The Lived Experience of Trans Nursing Students

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This dissertation has been accepted for the faculty of

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Table of Contents

LIST OF TABLES

LIST OF FIGURES

Abstract

It is widely accepted that gender diversification of the nursing workforce will positively influence healthcare access and outcomes. Gender diversification of the nursing workforce is desired to enhance culturally congruent care, including gender-affirming care of trans persons. Trans persons experience discrimination in academic and employment settings, but trans persons' experiences during pursuit of a career in nursing have not been disseminated.

The purpose of this study was to explore the lived experience of trans students in U.S. prelicensure nursing programs. A phenomenological approach was used. Analysis of individual interviews with four participants representing baccalaureate programs from across the United States resulted in the emergence of six themes: (a) language is a barometer for respect and safety, (b) traversing deep-rooted assumptions about gender and nursing, (c) the burden of altruism as default educators and advocates, (d) navigating transition and coming out, (e) pride in nursing, and (f) personal gender experiences enhanced nursing care. The burden of altruism as default educators and advocates resulted from three subthemes: (a) faculty were unprepared to teach trans students and to teach trans health concepts and, (b) the formal curricula on trans health were inadequate, cisnormative, and pathologizing, and (c) transinvisibility on campus.

Illuminating experiences of nursing students who identify as trans, a historically marginalized and stigmatized sector of the population, holds the power to transform future experiences for trans students. Study findings inform gatekeepers of the nursing profession about systems and interactions with potential to influence trans students' experiences. The study findings lead to short-term and long-term recommendations for gatekeepers to mitigate minority stress of trans nursing students, including enhancing

integration of trans health concepts in formal curricula and supporting faculty to develop knowledge of trans students and trans health. Finally, this study implores the nursing profession at-large to consider the mutual value in actively welcoming gender diverse individuals into the profession, benefitting trans persons as future nurses and benefitting future recipients of their care.

The Lived Experience of Trans Nursing Students

CHAPTER I: INTRODUCTION

A rapidly growing body of literature indicates trans persons experience challenges in academic, healthcare, and employment settings. Prelicensure nursing education uniquely intersects academia and healthcare, providing clinical education in authentic healthcare employment settings. At the heart of this intersection, prelicensure nursing education is positioned to deeply impact academic experiences of gender diverse students and to prepare graduates to provide gender-affirming care to patients. Yet, little is known about the experiences of trans students in prelicensure nursing education.

Trans, or transgender, is an umbrella term used to signify a person whose gender identity does not align with their assigned sex, derived from biological characteristics noted at birth. Nurses must be prepared to care for trans patients and nurse educators must be prepared to teach trans students. Provision 1 of the *Code of Ethics for Nurses with Interpretive Statements* published by the American Nurses Association (2015) mandates all nurses, in every setting, practice with "compassion and respect for the inherent dignity, worth, and unique attributes of every person" (p. 17). Gender is a unique attribute of every person. Therefore, nurse educators are ethically obligated to ensure students of all genders experience compassion, respect, and dignity in their nursing education, and students are prepared to extend the same to the populations they serve as practicing nurses.

Background and Rationale

Gender diversification of the nursing workforce has been projected to improve culturally competent healthcare and access for minorities (Douglas et al., 2014; National Academies of Science, Engineering, and Medicine [NASEM], 2016). Thus far, diversification efforts have

targeted gender as a male-female binary, failing to acknowledge the full gender spectrum and potential needs and contributions of trans persons joining the nursing workforce (Eliason, 2017; Johnson, Smyer, & Yucha, 2012; Kellet & Fitton, 2017; Merryfeather & Bruce, 2014; NASEM, 2016). The United States (U.S.) has historically applied a binary, biological lens to gender, sex, and sexuality (Eliason & Chinn, 2018). Likewise, the nursing profession has viewed gender through a binary lens and retained a predominantly female workforce ill-prepared to meet the needs of trans patients or students (Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015; Greene et al., 2018; Lim, Johnson & Eliason, 2015; Manzer, O'Sullivan, & Doucet, 2018).

Trans persons reportedly experience higher rates of unemployment, discrimination, poverty, and homelessness, and inadequate access to healthcare (James et al., 2016; NASEM, 2017). As a result, health disparities in this population include harassment and violence, mental illness, suicide and other self-harm, sexually transmitted infections, substance use, and complications of gender-affirming medical or surgical treatments (Jackman, Dolezal, Levin, Honig, & Bockting, 2018; Messman & Leslie, 2018; McCann & Brown; 2018; Swanbrow Becker et al., 2017). Additionally, trans persons have avoided or left academic and employment settings due to harassment, discrimination, stigma, and marginