-validated questions. The overwhelming majority of respondents (80%) reported they did not receive any training on the care of the transgender patient. Time in practice was not associated with understanding or knowledge of caring for this population. Ninety-two percent reported feeling comfortable caring for LGB patients versus roughly 30% who were comfortable caring for a transgender patient. Sixty-five percent of the providers who responded were not knowledgeable about requirements for gender-affirming surgeries. The author goes on to state that "many medical providers have a poor understanding of transgenderism and the steps that many patients take to transition from their natal sex to their true gender" (Unger, 2014, p. 116).

A convenience sample study comprised of 119 nursing students who interviewed a total of 268 practicing RN's revealed that 79% of the participants had no LGBT patient-centered care training that was offered at their place of employment (Carabez et al., 2015). Some of the respondents stated they had received training on diversity and cultural competency but not specifically for LGBT. The authors stated that LGBT healthcare

education needs to start in nursing programs but research showed that educators are not yet well-prepared to teach LGBT content. This study also underscored that heteronormativity exists in nursing as the assumption among the respondents is that there are no differences in patient care for LGBT versus heterosexual patients (Carabez et al., 2015).

A literature review performed by Lim and Bernstein (2012) discovered significant deficits in LGBT-related topics contributing to the lack of content in nursing curriculum. As mentioned previously, the nursing profession lags behind other healthcare disciplines in the area of LGBT education. Currently, the American Association of Colleges of Nursing (AACN) offers no specific language for inclusion in curriculum although they have suggested incorporation of cultural competency for all baccalaureate programs (AACN, 2008). Additionally, Quality and Safety Education in Nursing (QSEN) makes references for competencies but nothing related to patient-centered care. Their recommendation was to "infuse curriculum with LGBT content and address existing knowledge deficit" beginning with curriculum review, assessment of research gaps and review of IOM recommendations (Lim & Bernstein, 2012, p. 173). Furthermore, they suggest providing faculty development training on LGBT health, use of more LGBT case studies, integration of LGBT identities in syllabi, higher utilization of standardized patient training and including LGBT issues in student clinical orientation. Formation of student special interest groups could increase interest in this area for those students who desire to make an impact in their patient care (Lim & Bernstein, 2012). However, in a different study by Lim and Hsu (2016), the authors state that nursing was historically built on the teachings of Christian values as illustrated by the work of Florence Nightingale. As a result, some students may have difficulties in reconciling "their personal attitudes and beliefs about

LGBT persons with their professional responsibility to provide care" (Lim & Hsu, 2016, p. 145).

Another study surveyed 113 nursing schools in Texas to determine whether or not the concepts of transgender, gender identity, and gender dysphoria were taught in nursing programs (Walsh & Hendrickson, 2015). The web-based survey consisted of 10 questions that required a "yes" or "no" answer followed by two questions that asked how transgender education could be incorporated and how many content hours were spent discussing transgender content. Only 21 responses were returned, a rate of 18.9%. (Walsh & Hendrickson, 2015). None of the respondents reported teaching or incorporating the World Professional Association for Transgender Health's (WPATH) standards of care which are considered to be the gold standard of guidelines for transgender care. Most importantly, the authors of this study stated that nurse educators are "responsible for not only teaching students how to integrate LGBT standards of care in their practice but also for requiring faculty competency in teaching this content" (Walsh & Hendrickson, 2015, p. 352). The study had a limited response rate resulting in a small sample size. The authors suggested that the results of their study may cause other researchers to replicate this study in the future further underscoring the need for more pure research in this area of nursing education.

In addition to caring for transgender patients, educators must also be knowledgeable when engaging with transgender students. Educators who are knowledgeable and experienced in LGBT persons can provide necessary support and guidance especially in the event of harassment or bullying (Greytak et al., 2012). Educators who already possess previous knowledge can also provide instruction to other students as well as other educators on transgender students. A qualitative study performed by Kitchen

and Bellini (2012) provided another aspect to the benefit to faculty education and training. The authors facilitated a series of workshops for teacher candidates in Canada on "Sexual Diversity in Secondary Schools" as a means of improving teacher practice and learning. Based on the feedback from these self-study and reflective letter writing workshops over a period of six months, the researchers determined that there was not enough content in teacher education programs addressing LGBT issues and homophobic bullying (Kitchen & Bellini, 2012).

Educators are obligated legally and ethically to maintain a safe environment for all students, including LGBT students. The authors concluded that teacher candidates were receptive to discussions regarding LGBT issues and how to make changes within the classroom and school to help make schools a safe and supportive environment. This further underscored the need for not just student education in this area, but faculty education and awareness.

During clinical rotations, students may be faced with dilemmas pertaining to the ethical treatment of patients. Educators are charged with the responsibility of teaching students about human rights, diversity and equitable treatment of patients. In a related article by Wilson-Mitchell and Handa (2016), midwifery students attended workshops led by a local diversity and equity specialist. These workshops were developed out of a growing concern by students about lack of diversity and inclusion (Wilson-Mitchell & Handa, 2016). Didactic sessions were followed by small group work concentrating on real-life case scenarios and round table discussions. Dominant themes that emerged included appropriate role-modeling, the need for the preceptor to demonstrate comfort with situations surrounding diverse populations, including the preparation of concepts of social justice and health equity as well as teaching students' self-reflection skills to avoid

assumptions, acknowledge fears and dispel myths (Wilson-Mitchell & Handa, 2016). The literature appears to suggest that if educators are appropriately trained to protect the rights of LGBT students, then this content should extend from not only teacher education but student education as well.

Homophobia and heterosexual biases exist among students as well as faculty and these biases impact the learning environment. Developing awareness provides a gateway to increased sensitivity towards this population of patients; however, individual nurse educators must first examine their own beliefs and values in an effort to then develop their willingness to teach this content. A variety of pedagogical teaching strategies can be employed to help students understand the complexities of the needs of the LGBTQI populations (Brennan et al., 2011). The authors, in their review of the literature, suggest development of LGBTQI panels comprised of individuals who identify as such and are willing to share their experiences with the health care community. Assignments that focus on personal beliefs as well as use of literature and current films assist with identifying themes and experiences to help aide with knowledge gains in this area. Simulation exercises, standardized patient training and role-playing also reinforce teaching and behaviors learned (Lim & Bernstein, 2012). These teaching experiences will increase the number of gender-sensitive providers and inclusivity of care. Lim and Bernstein (2012) suggested including LGBT issues in student clinical orientation, creating special-interest groups, creating partnerships with local LGBT agencies and integrating LGBT identities into the syllabus.

Cultural competence

Counselors and psychotherapists acknowledge lower levels of competency due to lack of training in this area (Bidell, 2013). A study comprised of 23 students enrolled in an LGBT master's level graduate counseling course with a comparison group of 23 students was performed. The comparison group did not receive any education or training for this study. Enrollees were given specific assessment scales on the first and last days of the course. Using a Background Demographic Questionnaire, a Sexual Orientation Counsellor Competency Scale (SOCCS) that is a self-report assessment of lesbian, gay and bisexual affirmative counselor competency and a Lesbian, Gay and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) instruments, the author identified that significant improvements on each assessment measure were demonstrated after the pre- and post-test scores were evaluated. The findings suggested that a full credit LGBT graduate course can significantly improve counseling student's competency and self-efficacy.

A model of culturally competent care examining three underrepresented NP groups discovered that diversity training had a direct effect on cultural competency behaviors but did not directly affect cultural awareness or sensitivity. The authors examined four components of cultural competence: cultural diversity, cultural awareness, cultural sensitivity and culturally competent behaviors analyzing survey data using structural equation modeling techniques (SEM). A booklet containing five questionnaires with 182 items comprised of several instruments that measured cultural competence, diversity, life experience and social desirability was mailed to 474 participants. Life experiences with exposures to diverse populations had direct effects on cultural awareness and sensitivity

(Benkert, Templin, Schim, Doorenbos, & Bell, 2011). The authors recommended that diversity training should be explored further.

Health care professionals receive little in the way of cultural competency in geriatric training and LGBT elders despite the need for appropriate provision of care for this population. In another large study consisting of registered nurses, the authors developed a curriculum based on the needs of the LGBT elder community. The 2012 study had 848 participants of registered nurses and health care providers who attended curriculum sessions at 23 locations. There was a diverse population and ethnicity represented among the participants. Pre- and post-studies were performed to measure knowledge gained. An evaluation was also performed by the participants at the conclusion of the study that reported personal attitude and response to the curriculum. The results of this study revealed a statistically significant increase in knowledge and confidence among the participants in LGBT cultural competency training in geriatric education (Hardacker, Rubinstein, Hotton, & Houlberg, 2014).

Synthesis and Critique of Research Findings

Overwhelmingly, the literature has a resounding theme of the lack of education and training with respect to the LGBT population across the health care spectrum. LGBT care is often fleetingly mentioned without specific consideration of each individual population of the umbrella acronym. The absence of solid content in health care provider education is also evident in workplace environments as well. The vast majority of articles, both research and literature reviews, all recommended that further research needs to be performed in this area, and that LGBT inclusion must be emphasized in all educational content and workplace education.

Conceptual Framework Further Defined

A descriptive qualitative study using Josepha Campinha-Bacote's Model of Transcultural Care guided the current study. Dr. Campinha-Bacote describes this model as "A culturally consciously model of care that defines cultural competence as the process in which the health care professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client (family, individual or community)" (Transcultural C.A.R.E Associates, 2015).

Campinha-Bacote's model enables one to become more culturally competent and not necessarily just achieve a minimally acceptable level of competence. The theoretical basis is the assumption that cultural competence is an evolving process in the ongoing care of patients, and the process is used to develop and implement culturally responsive care (Campinha-Bacote, 2002). The model is comprised of five constructs of cultural competence including: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. Cultural competence involves recognition of one's own biases, prejudices and assumptions about those persons who are considered different than one's own culture and values and this ideally addresses the research question of this study. Of the five constructs, cultural desire involves the concept of caring and desire to genuinely want to change one's own way of thinking, increase familiarity with cultural differences and engage in becoming more culturally knowledgeable (Campinha-Bacote, 2002). One must first acknowledge the desire to change and genuinely seek methods of accepting these differences. A cultural encounter is a process by which health care providers interact with patients from culturally-varied backgrounds, authenticating, refining or adapting existing beliefs and practices (Campinha-Bacote, 2002). Nurses may encounter patients of different cultures and practices. Patients of different cultures and

beliefs may not engage in health care that is similar to how nurses have been educated. Cultural awareness is described as a "deliberate self-examination and in-depth exploration of one's biases, stereotypes, prejudices and assumptions that one holds about individuals and groups who are different from them" (Campinha-Bacote, 2011, p. 45). The genuine desire to become more educated about culturally diverse groups is what defines the cultural knowledge construct. Cultural skill depends on one's ability to "collect relevant data regarding the patient's presenting problem, as well as accurately performing a culturally based physical assessment in a culturally sensitive manner" (Campinha-Bacote, 2011, p. 45).

The constructs are all interconnected allowing for some fluid movement when expanding one's knowledge and competency in caring for a culturally diverse population. Thus, the model encourages and motivates health care providers to develop styles of inquiry and exploration to learn more in an effort to be more culturally inclusive. All of these competences are of the utmost importance to nurse educators who desire to change their beliefs, accept the differences of this underserved population and increase the effectiveness of not just their teaching but their patient care abilities. It is also applicable to educators who may encounter a transgender student within the cohort. This model of cultural competence is most applicable for the purposes of this study to help understand faculty's personal attitudes and perceptions of transgender persons which may impact on teaching this content to future nurses that will ultimately change the landscape of diverse patient health care. This model is for health care providers in all areas of practice, including education and would serve as a basis for nursing faculty in their own learning and as a model for teaching (Campinha-Bacote, 2002).

Summary of Chapter Two

The results of the literature review identify the great need for diversity and cultural competency training and education across the spectrum of health care. Deficiencies in understanding gender diversity and the impact on students and health care providers dominates the literature. While the review of literature has demonstrated a dearth of content on this topic, it is believed that the proposed study will add to knowledge development in this area. There is a void in student learning as it pertains to transgender individuals across the health care spectrum. Community and health care agencies now recognize the need for appropriate and sensitive health care provider education and training to best serve the needs of the growing population of transgender patients. The findings consistently reveal that exposure to people who identify as LGBT has increased personal knowledge and fostered more positive attitudes. Those health care providers who have previous experience and exposure to LGBT persons tended to have more positive attitudes than those who had no exposure. Pervasive homophobia and heteronormativity require change. Inadequate knowledge was found to be related to individual beliefs based on gender, ethnicity and religion but exposures to diversity courses and patient care training changes knowledge and attitudes (Parkhill et al., 2014). Changes in attitudes towards LGBT individuals were improved after an educational intervention. Improvement in culturally competent care was statistically significant after participants attended courses devoted to providing care to underserved populations (Hardacker et al., 2014). Cultural competence and diversity may be commonly included in nursing education but does not always contain information on the LGBT population. Diversity training is greatly needed to improve or enhance cultural competency (Carabez et al., 2015). The articles reviewed recommend inclusion of this content at all levels of education; however, there was little in

the review of the literature that explained why this content is not being consistently taught in nursing curriculum further underscoring the need for this type of study.

CHAPTER THREE: METHODOLOGY

Introduction

The purpose of this qualitative descriptive study was to explore the attitudes, perceptions, knowledge and biases of nursing faculty regarding care for transgender persons and inclusion in nursing courses. The participants were nursing faculty who were currently teaching part-time, full-time or adjunct in baccalaureate programs. "The purpose of a descriptive study is to observe, describe and document aspects of a situation as it naturally occurs" (Polit & Beck, 2012, p. 226). It is essential to appreciate participants' comprehension of an event and correlate the commonalities as they may relate to the phenomenon (Hays & Singh, 2012). This study was performed to discover the reasons why nursing faculty chose to include or exclude this content from curriculum. One reason for conducting qualitative research on this particular topic is "to uncover and understand what lies behind any phenomenon about which little is yet known" (Roberts, 2010). As chapter two clearly defined the current gap in the literature on transgender education, there is little known as to why this content is not routinely included in nursing education.

This chapter explains the rationale for using this type of methodology, including the research questions, research design, target population, setting and sampling method, data collection and analysis procedures. It also discusses the process of informed consent, limitations, ethical considerations, IRB approval and storage of data as well as the trustworthiness criteria of Lincoln and Guba (Polit & Beck, 2012).

Research Design Overview

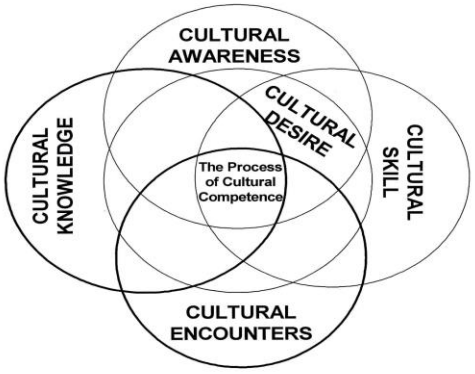
This research was a qualitative descriptive design to determine the personal meanings behind nurse educators' experience with transgender persons and their own individual beliefs that may impact why transgender content is not routinely included in

nursing curriculum. Qualitative descriptive research is performed when there is an area or issue that warrants exploration because the existing information on the topic is scarce (Creswell, 2015; Vaismoradi, Turunen, & Bondas, 2013). Also, this type of design permits guidance by employing a theoretical framework which allows further investigation of the phenomenon of interest. Like other qualitative studies, this study was considered basic given the small number of participants the researcher sought to interview but also "to differentiate this type of study from other types of qualitative studies such as phenomenology, grounded theory and ethnography" (Sandelowski, 2000, p. 335). Sandelowski (2000) states "there is no comprehensive description of qualitative description as a distinctive method of equal standing with other qualitative methods, although it is one of the most frequently employed methodologic approaches in the practice disciplines" (p. 335). There is merit in qualitative description given the knowledge that is yielded from the research but also the findings that establish meaning (Vaismoradi et al., 2013). Use of this type of research design increases the probability that the findings will be agreed upon among other researchers (Colorafi & Evans, 2016).

Open ended questions were used and every interview was audio-recorded and then the content was transcribed verbatim. Qualitative content analysis was employed to evaluate the data collected. This is a method by which the researcher examines content and categorizes emerging themes using a coding process into written documents (Hays & Singh, 2012). Inductive reasoning and logic served as the basis for organizing data to help establish themes (Creswell, 2013). Due to the nature of inquiry, it was possible that the research design may change and evolve as themes emerge necessitating further questioning or seeking clarification from participants (Hays & Singh, 2012). Sandelowski (2010) states "qualitative content or thematic analysis…are largely based on factist perspective" (2010,

p. 80). Factist perspective is based on the theory that interview data is assumed to be truthful and accurate. There may be an element of some differences in the interpretation of the data between what is considered scientifically credible and what is derived based on the interpretation of the researcher (Sandelowski, 2011).

Josepha Campinha-Bacote's model of cultural competence in health care delivery (2002) was used as the framework for this study. This model "views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client" (Campinha-Bacote, 2011, p. 43). The prototype for this model was developed in 1998 with subsequent revisions that expanded the scope to include and reflect changes in cultural competence in health care (Campinha-Bacote, 2011). The model is comprised of five constructs: cultural awareness, cultural knowledge, cultural encounters, cultural skill and cultural desires. These are all interconnected allowing some fluid movement when expanding one's knowledge and competency in caring for a culturally diverse population. Thus, the model encourages and motivates health care providers to develop styles of inquiry and exploration to learn more in an effort to be more culturally inclusive. Figure 1 depicts the interconnectedness of the five constructs of the model.



The Process of Cultural Competence in the Delivery of Healthcare Services

Figure 1. Used with permission from author.

A cultural encounter is a process by which health care providers interact with patients from culturally-varied backgrounds, authenticating, refining or adapting existing beliefs and practices (Campinha-Bacote, 2002). Cultural desire is based on the individual professionals' motivation and true aspiration to become culturally competent. Cultural awareness is described as a "deliberate self-examination and in-depth exploration of one's biases, stereotypes, prejudices and assumptions that one holds about individuals and groups who are different from them" (Campinha-Bacote, 2011, p. 45). The genuine desire to become more educated about culturally diverse groups is what defines the cultural

knowledge construct. Cultural skill depends on one's ability to "collect relevant data regarding the patient's presenting problem, as well as accurately performing a culturally based physical assessment in a culturally sensitive manner" (Campinha-Bacote, 2011, p. 45).

Target Population

In an effort to identify the rationale behind why nursing students do not learn about caring for transgender persons, the question begins with nurse educators. The participants were an accessible population of nurse educators who were recruited from large state universities in the Northeastern United States and who teach in Commission on Collegiate Nursing Education (CCNE) and/or Accreditation Commission for Education in Nursing (ACEN) accredited nursing programs.

Sampling Method

First, the researcher needed to identify educators who met the participation criteria. Inclusion criteria were those who currently teach part-time or full-time in CCNE and/or ACEN undergraduate accredited nursing programs. This was achieved by viewing the websites of all of the CCNE and ACEN accredited programs in the northeastern United States and the listing of program chairs and faculty members teaching in undergraduate programs. Electronic recruitment letters were sent to faculty emails listed on the individual university websites of the accredited undergraduate nursing programs. Purposeful and snowball sampling requires development and establishment of specific sample criteria (Hays & Singh, 2012). For this study, purposeful and snowball sampling were employed. These types of sampling are used when the population is small and meets established criteria (Hays & Singh, 2012).

The researcher used snowball sampling to gain additional participants to see if any like individuals who met the study criteria could be referred to the researcher. Some respondents to the initial email query stated that they were no longer teaching in undergraduate baccalaureate programs but forwarded the recruitment email to other faculty within their department. This resulted in four participants of the twenty who participated in this study. This type of convenience sampling strategy is based on asking participants if they can refer others who meet the participation criteria to the researcher after ascertaining their interest in participating in the study (Hays & Singh, 2012). Additionally, when it is necessary to recruit participants from a particular clinical setting or organization, this type of sampling may work better than other types of sampling (Polit & Beck, 2012). This particular method was more efficient as it directly targets the population necessary for the study which decreases the need to screen whether or not a participant is an appropriate candidate.

Once eligibility was determined through verification of employment status at the university, a signed, written consent to participate in the study was obtained from all participants. Verification of employment was established by checking each individual university website for the participant's names, contact information and biography.

Sample Size

A sample of approximately 20 participants was anticipated and achieved. The researcher stopped sampling once data saturation was met. Given the fact that the sample was comprised of only nurse educators, homogeneity occurred; therefore a small sample size was adequate (Polit & Beck, 2012).

Setting

Respondents were given the opportunity to meet with the researcher at a neutral location of their choice (such as a coffee shop, residence of choice, mall or restaurant) and at a time that was convenient for those who agreed to participate. It was more convenient for some respondents to complete a phone interview as an alternative method of interviewing. All of the participants chose a phone interview or a Vidyo conference for their interviews.

Recruitment

Data collection for this study was dependent upon IRB approval at the Southern Connecticut State University where the researcher was a doctoral student. After receiving approval, invitations to participate in the study were sent via United States Post Office mail as well as individual university department email to all program directors and faculty listed on individual university websites. A brief cover letter was also included describing the purpose of the study and confidentiality. Participants were asked to respond to the researcher by a particular date. Appointment schedule for interviews were developed and the date and times were confirmed with all who chose to participate.

Data Collection

Qualitative research relies primarily on in-depth interviews and observation (Polit & Beck, 2012). It was necessary for this study to correlate with the academic calendar of the universities in order to capture participation of nursing faculty. The best time to collect data is between October through November and January through April (Roberts, 2010).

A pre-determined list of interview questions was developed and designed to help understand the descriptions of the participants' experiences through broad questioning and in-depth interviews regarding their personal experiences and beliefs about transgender

persons. This also determined the impact of the interaction with transgender persons, if any, has had on the participants and whether or not this influenced attitudes, bias and knowledge of the participants. Qualitative research uses words to describe feelings, actions, perceptions and understanding of interpersonal behaviors (Roberts, 2010). The use of digital voice-recognition software was used to record the interviews and Rev audio transcription services to transcribe the interviews. This software transcribed the audio interviews into text thereby saving time on the part of the researcher (Fletcher & Shaw, 2011).

Participation in the study was voluntary. Audiotaped interviews took place on predetermined dates with those who chose to participate. Specific times were arranged with participants giving ample time for each interview. Data was obtained through several open-ended questions. The questions included the following:

1. What experience, if any, do you have with transgender persons?
2. Please explain what being transgender means to you?
3. Do you include information on transgender persons in your courses? If so, please tell me what you include. Are there parts that you exclude? If not, what reasons do you have for not including transgender health care content?
4. Are there any beliefs that impact on why you choose to include or exclude this content in your courses?
5. Does your institution have constraints regarding the teaching of this content?
6. Do you feel nursing students are adequately prepared to care for this population of patients?

Data Analysis Procedures

An audio-transcription service was used to transcribe the interviews into script. Interviews were transcribed into text within 24 hours, reviewed and read for clarity and accuracy by replaying the taped interview and comparing this to the transcription. The researcher reduced the data into themes through a coding process (Creswell, 2013). Hays and Singh (2012) state "the qualitative data analysis process should occur at the same time as the data collection" (p. 294). It was essential to categorically organize the data so that it was able to be reduced. Clusters of themes were identified and conclusions drawn thereby creating a list of topics (Hays & Singh, 2012; Roberts, 2010). Each transcription was read multiple times for clarity and familiarity as well as to get a sense of emerging themes by manually extracting significant statements, words and phrases into a coding framework. Coding is a process by which the data is placed into smaller categories and a label is assigned to designate a code (Creswell, 2013). The data was then broken into segments to compare concepts and similarities in an effort to determine phenomenological meaning (Polit & Beck, 2012). Once a group of similar and dissimilar statements and concepts was abstracted, it was coded as a theme. A computer spreadsheet matrix listing the themes was developed to assist with comparisons and categorization of the data. Individual responses were grouped by the interview question. The significant statements representative of each theme were organized in a word document file, re-read and again compared, highlighting similarities using color codes. This process allowed the researcher to identify and summarize similar responses as well as recognize patterns or divergent statements. An analysis of the responses to the research questions was conducted, resulting in identification of themes and categories (Roberts, 2010).

Qualitative content analysis produces data in the form of excerpts and quotations that can later be categorically organized and formulated into themes (Polit & Beck, 2012; Creswell, 2013). This researcher coded the entire data set and then it was collaborated with a seasoned qualitative researcher to compare, validate and evaluate the findings. The concept of validity is referred to as trustworthiness as established by Lincoln and Guba (Lincoln & Guba, 1985). It was vital to work with an experienced qualitative researcher who ensured that this process was performed correctly. Validation can be in the form of a peer review as an external verification of the research process (Creswell, 2013). Prominent themes and statements were discussed and agreed upon as significant between this researcher and the qualitative expert.

Trustworthiness

This study utilized Lincoln and Guba's five criteria of trustworthiness (Hays & Singh, 2012). Rigor of qualitative research is dependent upon establishing standards for trustworthiness: credibility, transferability, dependability, confirmability, and authenticity (Hays & Singh, 2012; Polit & Beck, 2012). Credibility is also referred to as the "confidence in the truth of data and interpretations" (Polit & Beck, 2012, p. 585). Credibility is established if the conclusions of the study make sense for a qualitative study. This was achieved by establishing the believability of the results. Additionally, field notes were kept during data collection and analysis stages of the study. Transferability is the generalizability of the findings. This study provided a detailed description of the research process so that others can replicate or apply the findings for their own use. The ability to replicate consistency and stability of findings over time and with other researchers is known as dependability. Future studies on this topic could utilize the interview questions with new participants in an effort to reproduce the findings. Reporting of data that are

considered true reflections of the participants and free from the researchers' bias in a study is known as confirmability. The interviews were structured with open-ended questions that allowed participants to answer and expand upon their opinions regarding the topic. The audiotaped interviews were transcribed then the interview was listened to again and compared to the transcript for accuracy. Confirmability occurred as a result of maintaining objectivity and neutrality with accuracy of data reporting. As the researcher, it was imperative to maintain authenticity by representing the perceptions of the participants as they stated during the interview.

Authenticity occurs as a result of true participant perspectives. Despite how well a study is performed, the research design may not properly answer the research question. This is referred to as coherence. Sampling adequacy is the use of an appropriate sample size and configuration that matches the research design; having a large enough sample size of participants who are knowledgeable on the research topic. Ethical validation consists of the moral and ethical responsibilities of the entire study and the relevance to future theory and practice. Substantive validation refers to the contribution the research will make to the profession either by adding new knowledge or validating previously learned knowledge. Lastly, creativity consists of using unique design methods that demonstrate rigor through flexibility in the research process (Hays & Singh, 2012). The goal of this research was to obtain sufficient information from nursing faculty about their perceptions of transgender persons. It was suggested that data from this study will be helpful in encouraging nursing faculty to include content on transgender individuals in their curriculum. It is also important that the study have replicability so that similar findings can be found in future studies on this topic. The sampling method corresponded with the research design so enough participants were representative of the method to ensure sampling adequacy.

Research must be respected for the process of finding meaning in relation to a particular problem. As such, this study was aligned with the moral and ethical values of research. Prior to the start of the data collection, the proposal for this study was reviewed and approved by the IRB at Southern Connecticut State University (SCSU). Informed consent was employed according to the Institutional Review Board protocols. Findings were reported honestly and justly. Confidentiality was maintained by eliminating any mention of place of employment or any other identifying information from the transcripts by blacking out that part of the transcript. Any potential risk was minimized by having only two people with access to the typed transcripts. These were the only people who examined the data. Pseudonyms were assigned to each participant. Once all interviews were transcribed, printed transcripts were locked in a safe at the home of the researcher along with a roster of the participants' initials and pseudonym. Additionally, data was analyzed using only one computer which was located at the home of the researcher. The computer was not internet enabled at the time when data was being analyzed. The computer had a two-step security sign-on thereby decreasing any risk of data corruption through firewall breach or intrusion.

Both the coding process and theme development affect the trustworthiness of the study; therefore it is the researcher's responsibility to examine the coded data for authenticity and accuracy of the transcripts. Member checking was offered to participants to read the transcription of their interview to ensure that they have nothing else to add, subtract or clarify. Member checking increases the trustworthiness of data by "accurately portraying intended meanings" (Hays & Singh, 2012, p. 206). It confirms and clarifies the transcribed data. Member checking also obtains feedback from the participants for validation purposes (Creswell, 2013). It verifies that the participant said something in the manner they intended to so that their words were not misconstrued. Thus, the participant

reviews the transcript to ensure accuracy, detect any biases on the part of the transcriber and expand upon any of the responses (Hays & Singh, 2012).

Limitations of Research Design

Purposeful sampling is a nonprobability method of sampling in which the researcher intentionally chooses participants whose characteristics that will most likely benefit the study and the phenomenon of interest (Polit & Beck, 2012; Creswell, 2015). There are two goals of this type of sampling: 1) finding or obtaining samples that are characteristic of a broader group on a phenomenon of interest and 2) sampling that has the potential for comparison or replication (Polit & Beck, 2012). It is essential to this type of sampling that specific criteria are established before sampling the population (Hays & Singh, 2012). Potential weaknesses of this study include researcher bias and errors in interpretation of data. The researcher attempted to reduce or eliminate bias by avoiding inferences through communication of personal experiences with participants. During the interviews, this researcher avoided offering any commentary, opinion or discussion with any of the participants on the research topic. This is referred to as bracketing, a process by which the researcher withholds any preconceived opinions about the phenomena of study that can flaw the research process (Polit & Beck, 2018, p. 187). If a participant asked the researcher questions of opinion, the conversation was turned back to the interview questions and topic at hand to avoid any personal discussion. Additionally, inadequate capturing of data and key themes can influence bias and distort findings (Polit & Beck, 2012). However, despite these weaknesses, it was hoped that this sample addressed the research questions and gave the researcher valid information about the phenomenon of interest.

Research Questions

The purpose of this study was to describe the reasons why nursing faculty do not routinely include information on the transgender population in nursing curriculum. The two broad research questions directing this study were:

1. What are nurse educators' attitudes, beliefs, and knowledge regarding transgender persons?

2. What factors contribute to the inclusion of transgender education in undergraduate nursing education?

In the course of interviews, the researcher occasionally needed to ask additional questions to prompt the participant to respond, clarify or elaborate on the subject matter.

Informed Consent

Ethically and legally, the researcher was responsible for clearly defining the research study and their rights and responsibilities to the research subjects (Hays & Singh, 2012). Participants were made fully aware of the potential risks involved in research before they agreed to participate in the study. Involvement in this study was voluntary and those who chose to participate could withdraw at any time without any consequences (Roberts, 2010). Confidentiality was assured and individual names or identifying data was not used. To maintain confidentiality, all participants were given an assigned code. Only the researcher and an expert qualitative researcher and tenured professor, had access to this data for extraction of significant statements, coding and emerging themes. Written transcriptions and digital voice recordings were securely stored in a locked safe with digital entry. These research materials will be destroyed by the researcher three years after study completion.

After obtaining permission from the participants, signed informed consent forms and assuring confidentiality, interviews were audiotaped to ensure the accuracy of the participants' responses (Polit & Beck 2012). The researcher explained the rationale for audiotaping the interview, how the recordings will be used, stored and ultimately destroyed following data transcription (Roberts, 2010). Face-to-face interviews took place through the use of Vidyo conferencing but only five participants chose to use this method for the interview. No one chose to meet in person due to their time and schedule commitments. The remaining interviews were conducted by phone. Storage of data requires security therefore a dedicated safe with digital code for entry was purchased for this purpose and stored at the researcher's personal residence. All digital recordings were coded with an identification number, pseudonym and with the date of collection. Data will be kept for three years per institutional policy then destroyed.

Summary of Chapter Three

Qualitative research is based on assumptions and the use of frameworks that help to guide the study of a particular problem (Creswell, 2013). This qualitative descriptive study recruited participants initially through purposive sampling. Therefore, the nurse educators were recruited for participation because they met the study's participation criteria. Later, to get a greater number of participants, these nurse educators were asked if they knew other nursing faculty who met the study criteria and who might like to participate as well. This technique is referred to as snowball sampling and is a type of convenience sampling strategy that uses some participants to refer other study participants (Polit & Beck, 2012) It was the responsibility of the new referrals to contact the nurse researcher and consent to take part in the study. Utilization of this particular method allowed the researcher to identify the sample but also allowed for quick access to potential participants.

Interviews were scheduled and conducted at the participants' convenience. The use of digital voice recognition software recorded the interviews and a transcription service was enlisted to transcribe the interviews. All participants were assigned a fictitious code. The researcher worked closely with an experienced qualitative researcher on the coding process to ensure that it was properly performed. The researcher upheld the trustworthiness criteria of Lincoln and Guba (1985). Credibility and confirmability were assured through audio-recording and transcribing the interviews; therefore the findings were based on the actual responses of the participants and without researcher bias. The study's findings were consistent and could be repeated thereby fulfilling dependability criteria. Transferability of the data is applicable to those who may desire to evaluate or apply the data elsewhere, such as faculty development. Authenticity of the findings was demonstrated through member-checking.

CHAPTER FOUR: DATA ANALYSIS AND RESULTS

Introduction

The purpose of this study was to examine the reasons why nurse educators choose to include or exclude content on caring for transgender patients in their respective courses. As previously stated in Chapter 1, this study was conducted to address the lack of new nursing research and theoretical frameworks, policy change and practice guidelines as they pertain to care of the LGBT patient (Carabez et al., 2015; Eliason et al., 2010; Lim & Bernstein, 2012). As a result, if nursing faculty are not well informed in this content, it is unlikely they will teach it in their courses. The vast majority of the literature consisted of articles about LGBT persons but it was difficult to find articles pertaining solely to transgender persons whose needs are uniquely different from those of the other populations represented under the umbrella term. This chapter includes a description of the sample, detailed analysis, and a summary of the research findings.

Description of the Sample

After obtaining IRB approval for the study, recruitment emails were sent to the Deans and program directors of 171 CCNE accredited undergraduate nursing programs and 39 ACEN accredited undergraduate nursing programs in the northeastern United States. The Deans and Directors then forwarded the email to their faculty. If faculty were interested in participating in the study, it was their responsibility to respond to the researchers' email and return a signed, informed consent. Twenty-six respondents expressed interest in the study. Informed consents were emailed to the 26 respondents and of those, 20 agreed to participate in the study. Current employment verification of all participants was performed by checking the individual university and college websites.

Two subsequent reminder emails were sent to the remaining six respondents but no further replies were received.

The participants included nurse educators teaching in CCNE and/or ACEN accredited baccalaureate nursing programs in the northeastern United States. Participants were recruited through purposive and snowball sampling. This type of purposive sampling allows for "access to a population of study" through the use of relationships with one another (Hays & Singh, 2012, p. 169).

Data was collected over a two-month period of time from 15 telephone and five Vidyo interviews with nurse educators who currently teach in baccalaureate nursing programs. There were no face-to-face interviews done. The interviews were audio-recorded with permission from the participants using Tape-A-Call and were then transcribed using Rev.com audio-transcription service. The participants answered ten demographic questions and six research questions pertaining to the subject of teaching transgender education in nursing curriculum. The demographic description of the participants' information included: the pseudonym assigned to each participant, type of interview (phone or Vidyo), age, gender, race/ethnicity, highest academic degree, any nursing certifications, length of time as an RN, length of time teaching, current clinical practice setting, number of courses taught each semester and number of courses that included transgender content (Appendix B).

Sample demographics are illustrated in Table 1. Only one of the 20 participants was male. All participants were Caucasian. Participant ages ranged from 35-68 years. The sample was evenly divided between those who were currently working in clinical practice in addition to teaching and those who were not currently in clinical practice. Eleven participants held some type of nursing certification. Doctoral degrees (DNP, EdD or PhD)

were earned by twelve participants; five participants were currently enrolled in some type of doctoral program and three had MSN degrees. The number of courses taught each semester ranged from one to four courses plus clinical supervision, coordination/oversight and capstone experiences.

Table 1

Sample Demographics

AGE	35-68
GENDER	Female: 19 Male: 1
RACE/ETHNICITY	Caucasian: 20
HIGHEST DEGREE EARNED	MSN only: 3 MSN with some doctoral work: 5 EdD: 4 PhD: 6 DNP: 2
# OF YEARS TEACHING	3-31 years
# OF YEARS AS AN RN	6-37 years
CERTIFICATIONS	WHNP/PNP; Board certified Nurse executive; CCRN/Acute care APRN; CNM; Certified Legal Nurse Consultant/APRN; Pediatric Board certified; Medical/Surgical Nursing Board certified
CLINICAL AREAS OF PRACTICE	General surgery, Medical/Surgical unit, CNS in adult ICU, out-patient clinics, PACU, FQHC, VA, Critical Care 10 participants are not currently practicing as an RN
# OF COURSES TAUGHT PER SEMESTER	1-4 courses per semester; some with capstone or clinical supervision/oversight/coordination

Summary of the Results

Six data-generating questions were asked during the interview:

1. What experience, if any, do you have with transgender persons?
2. Please explain what being transgender means to you?
3. Do you include information on transgender persons in your courses? If so, please tell me what you include. Are there parts that you exclude? If not, what reasons do you have for not including transgender health care content?
4. Are there any beliefs that impact on why you choose to include or exclude this content in your courses?
5. Does your institution have constraints regarding the teaching of this content?
6. Do you feel nursing students are adequately prepared to care for this population of patients?

Data saturation was met with twenty respondents. It occurred earlier but there were a few interviews that were already scheduled and it was felt that the interviews would only strengthen the findings. All twenty participants received a copy of their transcripts with a request to read and return any clarifications or corrections. Nine responded that there were no changes; one responded that their name was misspelled; one responded that her age was incorrect and one clarified meaning of a statement they made during the interview to be sure this researcher understood the concept. The participant whose name was misspelled was assured that upon member checking, all identifying information was blacked out and was assigned a pseudonym in place of a name. The remaining eight participants did not respond to a follow up email requesting verification of the transcribed interview.

Several themes emerged during the interview process including: experience with transgender persons; inclusion and exclusion of content in curriculum; teaching to the test; holistic care and diversity; lack of faculty knowledge; secular versus religious influence on teaching transgender content; and student preparation and readiness to care for transgender persons.

Detailed Analysis

The data collected from the interviews was obtained; transcripts were verified by listening to the audiotapes and confirming precision of the transcribed text. Member checking was performed allowing the respondents a chance to review their transcripts for accuracy and to clarify meaning. The transcriptions were then read multiple times by the researcher to determine meaning and identify themes. Data was coded and categories were formed.

Theme 1: Experience with transgender persons

Individual experiences with transgender persons were sparse among the participants. Some had limited interactions with a transgender person either personally or professionally.

Sophia: "Only in the clinical setting. I have never had experience with students. I have taken care of transgendered adolescents."

Lisa: "I had a nursing student, probably over 5 years ago who identified as transgender and he was in nursing school and he encountered some difficulties. He approached me for guidance really. I was not his advisor. I don't know why he approached me. He wasn't in my clinical group but he had a friend who was in my clinical group so he came to me and spoke with me about his difficulties. I was able to help him stay in the program. They had a dress code and he needed to adhere to that dress code. He was having trouble with the

terms of that dress code because he preferred to dress in female clothing but he identified as male. He preferred the masculine name. He preferred to dress in what would traditionally be seen as female. He dressed female but used the pronoun of male."

Elizabeth: "I would say none that I know of right?"

Hope: "Well, we actually had had a student that ... Initially she was not doing very well at school and she actually left for a while, came back, left for a while, came back and then she just had a very difficult time sharing with us on how ... She definitely had some other personal issues that we were aware of that could have contribute to her performance, but ultimately it really was a scenario where she was transitioning and now he came back, finished the last few courses that he had to finish, and did very well. Was a very industrious student as far as community service and clinical work. It was more of being accepted by his peers and I think concern about possibly what anyone one of us would think as far as faculty, which is unfortunate because that would never have been. If anything I think that we would have perhaps, I would like to think, helped with any concerns anyway. He came back, he passed his boards, he was able to get a job in the specific area that he was interested in too, which was ... A lot of the students aim high for working in ICU, ER. Whereas, this particular student really wanted to work more in the community health, homeless area. That's actually the profession that he was able to pursue."

Nan: "The first person I ever took care of who was, I guess, who was transgender, the patient's name was Jane and I went in the room to check Jane. Jane had boy parts. So that was my first experience. Then I double checked Jane's armband because I thought maybe I was confused. But that's my initial experience."

Tara: "None. I really don't have any."

Sandra: "None."

Maryann: "I have both in practice when I was practicing, well no, actually, I guess it was when I was teaching because back in the day I had students in the Acute Care setting when I taught Med-Surg. So I've had that experience of having students care for someone who's transgender. Interestingly, at the immigrant and refugee resettlement agency that we've been working at with students there is a ... person who's a man becoming a woman and it's very interesting because he's Arab and he's an immigrant or a refugee. And so that, I mean, the whole cultural thing where that is really forbidden and then ... to me it's just a fascinating thing to watch because it any other situation I think he would be ostracized but I think because everyone has been through so much so they're so accepting and it's actually really nice to watch but it's also amazing to watch."

Stephanie: "I have only clinical as an NP, both a PNP and a WHNP. Very minimal primary care. Some collaborative managing patients."

Leanne: "I have, most recently, I have a little bit of experience with a child, who is eight years old, that was born with male anatomy, but identifies as a female. I interact somewhat with a student that appears to be male gender, but might be identifying as a female, but I don't know that specifically. Just on a, in passing, basis. I have had, really that I know of, for sure, two transgender patients in my lifetime. And as far as I know, that is my experience."

Janie: "I have friends who are transgender. I have cared for a transgender patient in the hospital one time, and beyond that, just reading and trying to keep myself as informed as possible."

Cindy: "I would say that my only contact with transgender patients has probably been ... very limited patients in the critical care setting that I've taken care of, that have come in for various illnesses, so very limited."

Angela: "I can't say that I have met anyone who identified as transgender. They may not have said that they were transgender. I was aware of a patient that was transgender, but I did not feel as a nurse manager at that time that I had any reason to interact with the patient unless something came up."

Sue: "The only experience that I have is any interaction that I've had socially, which is fairly limited. I've been to conferences where we've had panelists that are transgendered, but other than that, not a whole lot of experience. Overall my experience is pretty limited"

Leanne: "I have, most recently, I have a little bit of experience with a child, who is eight years old, that was born with male anatomy but identifies as female. I interact somewhat with a student that appears to be male gender but might be identifying as a female, but I don't know that specifically. Just on a, in passing, basis, I have had, really that I know of, for sure, two transgender patients in my lifetime. And as far as I know, that is my experience."

Johnna: "The first experience I had was when I was in my clinical and specialist role and this is at least 15 years ago. I had a patient admitted who was transgender who had an ostomy and needed some help with ostomy supplies. So I went in to do the consult with her. It was my first experience working with a patient in that setting, but a very good experience. She was a very articulate, very well-versed in terms of negotiating what her needs were. I think if I did anything really significant was I made sure she had a private room, and then kind of focused on what she asked me to come in for, which was to focus

on getting the right supplies she needed for her ostomy. But beyond that, no, I've not had much experience, except one other thing was this past year."

Elena: "I have family experience and yeah, that's about it. I have some education in my Master's program about it, and that's about it."

Lynn: "I've had experience with a transgender teen in my practice when I was practicing. I did have a transgender teen whom was in the process of going from female to male."

Margaret: "I've had transgender patients on two separate occasions in my practice as a nurse."

Giovanni: "Personally for a long time. Clinically just within the past two years. That's taking care of patients."

Penny: "I was a social worker before I was a nurse and in the early 90s my area was HIV/AIDS and I worked in an outpatient HIV clinic and I was their social worker. And we had a fairly large transgender population, it was, I'm in Philadelphia and it was the main clinic that transgender people went to at that time and I guess the gay community in general." Penny went on to say, "I would say in general my experience in undergrad program is not a lot of information about the actual medical transition, like the details of surgeries, or, you know, the whole process more from a nursing perspective of working with people." She related that the school of nursing where she teaches is trying to include more information on LGBT content but it is more under the guise of looking at all populations.

The sample of nurse educators for this study had limited first-hand interaction or experience with transgender persons. Despite the years of practice experience, few cared for or had a student who was transgender. Only two respondents had any significant

experience with transgender persons and four participants stated they had no experience at all with transgender persons.

Theme 2: Inclusion and exclusion of content in curriculum

Thirteen of the participants stated that transgender content is only cursorily covered and is generally under the LGBTQ umbrella, usually pertaining to personalized care and cultural sensitivity. One participant reported that they include some of the generalized healthcare needs of a gay or lesbian patient and how their needs differ from those of other adults. The courses taught included family-centered care, nursing foundations, leadership management, adult health, physical assessment, community health and a course on Aging and End of Life. Three respondents reported that they include information in their courses as well as in the clinical setting if students bring up the subject for discussion.

Only four respondents stated that they do not include any transgender content due to a variety of reasons including the type of class and the perceived appropriateness of including content in specific courses. A few of the respondents stated that the only place this content was covered was in the psychiatric courses or an end of life course as though it was some type of disease state.

Janie: "So in the context of those courses, one would speak about the lifespan, or the family, or developmental models in terms of health/illness continuum, and factors that affect that. I always infused LGBT into my lectures." She further stated that she did not intentionally exclude any information but "it was more of a matter of whether it was relevant to the conversation or the topics at hand. She went on to say, "In terms of excluding, I try to think of it in terms of a lifespan development. So by nature of the course that I would be teaching, if it's not on human sexuality or for example, reproductive or STDs, or along those lines, that content's covered in some of the other courses in the

curriculum. But what I focus on predominantly was making sure the students had some foundational knowledge in terms of appropriate terminology, what they hear out there, helping them sort myths from fact and fiction if you will, and I entertained a lot of questions so that I could get a sense of where students were in terms of their knowledge base about this population."

Margaret: "There is nothing specifically that discusses gender identity in my syllabus of adult health. Additionally, I talk a little bit about hormone therapy that transgenders may be on when we do the endocrine module of my adult health course." She revealed that she teaches in a religious institution.

Cindy stated that the content was included only when vulnerable or marginalized populations were being discussed and in content on caring for victims of domestic and sexual violence.

Hope: "I would say that currently I don't think there's enough. I teach Public Health, so we do discuss it. We talk about communicable diseases and cultural differences. I think they also talk about it in our Death and Dying."

Lisa: "I try and include a broad definition of what could be the diversity in terms of identifying gender including perhaps gender fluidity. Basic knowledge really and then more into our values as nurses as being a judgment free zone and we accept people for who they are. When I'm speaking I do try and say I'm going to be using the him pronoun for the sake of convenience or I'm going to be using the she pronoun for the sake of convenience, this applies to all genders or whatever gender you're identifying with or not identifying with, you know. Because I think for many of my students it's a new topic. I know they're going to encounter it in their patient care population so they need to be prepared. The

textbooks really don't go into that much so I feel like I just give like a basic broad brush and if they have questions they can come to me."

Johnna: "I teach adult med-surg, and I have not yet done that except when I talk to people about inclusivity. Inclusivity's a major arm of (our) kind of three-prong education and I do use that as an example of being very acceptive *(sic)* of populations who come in."

Elizabeth: "Simple little article, I teach sophomores you know they're nineteen years old so it's nothing too heavy. An article, and then we go over the GLMA guidelines, we look at that document. I also have another document "Improving the Healthcare of Lesbian, Gay, Bisexual and Transgender People" by the Fenway Institute. And "Advancing Effective Communication and Cultural Competence in the LGBTQ Community" and you know we would just talk about the disparities and how the LGBTQ community, and now I understand there's another letter, "I" that they added on and I think "A". But you know they have their own issues and they're often stigmatized obviously. And that's really what we would talk about. Just like anybody else you just take care of them just like you would, if a terrorist comes into your ER you have to treat them the same so it shouldn't matter, you know?"

With respect to the exclusion of content, the majority of participants stated that exclusion of content was not done purposefully.

Margaret: "I teach in a religious institution, and when I looked at the syllabus, there is nothing specifically that discusses gender identity in my syllabus of adult health. However, because male urogenital health is not covered in detail like women's health is in the pregnancy and birth courses, I do cover men's prostate health issues in my adult health course. In that section, I do talk about the need for prophylactic prostate care for transgender women who have not done a surgical completion of the reassignment."

Lynn: "It depends on the course. We do include it in my entire program that I'm responsible for. We do include it in physical assessment. We include it in the history taking so that it has to come up just in case the patient wasn't going to voluntarily speak about it."

Giovanni: "It starts out as an umbrella, but then we take specific challenges from each. I like to separate out transgender from Lesbian, Gay, and Bisexual. The way I teach to my students is for political motivations it makes sense for Lesbian, Gay, Bisexual, and transgender folks to work together, but when we talk about the medical challenges and the specific social context, I think it works better to tease out the transgender from Lesbian, Gay, and Bisexual even though someone can be transgender and also be Lesbian or Gay, there's a specific set of challenges, I think, among transgender."

Nan: "I talk about all different types of cultures and people of different backgrounds in the format of, you know, we take care of people and we're supportive and that we need to be there for the patient and keep our judgements at the door. Maybe someone comes in and they say they're the patients' wife or husband and whoever they are and whatever they look like it's not our place to judge them. They're here; it's our job to be supportive of them. We have to put on our hospital face and treat everybody the same way. I don't specifically talk about "this is how you need to talk to these types of people as opposed to those types of people" because everybody is different. She stated that she included transgender in her courses because she felt that as nurses they will encounter all kinds of people and there is a need to be open-minded."

Sandra: "The only place that we have transgender information is unfortunately in our psychiatric course, almost like it's a disease. It's only found in our psychiatric course. We have a new program. Our curriculum and our content outline were set up by consultants

prior to us getting here. I just don't think it was in any of the textbooks as well to identify that we had a gap in our program."

Inclusion of transgender content in curriculum is not consistent among nursing programs. While the respondents are of the opinion that it should be included, content in curriculum is not consistent and is only minimally covered under the LGBT umbrella. Participants spoke about the content of their courses and whether or not there was a relevant place for transgender education in those courses. Generally this content was covered as a broad definition within the perspective of diversity but no specific care of transgender patients was covered. The majority of the respondents stated that they included it under the umbrella of LGBTQ.

Theme 3: Teaching to the test

Many of the participants stated that content for NCLEX took priority and since transgender content was not on the NCLEX exam, it was not likely to be covered in courses given that curriculum is exam-driven.

Hope: "I'm not as well versed. It's the problem of nursing in general and hanging its identity on tangible outcomes, NCLEX scores and I think it's a bigger question on self-identification of what nursing really is in the new millennium, in this complex health care environment. Because there is no unified agreement, it's almost like we scramble backwards a little bit. When in doubt, NCLEX scores. We're teaching to the test. We're no different than secondary education right now."

Penny: "Well for my experience with the transgender population and just seeing how transgender people often are overlooked, their healthcare disparities. I am myself bisexual so I have been just familiar with how the whole LGBT population is underserved and may

not seek medical care and healthcare providers being inappropriate and uneducated. So I think it's really important in nursing."

Stephanie: "I work in a very small Catholic college where they try to be progressive, but their focus right now is very content driven on certification rates, pass rates for NCLEX and for pass rates for the Nurse Practitioner Board."

Johnna: "Based on the curriculum that is set out for us in terms of what I need to cover with med-surg, my med-surg courses cover more than any of the others and is very much driven by the NCLEX blueprint. About 70% of the NCLEX exam is med-surg so what I have to make sure is that's covered. Now, does that give me the excuse that because it's not a big focus of the NCLEX blueprint, I don't think that's an acceptable reason. I'm not happy saying that transgender issues fall under "nice to know but not need to know", but based on the NCLEX blueprint, that's where it is. That's not making excuse, it's not a good excuse, but it's getting into that kind of concrete (*sic*) what do I need to do to make sure that they have all the prep they need that has to be critical, more than (*sic*) their diploma so they can then have the credential of RN after their name?"

Sophia: "It's not purposeful, but you know, NCLEX currently doesn't test yet on that topic and we're really bound to the test blueprints that NCLEX identifies. This is definitely an area that I would love to grow in our content, but with a 13-week course that only meets twice a week, you can only get so much content in."

NCLEX blueprints appear to be the driving force behind why transgender content is not included in nursing curriculum. Given the vast amount of information faculty need to cover in their courses to prepare students for NCLEX and the fact that transgender content is not currently included on the exam, educating students on this topic is not a priority for those who participated in this study.

Theme 4: Holistic care and diversity

Diversity coupled with holistic care emerged as another theme. The respondents overwhelmingly believed that regardless of gender, all patients deserve the same treatment and care.

Janie: "Philosophically if we're providing holistic care to all people, and we're trying to provide care that is truly authentic, patient-centered, I hope and pray that all my students have a sense of what it means to be human and that there's multiple dimensions as well as there are multiple dimensions in use of gender. And so I hope I expand their thinking by giving them these exposures, experiences, and opportunities to discuss matters that are not solely grounded in the heteronormative and gender binary system that we live in."

Margaret: "I just teach it without putting it in the syllabus, without asking permission if you will because I feel it's really important for students who are going to be seeing transgender patients more and more to be armed with this information, but when I asked one faculty, the one women's health faculty if she included it in hers, her courses, her impression was that we weren't supposed to teach that because we work for a Catholic institution. However, Catholic or not, we need to deal with a holistic human being, and if your patients are going to be transgender, then you need to address everything that they could possibly encounter."

Elena: "I have a belief in that all people deserve health care, and so I think that there are marginalized and underserved populations, and so I talk about them a lot in community."

Elizabeth: "The belief that I have, yeah I have the reason I put it in the course. I have a strong belief, and I don't know if I'm going to say it politically correctly but, that this population of the LGBTIA, it doesn't matter, community. I just have a really hard time with the stigma against them, and the exclusion and the healthcare providers that won't care

for them in certain parts of the country. And I just think it's really important they're just like everybody else. I don't ... like, what's the difference You don't have to agree, this isn't ... you don't have to like it, you don't have to agree it doesn't matter. Like you're taking care of rapists and murderers, you may or may not know that. So what difference does it make? You know it's just the core of nursing, we care for everyone, it doesn't matter."

Giovanni: "When you look at not just what suicidal ideation but suicidal attempt is among the transgender it's above and beyond what it is for general populations. It's astounding, and when I give the students results from the transgender health survey, and American General Public Health just had a really great article with a large "n" I think it was over a couple thousand, they're staggering percentages. Drug use, sexually transmitted infections, suicidal ideation and suicidal attempt is just so much higher than within the general population and so much higher than in the Lesbian, Gay, and Bisexual population. I think that they deserve the attention certainly within the nursing profession. If we're gonna advocate that needs to include everyone."

Nan: "I include it because you're going to encounter all types of people. Unless you're not a nurse, you're going to encounter all kinds of people, unless you live in a box you're going to encounter all types of people and you have to be open-minded and you have to take everybody as an individual."

Angela: "I think it's a good idea to include any type of diversity for our patients and there to be no reasons for me that I would have a particular reason, cultural, religious, any of that, to not want to teach it or not want to address it. I feel very comfortable discussing the topic, and I don't think that there is any reason why it shouldn't be included at the appropriate level for the students."

Maryann: "Well I'm a Quaker so my personal belief is that there's dignity of all people so I would include it and fight for to include it. As I've said, I'm at a Catholic university and actually the mission of the university is to serve kind of the most vulnerable…"

Sophia: "I think that most nursing programs, if not all, really support the concept of treating patients holistically and really working with our patient to the best need of their needs. I think that we all encourage open mindedness, but the practice of that, both by faculty and by the students themselves, we've all seen in our practice and in our work, can vary."

Diversity and inclusion coupled with holistic care emerged as a theme. Across the board, all of the respondents felt strongly about including holistic care and diversity in nursing courses. The respondents overwhelmingly believed that regardless of gender, all patients deserve the same treatment and care.

Theme 5: Lack of faculty knowledge

Many of the participants admitted they did not have any negative beliefs that impacted on inclusion or exclusion of content but it was based on their own knowledge deficit and not feeling entirely comfortable in teaching content they were not educated in themselves.

Cindy: "I think that it's probably my own lack of knowledge. Probably, part of that lack of knowledge is, again, I don't have a comfort with it as far as teaching. I think that that ... you know, you could read something in a book. Again, unless you've actually dealt with people who are transgender, I don't think you have a comfort level with that population."

Elena: "A part of my passion or driving force is to expose the students to ideas that they sometimes or concepts that they sometimes don't get in their mainstream nursing education. That, transgender, doesn't seem to be something that is included in the curriculum…"

Sue: “I am interested to figure out how I could…I think that it is in our best interest in preparing our students to try to integrate it into the curriculum. I really think it's a knowledge deficit on the part of the faculty.”

Janie: “I don’t think it’s a topic that all faculty, at least all nursing faculty, comfortably embrace enough to be able to engage students in discussions.” Janie went on to say, “I think this is driven by a lot of personal demographics for some people, in terms of their comfortableness, and value that they place on teaching this content and it’s their job.”

Lynn: “Probably just my own knowledge base. In all fairness, if I needed it, I would learn it.”

Tara: “I don't think the general nursing staff is either. Because we're in a rural area…I think you really need hands on training and you actually have to be exposed more to transgender patients and we're really not where we live. I don't think even the nursing staff at the hospital is really trained to be able to care for transgender patients.”

While many of the respondents stated the need to include this information in nursing curriculum, they felt they were not well-educated on this topic enough to teach it. Sophia stated, “I think this is a great opportunity for curriculum development for all of us as educators, academics.”

Tara: “I could suggest a faculty development day and bringing in an expert to talk about it but I’m sure it would not go over right now. I think that would definitely help.”

Sandra: “Our faculty are on board. What kind of conference can we have onsite to learn about this with all of us learning about transgender health and how we can assess them now in our programs, in our school as well as the community?”

Despite many of the participants affirming that this content was something that should be included in curriculum, only three stated that it was important to be part of

faculty development and training for the future. After the interviews were completed, these three participants then inquired about how they can bring this type of faculty education to their campus.

Theme 6: Secular versus religious influence on teaching transgender content

There were eleven participants who taught at a variety of faith-based or religious institutions. The majority of them stated that their respective institutions did not have any limitations on including transgender content within their courses and felt their programs were very progressive in terms of this content. However, a couple of participants adopted a "Don't ask, don't tell" policy. Lynn: "I teach for a Dominican college so that I have to be very mindful of their mission, but, in all fairness, the motto of this college is 'Teach the Truth.' I have not hit any constraints per se. There are certain things that constrain us in the clinical area, but it wouldn't be anything to do with transgender."

Janie: "I never felt inhibited to teach. I did feel that I had a lot of academic freedom. But at the same time, I was always sensitive to the fact that it is a religious organization, university, Catholic university, and you know, I did at times feel like there was, perhaps more self-imposed constraints as opposed to institutional, overt constraints."

Leanne: "I do not believe that our college has restraints against the teaching of the content, no written constraints against that. I think that the program itself, the nursing program, would say, if you mentioned that you were going to include transgender content, or you were going to add that in to your course, what is your reasoning for this? What is the data behind it? Will they be tested on it? What's your rationale? I think that, that would be questioned pretty heavily, however, the college, as a whole, I think, is very supportive and becoming more and more supportive every day, of issues with students' identity."

Margaret: "I don't know because I'm not going to ask. Maybe one of these days, I'll get the guts to ask that question and to really stand my ground."

Sandra: "We're actually a very diverse, forward-thinking supportive campus that has an entire department for diversity and transgender and LBTQ and talking about pronouns."

Giovanni: "I wouldn't be there if they did. I did have a situation at the prior university that I taught at where they were not very welcome to the content, which is why I chose (this university). The overall mission of the university is to embrace diversity. Even though no other faculty members in the college of nursing have a handle on transgender stuff, they've been more than welcome and, indeed, excited to have someone covering that content. So we really do put our money where our mouth is as far as the larger university mission is embracing diversity, and certainly that's reflected in the College of Nursing."

Tara: "Nothing in writing. I mean, it's a private school, so even hiring, they definitely ask you, "Do you believe in Jesus as your savior? If you were gay, they would not hire you."

Sue: "We are a fairly liberal Catholic institution so there's no reason from an administrative standpoint or policy or procedure that we would exclude anything. I don't think that there's any reason that our faculty exclude the content based on belief."

Faith-based institutions did not have any restrictions on teaching this content to students. The respondents were strong advocates for embracing diversity. Despite being strong advocates, there was a sense from a few participants of being fearful to ask their administrators to include this content.

Theme 7: Student preparation and readiness to care for transgender persons

The lack of preparation of nursing students was a consistent theme throughout the majority of the interviews. Only four out of 20 participants felt that their nursing students were adequately prepared to care for a transgender patient. Conversely, the remaining 16

respondents were in agreement that there is simply not enough in the curriculum to adequately cover this content but several stated that students are asking for this information.

Sophia: "I think on a very primary level we're prepared, but we could always use additional education and training."

Angela: "I would think that our nursing students would be competent to care for any patient and that they would have the skills to make any encounter with a patient of any type of difference, to be able to have the skills to address it properly. I would think that yes, they would be able to care for and would have the skillset to find the information to better help them."

Two participants teach in an urban area where large transgender clinics are available to that population and as a result, their students are exposed to this population of patients during their clinical rotations. The faculty who taught in rural or suburban areas seemed to believe that their students would be less likely to have clinical encounters with a transgender patient. This assumption could be another indication of the lack of education about transgender people.

Margaret: "People are stumped as to what to do for these patients or how to even approach these patients, so reaching out and teaching practicing … people that are already practicing is a step in the right direction, but I really think that we need to teach students how to approach these patients because they're going to see them in a clinical setting, and then they're going to need to know how to talk to them and practice for them in the practice center."

Johnna: "But your goal in the baccalaureate program is to prepare a generalist. When you're doing the generalist, they've got to have enough information so they can answer

questions about med-surg, psych, community, Pedi, OB. They've got to kind of be able to do those things to get through their NCLEX preparation. But when you're doing generalist preparation, there's a whole list of things that you can't go in-depth on because there's not enough time. The generalist curriculum is too broad."

Penny: "They're not getting enough, I think most don't come into the program with much experience or knowledge to begin with and then if we don't provide it then they're not going to get it."

Sue: "It's a knowledge deficit on the part of the faculty. I think that there is a knowledge gap, there's a research gap, and the question is how do we integrate it into our undergraduate education? I don't have an answer for it. I do think we need to because we do have a large group of transgendered individuals in our community that are seeking care. I think in this community we're seeing more and more people come in to the acute care setting, we're seeing them more in the community setting. I don't think that we are preparing them enough and I think that we need to start. It's just a matter of how and where. I don't think that question is fully answered yet.

Sandra: "We don't run any simulations on transgender health. We don't assign patients that I know of. They haven't gone to any conferences. No. There's definitely a gap in our curriculum."

Hope: "It's interesting that you do ask that question because the students are asking for more experiences with transgender patients. I actually had a simulation lab and we do have mannequins that are set up so that the students can remember to ask transgender questions. The anatomy is arranged, in fact, that maybe your patient may be a transgender patient. It was more making sure that we correct the fact that that may be the case and making sure that you're asking appropriate questions and not just stereotyping. Someone may not have a

same sex partner. They're asking for more experiences and scenarios where they can be more cognizant."

Elizabeth: "That's a good question. You know part of me thinks these kids today the way they grow up in the world they're in they're more accepting and culturally diverse than I am… the majority I think are definitely prepared and I think that this is a non-issue for them."

Leanne: "I would say, on a scale of zero to ten, ten being completely adequate, and zero being not adequate at all, I'd say maybe a four or a five. I think that our students, from this college, are coming out compassionate and I think that they are somewhat open minded, but I also feel like until you get into some situations, or you really think about it in a very poignant manner, you don't realize. We don't realize. People don't realize how close minded we all are, on certain topics. So they're adequate on being somewhat open minded and compassionate, but on the specific transgender issue itself, there's more room for improvement than there is already situated in their mind."

Faculty agree that students overall possess the skills to care for any patient but do not have the specific education necessary to care for the specific needs of a transgender patient after graduation. This may be influenced by lack of faculty knowledge, lack of time in already burgeoning curriculum or the assumption that today's students are already more culturally diverse than faculty.

Summary of Chapter Four

There was a variety of representation of participants from religious or faith-based as well as public and private institutions. The participants varied in ages and level of education as well as the type of courses that they teach. The majority of the participants had completed doctoral programs and five were currently enrolled in some type of doctoral

education program. The participants also had a great variation on the type of experience and clinical practices. Data saturation was achieved. The majority of participants preferred a phone interview over a face-to-face or Vidyo meeting due to time constraints, and their perceived ease of a phone interview versus having to download Vidyo software for those who did not have access to it.

Themes that emerged during the interview process included: Experience with transgender persons; inclusion and exclusion of content in curriculum; teaching to the test; holistic care and diversity; lack of faculty knowledge; secular versus religious influence on teaching transgender content, and student preparation and readiness to care for transgender persons.

Experience with transgender persons among the participants was limited, either personally or professionally. Some of the participants cared for a patient during their career or knew of someone who was transgender. There were only two respondents who had any significant experience with transgender persons. The majority of respondents stated that transgender content was only briefly covered and was generally under the LGBTQ umbrella or included in discussions of marginalized and vulnerable populations. Inclusion of content was not consistent among the nursing programs represented in the sample. NCLEX blueprints were given high priority in terms of inclusion of content in curriculum. Diversity and holistic care was represented by many of the participants who felt their programs were teaching students the concept that all people deserve health care, caring for everyone regardless of the population. Cultural diversity was included in some of the programs' mission statements. Respondents were quick to admit their own lack of knowledge on transgender content as well as general nursing staff at respective institutions. Many of the respondents stated that the reason they did not include this information in their

courses was due to their own deficiency of familiarity with this population. Faith-based institutions did not overly appear to have any limitations on teaching transgender content within their programs and incorporated diversity within their courses. However, there were at least two responses indicating that participants felt their administrations would be less-than-encouraging of proposals to integrate transgender content into courses.

With respect to student preparation and ability to care for a transgender patient, only four of the participants felt their students were sufficiently prepared to care for this population after graduation. This may be influenced by the lack of faculty knowledge as well as NCLEX blueprint requirements and the lack of time to include more information in courses.

CHAPTER FIVE: CONCLUSIONS AND DISCUSSION

Introduction

This chapter presents a summary of the study results and conclusions drawn from the data that was presented in chapter four as well as the limitations of the study. This chapter discusses the implications for action and recommendations for future research.

It is well-documented throughout the literature that a deficit exists in nursing curriculum with inclusion of transgender education largely due to lack of faculty knowledge and bias in this area, lack of new research, theoretical frameworks and publications (Carabez et al., 2015). More people are identifying as transgender and as such, the importance for all health care providers to become educated on caring for this population has an increased implication in order to eliminate barriers to care (Sedlak & Boyd, 2016; Wylie et al., 2016). Owing to the lack of faculty knowledge, nurses as some point in their career will care for a transgender patient but will be inadequately educated on the unique needs of this patient population to deliver culturally sensitive care (Carabez et al., 2015).

Summary of the Results

The purpose of this qualitative study was to explore the attitudes, beliefs, and knowledge of nurse educators regarding transgender patients and the factors which contribute to inclusion or exclusion of transgender education in undergraduate nursing curriculum. After conducting a qualitative content analysis of interview data from twenty participants, seven themes emerged on these topics. The seven themes are: experience with transgender persons; inclusion and exclusion of content in curriculum; teaching to the test; holistic care and diversity; lack of faculty knowledge; secular versus religious influence on

teaching transgender content; and student preparation and readiness to care for transgender persons.

The results of this qualitative study answered the research questions: What factors contribute to the inclusion or exclusion of transgender education in undergraduate and graduate nursing education? What are nurse educators' attitudes, beliefs, knowledge and biases regarding transgender persons? These factors included influence of previous experience with transgender persons, lack of faculty knowledge and comfort in teaching this content to students, and time constraints due to NCLEX blueprint requirements.

Theme 1: Experience with transgender persons

The study revealed that experience with transgender persons, personally and/or professionally was either completely absent or limited for the majority of the respondents which may or may not have influenced whether or not they included information on transgender persons in their courses. Participants who had previous or personal experience with LGBTQ patients were more likely to include transgender content in their classes.

Theme 2: Inclusion and exclusion of content in curriculum

The vast number of participants stated that transgender content, if it is included, is generally under the umbrella of LGBT or only briefly mentioned in across a variety of courses. It is often discussed in relation to cultural diversity or vulnerable populations. Exclusion of transgender content was primarily due to two factors: faculty having little knowledge on the topic and faculty did not feel adequately prepared to teach this topic to students. The majority of participants did not purposefully include or exclude transgender content but considered the nature of the individual course they were teaching and whether or not there was an appropriate place for this content in that course.

Theme 3: Teaching to the test

NCLEX and "Teaching to the test" was pervasive throughout the interviews with many of the participants citing lack of time to include more content in an already burgeoning curriculum despite the importance of this information. Curriculum is exam-driven and until transgender content is included on NCLEX, participants stated it was unlikely that they would find the time in their courses to cover this information. This was more out of concern for covering necessary content and ultimately, student success on NCLEX. Courses typically meet just twice a week and respondents stated they had so much other med/surg content requirements that were their priority over transgender education.

Theme 4: Holistic care and diversity

Holistic care, diversity and inclusion were identified as important; however, this was most often expressed in the context of homogeneity and the belief that all people are treated the same regardless of gender or sexual identity. Respondents stated their belief that all people deserve health care, including marginalized and underserved populations. Open-mindedness and caring for diverse populations was reflective of their respective program mission statements.

Theme 5: Lack of faculty knowledge

None of the faculty interviewed admitted any overt bias towards or against teaching this content; therefore, that was not a source of exclusion. The majority who do not include this content in their courses readily admitted that it was due to their own lack of knowledge, comfort and unfamiliarity in teaching transgender content. Lim, Brown and Jones (2012) state that nurse educators play a pivotal role in educating future nurses to help eliminate the health care disparities of transgender persons. The void in faculty knowledge

and readiness to teach this content was a recurring theme in the review of the literature. Identification of ones' own personal beliefs and openness to learning are necessary when creating an environment conducive to student learning and teaching equitable health care (Brennan et al., 2012). All of the participants wholeheartedly agreed that lack of faculty knowledge was the reason why this content was typically not included. This feeling was widespread among nursing faculty in this study.

Theme 6: Secular versus religious influence on teaching transgender content

Teaching in a faith-based or religious institution appeared to have no bearing on inclusion or exclusion of this content for any of the participants. More than half of the respondents taught at faith-based institutions. The majority of participants stated that their respective institutions did not have any limitations on including this content in courses; however, a few participants did adopt a "Don't ask, don't tell" policy. There were no differences among faculty who taught at secular or faith-based institutions. None of the respondents felt they were constrained by the mission statements of their respective programs to teach on this content. However, several implied that their administrations may not be ready to consider adding this material to curricula. Two respondents gave answers that implied fear of even broaching the topic with their administrations.

Theme 7: Student preparation and readiness to care for transgender persons

The majority of respondents did not feel their students were appropriately prepared to care for transgender persons, agreeing that nursing programs prepared generalist nurses and if faculty did not provide the content, the students would not be prepared to care for this population in a way that was meaningful and respectful to the patient. The few participants who regularly included transgender content in their courses were involved with LGBTQ groups on campus and admittedly advocated for more of this content to be

included in nursing courses at their respective institutions. Many of the participants were eager to share their opinion that this content should be included in nursing courses and verbalized the impact of unknowledgeable students and the importance of knowing how to care for this population.

Discussion of the Results in Relation to the Literature

The review of the literature revealed little in the way of publications focusing on the reasons why nursing faculty do not include transgender content in nursing courses. Overarching key themes in the literature review included knowledge and attitudes, need for diversity training, barriers to care for transgender patients, cultural competence and LGBT content in nursing education; however there was little that specifically addressed what factors impacted on inclusion or exclusion of transgender content in nursing education.

The National Council of State Boards of Nursing (NCSBN) is the certifying body for all RNs by which they practice. This is achieved by testing new graduate nursing students on a computer-adaptive test that demonstrates safety and competency. The board collaborates with nurse educators, stakeholders and state boards of nursing for regulating nursing practice. Content for the exam is reviewed by NCSBN and reflects current entry level practice for RNs (NCSBN, 2018). It is unclear how often content is reviewed and updated to reflect current trends in practice. The NCLEX Test plan is a blueprint by which nurse educators base their curriculum. Individual nursing programs are dependent upon state funding, grants and donations for first-time pass rates on NCLEX (Simon, McGinnis, & Krauss, 2013). The distribution of content on the 2016 version of the NCLEX-RN Test Plan includes culture and spirituality, health promotion and disease prevention as well as client advocacy but does not delineate specific LGBTQ needs. There is a global reference to cultural awareness, gender, ethnicity and lifestyle (NCSBN, 2016).

Many participants in this study verbalized that content for NCLEX and "Teaching to the Test" was their priority. The rationale for this emphasis was due to the fact that faculty wanted their student to pass NCLEX. While the participants felt transgender content is important to teach nursing students, until it is included on NCLEX, it is unlikely there will be any in-depth inclusion of this information in nursing courses due to the vast amount of information necessary for NCLEX preparation. Overall, the consensus among the participants revealed the need for transgender content should be included in nursing education but that NCLEX content and scores ultimately drive what content is included in their respective courses. Despite the importance of NCLEX preparation, there is enough in the literature to support that lack of cultural competence, awareness and education on this population significantly hinders the ability of transgender patients to receive non-discriminatory care and inclusive care (American Geriatrics Society, 2015; Chapman, et al., 2011; Cornelius & Carrick, 2015; Daley & MacDonnell, 2014; Fulbright-Sumpter & Brooks-Carthon, 2011; Lim & Bernstein, 2012; Lim et al., 2012; Lim et al., 2014; Markwick, 2016; Mead, Dana & Carson, 2017; Merryfeather & Bruce, 2014; Peate 2008; Sedlak & Boyd, 2016; Selix & Rowniak, 2016; Singer, 2015). Providing equitable healthcare is a predominant theme in the literature and “providing individualized, patient-centered care is fundamental to the nursing process” (Faught, 2016, p. 285).

The participants overall had limited experience with transgender persons further impacting on their lack of experience and knowledge on caring for this population. However, those participants who identified as non-binary or those who had some type of experience with LGBTQ persons had a greater awareness of the importance of including this content in their courses. Health care providers and nurses in general receive little education regarding the health care needs of transgender persons. As a result, providing

care to this population may be challenging (Shires & Jaffe, 2015). Transgender patients may have prior negative experiences and health care disparities with providers that may cause them to avoid seeking health care until absolutely necessary (Buttaro et al., 2017; IOM, 2011; Levitt, 2015; Strong & Folse, 2015; Stroumsa, 2014; Unger, 2015). There appeared to be a relationship between faculty lack of experience and knowledge that played a role in exclusion of content from their courses. Although this was a prevalent theme throughout the interviews, it did not appear to play a negative role. Participants acknowledged that their own personal knowledge deficit was a factor in lack of inclusion of content in their courses. Many of the participants stated a lack of comfort teaching this content due to their own lack of knowledge. Walsh and Hendrickson (2015) state there is a responsibility on the part of nursing programs to incorporate this content for students but also to require faculty competence in teaching this. Despite the fact that the health and welfare of the transgender population is identified as a health priority by the IOM, the Agency for Healthcare Research and Quality, and Healthy People 2020, there is well-documented discrimination by health care providers, and there remains a "conspicuous absence of LGBT content in the education of nursing faculty, nursing home administrators, nurses, and physicians" (Lim et al., 2012, p. 200). The integrative review of the literature for this study demonstrated that students lack the knowledge necessary to care for this population of patients (Brennan et al., 2012; Eliason et al., 2010; Rondahl, 2009). Only four out of 20 participants in this study felt their students were adequately prepared to care for a transgender patient after completing their nursing programs. There was a general consensus among those four respondents who felt that students were competent to care for any patient but that specific education on this population would enhance the new nurses' skill set.

The majority of participants agreed that diversity and inclusion of holistic care was a necessity in nursing education and felt all patients deserve the same treatment and care that is authentic and patient-centered. They also believed that students should be equipped with the appropriate education to provide this type of culturally responsive care for transgender persons. Some of the respondents stated that all patients should be treated holistically taking into consideration the marginalization of this population, and they will expose students to concepts and ideas that students would not otherwise get in their mainstream nursing courses. The respondents were all in agreement with holistic care for all patients, but they were also aware that without appropriate education, the unique and specific needs of the transgender patient will not be learned. Some of the participants did recognize that students today are more socially accepting and culturally diverse than the faculty themselves. Nevertheless, Cornelius and Carrick's survey (2015), revealed that while students indicated they would care for all patients regardless of sexual preferences, they felt incompetent to care for LGBT persons (Cornelius & Carrick, 2015). Nurses are in a unique position to engage patients in wellness behaviors but without the appropriate understanding of the unique needs of these marginalized populations, nurses will miss the opportunity to provide this care. Camann and Long (2014) state, "Both the process and outcomes of partnerships among nursing faculty, nursing students and members of vulnerable population groups are important to the success of changing behaviors" (p. 31). Additionally, Van Zandt et al., (2008) stressed the importance of "having an appreciation of the economic, social, and cultural influences on health within a population leads to formulating successful individualized care plans" (p. 129).

Limitations (revised from chapter one)

The study was limited to faculty teaching in CCNE and/or ACEN accredited baccalaureate nursing programs in the Northeastern United States. The optimal time for data collection is between October through November and January through April (Roberts, 2010). Due to the timing of the proposal defense and IRB approval, invitations to participate in the study were emailed to all program directors of accredited baccalaureate programs during the middle of May, 2017, just as many educators left for semester break. Flyers were not posted in individual departments due to the distance necessary for the researcher to travel the geographic area for the study and the high number of nursing programs. Despite the fact that invitations went out after the spring semester concluded, there were enough respondents who agreed to participate in the study. Responses potentially could be skewed based on the geographical area and beliefs of those living in the northeastern United States. Results might have been more varied if a national sample was obtained and would add to the transferability of the findings.

The participants all verbalized their interest in the topic of the study as well as the outcome. There did not appear to be any differences between those participants employed by a faith-based or religious institution and public and private institutions. Those who participated in this study verbalized an interest in the topic and/or interested in participating in a doctoral student's study who wanted to be supportive of student research. It is possible that faculty who had some bias towards this topic selectively chose not to participate in the study.

Implication of the Results for Practice

Transgender persons are considered a marginalized population and in order to understand how policies and practice patterns develop for transgender persons versus

others, it may be beneficial to understand the demographic characteristics of transgender adults. Data on transgender populations regarding demographic and health characteristics are gleaned from nonprobability samples; therefore, data remains subject to unknown sampling bias (Meyer, Brown, Herman, Reisner, & Bockting, 2017). Transgender persons live in rural as well as urban environments. The District of Columbia has the highest percentage of transgender persons of the federal district population (14, 500) or approximately 2.77%. Several states have more than 100,000 identified transgender adults: California=218,000 (0.76%); Florida=100,300 (0.66%); and Texas=125,350 (0.66%). The highest percentage of adult transgender individuals per state includes Hawaii, California, Georgia and New Mexico (0.8%) followed by Texas and Florida (0.7%). The lowest percentage of identified transgender adults is 0.3% found in North and South Dakota, Iowa, Wyoming and Montana (Flores, Herman, Gates & Brown, 2016). Given these statistics, an assumption by this researcher arises that in areas where there are not many transgender persons residing, there is a significantly decreased chance that a nurse practicing in those areas will care for a transgender patient. Nurses gain experience through their clinical rotations and preceptors by providing direct patient care. These experiences are based on an individualized learning setting and not necessarily standard for all nursing students. Without appropriate educational guidelines for vulnerable populations, nurses will be unprepared to care for this population of patients (Van Zandt et al., 2008).

LGBTQ youth are prone to abuse and rejection by their families causing an increased number of these at-risk persons to enter into the welfare system placing them at greater risk for substance abuse, sexually transmitted infections, social stigma, harassment and victimization. They are further denied necessary treatment for gender identity disorder (GID) (Child Welfare League of America (CWLA), 2012). Some national groups have

acknowledged the need for further policy development and care of these patients. Professional organizations such as the American Academy of Pediatrics, the American Psychological Association, the National Association of Social Workers, and the American Academy of Child and Adolescent Psychiatry all agree that LGBTQ youth "should be afforded the same treatment and respect regardless of sexual orientation or gender identity" (CWLA, 2012, p. 4). As a result of the identification for the specific needs of this population, Lambda Legal in conjunction with CWLA and the aforementioned professional organizations developed reports and manuals to assist with educating the public on creating safe and affirming environments for this at-risk population. In their 2012 report, CWLA recommends mandatory training and education for staff, foster and adoptive parents on non-discriminatory policies regarding gender identity, sexual orientation and other challenges for this population. They further recommend that child welfare agencies make certain that health care providers who may treat LGBTQ youth are not only trained and educated on the risks associated with this population but that they provide "developmentally appropriate sexual health education and services" (CWLA, 2012, p. 12).

Nurses play a vital role in caring for patients when they are in their most vulnerable state. In order to convey sensitivity to patients' needs, nursing students as well as nursing faculty must be educated on the specifics of transgender experience including, appropriate terminology, use of preferred pronouns, avoidance of assumptions and stereotypes as well as knowledge of specific health care needs of this population (Landry, 2017; Levitt, 2015; Markwick, 2016; Peate, 2008; Rondahl, 2009; Selix & Rowniak, 2016; Wylie et al., 2016). There are an estimated 700,000 transgender persons living in the United States and approximately 25 million worldwide (Gates, 2011; Winter et al., 2016). At some point, most nurses will care for a transgender person during their career.

The participants in this study clearly acknowledged their own lack of familiarity with caring for transgender persons as a reason for not including this content in nursing courses. The absence of literature on this topic further reinforces the need for more faculty education to increase knowledge so they will be more willing to include this content in their particular courses. This study was guided by the Model of Transcultural Care by Dr. Josepha Campinha-Bacote. The model enables health care providers to become more culturally competent based on the assumption that cultural competence is an evolving process used to cultivate and implement socially responsive care. Cultural desire is one of the models' concepts that aligns with the individual's need to change how they think about a particular culture, increase their own familiarity and understand the differences to become more culturally knowledgeable. If nursing faculty becomes more knowledgeable in this area, it may change their own perceptions and beliefs about transgender persons. As a result, the knowledge learned and shared with future nurses will ultimately impact on the quality of care received by transgender patients. It is evident that until NCLEX, the national standardized exam for nurses, includes transgender content on their exams, faculty are unlikely to include content-specific care for transgender persons. The lack of inclusion of this content in nursing education will negatively impact on the appropriate and sensitive care of a transgender patient by a nurse who is not educated on the specific needs of this population. This will only further perpetuate discrimination, disparities and harassment. It would benefit future nurses if NCLEX would begin to include this content on their exam.

Standards of best practices for the LGBT and transgender community, specifically for healthcare professionals and institutions, are lacking policies, training and education. The changing patient demographics and increasing numbers of persons identifying as transgender cannot be ignored. Nurses and other healthcare providers need to adapt to these

changes to meet the needs of transgender patients. Incorporation of cultural competency requirements and specific didactic and clinical learning experiences of both faculty and nursing students will enhance the delivery of competent care to this population of marginalized and vulnerable patients.

Suggestions for Further Research

The IOM (2011) recommendations embrace inclusion of transgender education in nursing curriculum coupled with more evidence-based practice guidelines for this population. Additionally, the American Academy of Nursing supports this to help reduce barriers to care for transgender persons (Sedlak & Boyd, 2016). Cultural competence begins with having awareness for differences among populations. Without future studies, transgender persons will remain a marginalized population at risk for continued health care disparities. Education on this population should begin early on in nursing courses and content threaded throughout curriculum to reinforce and build upon newfound knowledge.

Considerations for further studies in this area should include the use of social media for recruitment that would allow more national exposure and greater representation of beliefs. This study was limited to the northeast which may have skewed the results due to the geographical area. It would be easier and more convenient for participants to use Survey Monkey, an easy-to-use online survey tool that can be utilized to send and sign the informed consent. Many participants did not have access to a scanner or electronic signature capabilities over the semester break with which to return the signed informed consents. Signed informed consents were mailed through the United States Postal Service, further delaying scheduling of interviews and adding, the risk of the mail being lost or not delivered in a timely manner.

It would be valuable for nursing programs to arrange faculty development days focusing on the care of transgender persons that would help translate faculty knowledge into increased comfort teaching this content. Additionally, online offerings on this topic might be of benefit and interest to those who are unable to attend an in-person presentation at a faculty development day or at a conference. Inviting guest lecturers to campus who are experts in the field on this topic would be advantageous to both students as well as faculty. An educational event that is offered live as well as online, via webinars or on-demand continuing education courses would be beneficial to nursing faculty who are interested in becoming more educated about this population. Local, regional and national nursing conferences should consider continuing education offerings given by experts on this topic, including administrative, educational and clinical conferences. NONPF conferences are an excellent example of a national platform for nursing faculty to educate themselves on this topic. Simulation experts could work with transgender content experts on developing simulation cases for students. Case studies would add depth to the clinical arena as well as classroom and online student discussions. Additionally, publishers of nursing textbooks should include transgender content in both textbooks and interactive discs that often accompany them.

It would be advantageous for NCSBN to consider including transgender content on future NCLEX exams. Expert clinicians and educators could develop test items on this information for both the NCLEX as well as the review courses. Clinicians and educators could also serve as item reviewers for questions written by others on this content. Additionally, the possibility exists that other national professional associations such as Commission on Collegiate Nursing Education, the American Nurses Association and the National League of Nursing would consider including this specific population in their

competency documents and position statements for baccalaureate nursing education. NONPF (2013) has already included this in the Population-focused Nurse Practitioner competencies.

Future studies should look at improving knowledge among faculty in an effort to help them feel better prepared to teach transgender content. Replicating the current study may reveal further insight into faculty beliefs in a different geographical area or nationally. Educators who are simulation experts could learn about transgender care and help develop simulation cases to educate other faculty. Pilot testing an online educational program on transgender care or a simulation on transgender care might be the next step in improving faculty knowledge which may result in greater inclusion of this content in nursing education. Studies using pre- and post-tests with an educational intervention would help measure whether or not a particular teaching methodology is of benefit to improving faculty knowledge in this area. The use of standardized patients would be an additional opportunity for faculty to interact with, interview and examine a transgender patient thereby enhancing comfort level and knowledge development.

REFERENCES

Aguilar, El, & Fried, J. (2015). Enhancing dental and dental hygiene student awareness of the lesbian, gay, bisexual, and transgender population. *The Journal of Dental Hygiene*, *89*(1), 11-16.

Alegria, C. (2011). Transgender identity and health care: implications for psychosocial and physical evaluation. *Journal of the American Academy of Nurse Practitioners*, *23*(4), 175-182.

American Association of Colleges of Nursing. (AACN) (2006). *The essentials of doctoral education for advanced nursing practice.* Retrieved from http://www.aacn.nche.edu/dnp/Essentials.pdf.

American Association of Colleges of Nursing. (AACN) (2008). *Tool kit of resources for cultural competent education for baccalaureate nurses.* Retrieved from http://www.aacn.nche.edu/education-resources/toolkit.pdf.

American Geriatrics Society Ethics Committee. (2015). American Geriatrics Society care of lesbian, gay, bisexual, and transgender older adults position statement. *Journal of the American Geriatrics Society, 63*(3), 423-426.

American Psychiatric Association. (2017). *Diagnostic and statistical manual of mental disorders*. (DSM-5). Retrieved from https://www.dsm5.org.

Benkert, R., Templin, T., Schim, S., Doorengos, A., & Bell, S. (2011). Testing a multi group model of culturally competent behaviors among underrepresented nurse practitioners. *Research in Nursing & Health, 34*(4), 327-341.

Bidell, M. (2013). Addressing disparities: The impact of lesbian, gay, bisexual and transgender graduate counselling course. *Counselling and Psychotherapy Research, 13*(4), 300-307.

Brennan, A., Barnsteiner, J., De Leon Siantz, M., Cotter, V., & Everett, J. (2012). Lesbian, gay, bisexual, transgendered, or intersexed content for nursing education. *Journal of Professional Nursing*, *28*(2), 96-104

Buttaro, T., Trybulki, J., Polgar-Bailey, P., & Sandberg, C. (2017). *Primary care: A collaborative practice.* (5th ed.). St. Louis, Missouri: Elsevier.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, *13*(3), 181-184.

Campinha-Bacote, J. (2011). Coming to know cultural competence: An evolutionary process. *International Journal for Human Caring, 15*(3), 42-48.

Camann, M., & Long, J. (2014). Health promotion with vulnerable population groups. *Online Journal of Cultural Competence in Nursing and Healthcare, 4*(1), 29-37.

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., Ciano, M., & Scott, M. (2015). Never in all my years…: Nurses education about LGBT health. *Journal of Professional Nursing*, *31*(4), 323-329.

Chapman, R., Watkins, R., Zappia, T., Nicol, P., & Shields, L. (2011). Nursing and medical students' attitude, knowledge and beliefs regarding lesbian, gay, bisexual and transgender parents seeking health care for their children. *Journal of Clinical Nursing, 21*(7/8), 938-945.

Child Welfare League of America. (2012). *Recommended practices to promote the safety and well-being of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth and youth at risk of or living with HIV in child welfare settings.* Retrieved from Lambda Legal Website: https://www.lambdalegal.org/sites/default/files/publications/downloads/recommended-practices-youth.pdf.

Colorafi, K., & Evans, B. (2016). Qualitative descriptive methods in health science research. *Health Environments Research & Design Journal*, 9(4), 16-25.

Cornelius, J., & Carrick, J. (2015*).* A survey of nursing students' knowledge of and attitudes toward LGBT health care concerns. *Nursing Education Perspective, 37*(3), 176-178.

Creswell, J. (2013). *Qualitative inquiry & research design: Choosing among five approaches*. (3rd ed). Los Angeles, CA: Sage.

Creswell, J. (2015). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research.* (5th ed.). Boston, MA: Pearson.

Crisp, C. (2006). The Gay Affirmative Practice Scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work*, *51*(2), 115-26.

Daley, A., & MacDonnell, J. (2015). "That would have been beneficial": LGBTQ education for home-care service providers. *Health and Social Care in the Community*, *23*(3), 282-291.

Eckstrand, K., & Ehrenfild, J. (2016). *Lesbian, gay, bisexual and transgender healthcare: A clinical guide to prevention, primary care, and specialty care.* Switzerland: Springer.

Eliason, M., Dibble, S., & DeJoseph, J. (2010). Nursing's silence on lesbian, gay, bisexual and transgender issues: The need for emancipatory efforts. *Advances in Nursing Science, 33*(3), 206-218.

Faught, D. (2016). Coming full circle: The old becomes new again-cultural competence and the transgender client. *Medsurg Nursing, 25*(4), 285-286.

Flemmer, N., Doutrich, D., Dekker, L., & Rondeau, D. (2012). Creating a safe and caring health care context for women who have sex with women. *The Journal for Nurse Practitioners, 8*(6), 464-481.

Fletcher, A., & Shaw, G. (2011). How voice-recognition software presents a useful transcription tool for qualitative and mixed methods researchers. *International Journal of Multiple Research Approaches, 5*(2), 200-206.

Flores, A., Herman, J., Gates, G., & Brown, T. (2016). *How many adults identify as transgender in the United States?* Retrieved from https://williamsinstitute.law.ucla.edu/.

Fulbright Sumpter, D., & Brooks Carthon, JM. (2011). Lost in translation: Student perceptions of cultural competence in undergraduate and graduate nursing curricula. *Journal of Professional Nursing, 27*(1), 43-49.

Gates, G. (2011). *How many people are lesbian, gay, bisexual, and transgender?* The Williams Institute website. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf.

Gay & Lesbian Alliance Against Defamation. (GLAAD) *Media Reference Guide*. Retrieved from https://www.glaad.org.

Gieseking, J. (2008). Queer Theory. In Parrillo, V.N, Andersen, M., Best, J., Kornblum, W., Renzetti, C.M. & Romero, M. (Eds.), *Encyclopedia of Social Problems* (pp. 737-738). Thousand Oaks, CA: Sage Publications.

Greytak, E., Kosciw, J., & Boesen, M. (2012). Educating the educator: Creating supportive school personnel through professional development. *Journal of School Violence, 12*(1), 80-97.

Hancock, A., & Haskin, G. (2015). Speech-language pathologists' knowledge and attitudes regarding lesbian, gay, bisexual, transgender and queer (LGBTQ) populations. *American Journal of Speech-Language Pathology*, *24*(2), 206-221

Hardacker, C., Rubinstein, B., Hotton, A., & Houlberg, M. (2014). Adding silver to the rainbow: The development of the nurses' health education about LGBT elders (HEALE) cultural competency curriculum. *Journal of Nursing Management, 22*(2), 257-266.

Harris, M. (1995). Knowledge about homosexuality questionnaire. In Davis, C., Yarber, W., & Bauserman, R. (Eds.), *Handbook of sexuality-related measures* (pp. 383-385). Sage Publications, London.

Hays, D., & Singh, A. (2012). *Qualitative inquiry in clinical and educational settings.* New York, NY: The Guilford Press.

Health and Human Services (HHS). (2017). *About the Affordable Care Act.* Retrieved from https://www.hhs.gov/healthcare/about-the-aca/index.html.

Healthy People 2020. (2018). Retrieved from https://www.healthypeople.gov.

Herek, G.M. (1998). *Attitudes towards lesbians and gay men scale.* Retrieved from www.psycholoogy.ucdavis.edu.

Institute of Medicine (IOM). (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academies Press.

Khalili, J., Leung, L., & Diamant, A. (2015). Finding the perfect doctor: identifying lesbian, gay, bisexual, and transgender-competent physicians. *American Journal of Public Health*, *105*(6), 1114-1119.

Kitchen, J., & Bellini, C. (2012). Making it better for lesbian, gay, bisexual, and transgender students through teacher education: A collaborative self-study. *Studying Teacher Education, 8*(3), 209-225.

Kotunen, K., Rijks, B., Motus, N., Iodice, J., Schultz, C., & Mosca, D. (2014). Ensuring health equity of marginalized populations: Experiences from mainstreaming the health of immigrants. *Health Promotion International, 29*(S1), i121-129. https://doi.org/10.1093/heapro/dau042.

Landry, J. (2017). Delivering culturally sensitive care to LGBTQI patients. *The Journal for Nurse Practitioners, 13*(5), 342-347.

Levitt, N. (2015). Clinical nursing care for transgender patients with cancer. *Clinical Journal of Oncology Nursing, 19*(3), 362-367.

Lim, F. and Bernstein, I. (2012). Promoting awareness of LGBT issues in aging in a baccalaureate nursing program. *Nursing Education Perspectives*, *33*(3), 170-175.

Lim, F., Brown, D., & Jones, H. (2013). Lesbian, gay, bisexual, and transgender health: fundamentals for nursing education. *Journal of Nursing Education, 52*(4), 198-203.

Lim, F., Brown, D., & Kim, S. (2014). Addressing health care disparities in the lesbian, gay, bisexual, and transgender population: A review of best practices. *American Journal of Nursing, 114*(6), 24-34.

Lim, F., & Hsu, R. (2016). Nursing students' attitudes toward lesbian, gay, bisexual, and transgender persons: An integrative review. *Nursing Education Perspectives, 37*(3), 144-152.

Lim, F., Johnson, M., & Eliason, M. (2015). A national survey of faculty knowledge, experience, and readiness for teaching lesbian, gay, bisexual, and transgender health in baccalaureate nursing programs. *Nursing Education Perspective, 36*(3), 144-152.

Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry.* Newbury Park, CA: Sage Publications.

Markwick, L. (2016). Male, female, other: Transgender and the impact in primary care. *The Journal for Nurse Practitioners, 12*(5), 330-338.

McNair, R., & Hegarty, K. (2010). Guidelines for the primary care of lesbian, gay, and bisexual people: a systematic review. *Annals of Family Medicine, 8*(6), 533-541.

Mead, D., Dana, R., & Carson, C. (2017). The primary care approach to lesbian, gay, bisexual, transgender, and queer/questioning populations. *The Consultant, 57*(2), 84-88.

Merryfeather, L., and Bruce, A. (2014). The invisibility of gender diversity: Understanding transgender and transsexuality in nursing literature. *Nursing Forum*, *49*(2), 110-123.

Meyer, I., Brown, T., Herman, J., Reisner, S., & Bockting, W. (2017). Demographic characteristics and health status of transgender adults in select US regions: Behavioral Risk Factor Surveillance System, 2014. *Research, 107*(4), 582-589.

Moll, J., Krieger, P., Moreno-Walton, L., Lee, B., Slaven, El., James, T., …& Heron, S. (2014). The prevalence of lesbian, gay, bisexual, and transgender health education and training in emergency medicine residency programs: What do we know? *Academic Emergency Medicine*, *21*(5), 608-611.

Murphy, A., Griffith, V., Mroz, T., & Jirikowic, T. (2017). Primary care for underserved populations: Navigating policy to incorporate occupational therapy into federally qualified health centers. *The American Journal of Occupational Therapy*, *71*(2), 1-5.

National Center for Transgender Equality. (2016). *National transgender discrimination survey.* Retrieved from https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf .

National Council of State Boards of Nursing (NCSBC) (2016). *NCLEX-RN*® *examination detailed test plan for the National Council Licensure Examination for Registered Nurses item writer/item reviewer/nurse educator*. Retrieved from https://www.ncsbn.org/2016_RN_DetTestPlan_Educator.pdf.

National Council of State Boards of Nursing (NCSBC). (2018). *NCLEX and other exams.* Retrieved from https://www.ncsbn.org/nclex.htm.

National LGBT Task Force (2018). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Retrieved from http://www.thetaskforce.org/.

National Organization for Nurse Practitioner Faculties (NONPF). (2013). *Population focused nurse practitioner competencies*. Retrieved from https://www.nonpf.org/resource/resmgr/Competencies/CompilationPopFocusComps2013.pdf.

New York Daily News (2014, April 30). Connecticut judge puts transgender girl in women's prison, debate. Retrieved from https://www.nydailynews.com/news/crime/connecticut-judge-puts-transgender-girl-women-prison-sparks-debate-article-1.1774263.

Obedin-Maliver, J. (2015). Time for OBGYNx to care for people of all genders. *Journal of Women's Health, 24*(2), 109-111.

O'Brien, M., & Ellis, C. (2016). Perspectives: "Acceptance without exception for lesbian, gay, bisexual and transgender people in health and societal care"? *Journal of Research in Nursing, 21*(3), 242-244.

Parkhill, A., Mathews,J., Fearing, S., & Gainsburg, J. (2014). Instructional design and assessment: A transgender health care panel discussion in a required diversity course. *American Journal of Pharmaceutical Education, 78*(4), 1-7.

Peate, I. (2008). Caring for transgendered people: Opportunities and challenges. *British Journal of Nursing. 17*(8), 540-543.

Polit, D., & Beck, C. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. (9th ed.). Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins.

Polit, D., & Beck, C. (2018). *Essentials of Nursing Research: Appraising evidence for nursing practice.* (9th ed.). Philadelphia, PA: Wolters Kluwer.

Roberts, C. (2010). *The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation.* (2nd ed.) Thousand Oaks, CA: Corwin.

Roller, C., Sedlak, C., & Draucker, C. (2015). Navigating the system: How transgender individuals engage in health care services. *Journal of Nursing Scholarship, 47*(5), 417-424.

Rondahl, G. (2009). Students' inadequate knowledge about lesbian, gay, bisexual and transgender persons. *International Journal of Nursing Scholarship, 6*(1), 1-15.

Rutherford, K., McIntyre, J., Daley, A., & Ross, L. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education, 46*(9), 903-913.

Sanchez, N., Rabatin, J., Sanchez, J., Hubbard, S., & Kalet, A. (2006). Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Family Medicine, 38*(1), 21-27.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334-340.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*(1), 77-84.

Sandelowski, M. (2011). When a cigar is not just a cigar: Alternative takes on data and data analysis. *Research in Nursing & Health, 34*(4), 342-352.

Sedlak, C., & Boyd, C. (2016). Health care services for transgender individuals: Position statement. *Nursing Outlook, 64*(5), 510-511.

Selix, N., & Rowniak, S. (2016). Provision of patient-centered transgender care. *Journal of Midwifery & Women's Health, 61*(6), 744-751.

Shires, D., & Jaffee, K. (2015). Factors associated with health care discrimination experiences among a national sample of female-to-male transgender individuals. *Health & Social Work, 40*(2), 134-141.

Silva, D., Smith, M., & Upshur, R. (2013). Disadvantaging the disadvantaged: When public health policies and practices negatively affect marginalized populations. *Canadian Journal of Public Health, 104*(5), 410-412.

Simon, E., McGinness, S., & Krauss, B. (2013). Predictor variables for NCLEX-RN readiness exam preparation. *Nursing Education Perspectives, 34*(1), 18-24.

Singer, R. (2015). LGBTQ focused education: Can inclusion be taught? *International Journal of Childbirth Education, 30*(2), 17-19.

Smedley, B. (2012). The lived experience of race and its health consequences. *American Journal of Public Health, 102*(5), 933-935.

Smith, F. (2016). Perioperative care of the transgender patient. *AORN Journal, 103*(2), 151-163.

Stroumsa, D. (2014). The state of transgender health care: Policy, law, and medical frameworks. *American Journal of Public Health, 104*(3), e31-38.

The Joint Commission (JNC). (2001). *Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: A field guide*. Retrieved from https://www.jointcommission.org.

Transcultural C.A.R.E Associates. (2015). *The process of cultural competence in the delivery of healthcare services.* Retrieved from https://www.transculturalcare.net.

Unger, C. (2015). Care of the transgender patient: A survey of gynecologists' current knowledge and practice. *Journal of Women's Health, 24*(2), 114-118.

United Nations. (1948). *Universal Declaration of Human Rights.* Retrieved from http://www.un.org/en/universal-declaration-human-rights/.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences, 15*(3), 398-405.

Van Zandt, S., Sloand, E., & Wilkins, A. (2008). Caring for vulnerable populations: Role of academic nurse-managed health centers in educating nurse practitioners. *The Journal for Nurse Practitioners, 4*(2), 126-131.

Walker, K., Arbour, M., & Waryould, J. (2016). Educational strategies to help students provide respectful sexual and reproductive health care for lesbian, gay, bisexual, and transgender persons. *Journal of Midwifery & Women's Health, 61*(6), 737-743.

Walsh, D., & Hendrickson, S. (2015). Focusing on the "T" in LGBT: An online survey of related content in Texas nursing programs. *Journal of Nursing Education, 54*(6), 347-351. DOI: 10.3928/01484834-20150515-07.

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*. *52*(5), 546-553.

Wilson-Mitchell, K., & Handa, M. (2016). Infusing diversity and equity into clinical teaching: Training the trainers. *Journal of Midwifery & Women's Health, 61*(6), 726-736.

Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., & Wylie, K. (2016). Transgender people: Health at the margins of society. *The Lancet, 388 (10041),* 390-400.

World Professional Association for Transgender Health (WPATH). (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people.* (7th ed.) Retrieved from https://www.wpath.org.

Wylie, K., Knudson, G., Khan, S., Bonierbale, M., Watanyusakul, S., & Baral, S. (2016). Serving transgender people: Clinical care considerations and service delivery models in transgender health. *The Lancet*, *388*(10042), 401-411.

Zuzelo, P. (2014). Improving nursing care for lesbian, bisexual, and transgender women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing (JOGNN)*, *43*(4), 520-530.

Appendix A

Vanessa Pomarico-Denino, MSN, APRN, FNP-BC, FAANP

vpdenino@sbcglobal.net

Dear Undergraduate Faculty Member,

I am a doctoral student pursing an Ed.D. in Nursing Education at Southern Connecticut State University in New Haven, CT. As part of the requirements for the doctorate in Nursing Education, I am conducting a qualitative research study on Transgender Education in Nursing: A Qualitative Study Investigating Faculty Beliefs.

I am in the process of recruiting nursing faculty who teach on the undergraduate level to participate in my study. Participation will involve a 30-60 minute interview with me at a location that is convenient for you and outside of your work place. You will be asked to describe your experience with transgender education with baccalaureate nursing students. Please feel free to forward my email to other undergraduate nursing faculty who teach in CT, NY, RI, and MA that you believe may be interested in participating in my study.

Participation is voluntary and an informed consent form is attached for your convenience. Please review the form and sign it when we meet for the interview. If geographic distance does not permit a face-to-face interview, I can arrange for you to have a telephone interview or a video conference interview with me. Participants can withdraw from the study at any time. If you have questions about your rights as a research participant, please contact the IRB at SCSU. Confidentiality of participating in the study will be maintained at all times. Your name will not appear on any forms or in any transcription of data. Pseudonyms will be used for all study participants. Demographic data collected will be reported in aggregate form only, without any identifying information.

All study materials will be stored in a secure location, in a locked file cabinet where only the researcher has access. On completion of the study, study materials will remain for 3 years and then will be destroyed.

I do not anticipate any negative consequences arising from participation in this study. While no direct benefit to participation has been identified, I hope to inform and advance the state of the science of nursing education by studying transgender education in nursing with faculty teaching baccalaureate students.

If you wish to participate in this study, please email me at: vpdenino@sbcglobal.net or call me directly at . Please feel free to contact me if you have additional questions or concerns. Thank you.

Sincerely,
Vanessa Pomarico-Denino, MSN, APRN, FNP-BC, FAANP

Appendix B

Demographic Information Sheet

Family Name_____ Pseudonym_____

Date of Interview_____ Type of Interview_____

Location of interview_____

Age_____ Gender_____ Race/Ethnicity_____

Highest academic degree _____ Nursing Certification_____

How long have you been an RN ? _____

How long have you been teaching?_____

Are you working in a clinical setting in addition to our academic setting?_____

If yes, describe your setting_____

How many courses do your teach?_____

How many courses involve transgender education?_____

Appendix C

(Campinha-Bacote Permission Letter)

TRANSCULTURAL C.A.R.E.
Clinical, Administrative, Research & Educational Consultation in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, PMHCNS-BC, CTN-A, FAAN

Transcultural Healthcare Consultant

Date: December 27, 2016
To: Ms. Vanessa Pomarico-Denino
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates
RE: **Contractual Agreement for Limited Use of Campinha-Bacote's Model of Cultural Competence in a Dissertation**

This letter grants one-time permission to Ms. Vanessa Pomarico-Denino to copy my 1998 Venn diagram graphic/pictorial model of cultural competence, as it appears on my website at http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/ in her dissertation.

TIME FRAME: Permission to use my model is a one-time use in January 2017 when she submits it to her professor in this paper.

RESTRICTIONS OF COPYING: This permission only allows the copying/ reprinting of my model in her academic paper. **She agrees that my model cannot be copied for any other reason outside of this paper.** This includes, but not limited to, not being copied in another formal or informal publication, a journal article, in another academic paper, handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats for presentations or for any other purpose.

Ms. Vanessa Pomarico-Denino will use the following citation when citing my models in her dissertation:

The Process of Cultural Competence in the Delivery of Healthcare Services
Copyrighted by Campinha-Bacote 1998
Reprinted with Permission from
Transcultural C.A.R.E. Associates

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of Campinha-Bacote's Models of Cultural Competence is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Dr. Josepha Campinha-Bacote — 12/27/16 Date

Ms. Vanessa Pomarico-Denino — 2.10.17 Date

☎ 513-469-1664
🖷 513-469-1764
meddir@aol.com

www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

Appendix D

Informed Consent

Informed Consent Participant
Transgender Education in Nursing: A Qualitative Study Investigating Faculty Beliefs
Undergraduate Nursing Faculty
BY
Vanessa Pomarico-Denino, MSN, APRN, FNP-BC
Southern Connecticut State University

Introduction:
I am an Ed.D. in Nursing Education student at Southern Connecticut State University and am conducting a study of baccalaureate nursing faculty to determine what factors influence the inclusion or exclusion of transgender content in nursing curriculum. In order to decide whether or not you wish to participate in this study, you should be aware of all aspects of the study, its purpose, the procedures to be used and any risks and/or benefits. This consent form provides you with the detailed information about the research study. I will discuss any aspects of the study that you may not understand. Once you understand the study, you will be asked if you wish to participate. If you say yes, you will be asked to sign this form.

Purpose:
The purpose of this study is to examine the reasons why nurse educators choose to include or exclude content on caring for transgender patients in their respective courses. The discovery of nurse educators' attitudes, knowledge, perceptions and biases towards transgender persons may influence inclusion or exclusion of this material in nursing curriculum. The knowledge gained from this study may impact nursing education and help make the necessary changes in course content to benefit both educators and nurses which will ultimately result in culturally competent and compassionate care for transgender persons.

Procedures:
Any nursing faculty teaching in a baccalaureate program accredited by CCNE or ACEN in a full time, part time or adjunct position will be invited to participate in this study. Face to face interviews or Vidyo conferences will be conducted at your convenience.

Risks and Inconveniences:
Process consent will be employed allowing participants a collaborative role in the decision-making process. Participants may become uncomfortable with the topic, however, it is assumed that those who choose to participate in this study will be aware of the topic prior to this interview. If at any time you become uncomfortable with the interview, you may withdraw from the study.

Participant's Initials_____

Benefits:
Nurses will care for transgender persons at some point in their career and without the appropriate education to prepare them to care for this population, there will be repercussions on the health care needs of these patients. Faculty must be willing and open to understand and explore their own personal values and beliefs in order to create the appropriate environment for learning about this population. Faculty will benefit from this study to examine why this content may be important for them to learn about and teach their students about transgender care.

Cost/Compensations:
There will be no direct costs to you for participating in this interview other than the time it will take to participate in the study.

Voluntary Participation:
Your participation in this study is entirely voluntary. You may decline to participate or withdraw from this research without any negative consequences. It is very important to this researcher that participants do not feel any coercion or pressure to participate in this study.

Confidentiality:
Any and all information obtained during this study will be kept confidential. There will be no identifying information. Each participant will receive a fictitious name or code. Data will be stored in a digital entry safe that was purchased specifically for this study and saved for three years per the Southern Connecticut State University IRB policy. Data collected from this study may be used for publication, papers and presentations as teaching and training strategies.

Signature Section:
Before you sign this form, please ask for clarification on any part of this interview that may be unclear to you. You may take as much time as you need to decide if you wish to participate in this study. If you have further questions after this interview, please contact me, Vanessa Pomarico-Denino at vpdenino@sbcglobal.net or at 203-710-1480. If you have questions regarding your rights as a research participant, you may contact the SCSU Institutional Review Board at 203-392-5243.

Investigator Signature: I have explained to _____(participant) the purpose, procedures, possible risks and benefits of this research to the best of my ability. To the best of my knowledge, the information contained in this consent form is true and accurate.

_____

Principal Investigator Date

I, _____ , confirm that Vanessa Pomarico-Denino, Principal
(Name of participant),
investigator, has explained to me the purpose of this research, the study procedures, possible risk, benefits and discomfort that I may experience. I have read or have had read to me this consent form. By signing this form, I agree that I understand it and give my consent to be engaged in this research project.

_____

Participant Signature Date

Participants' Initials_____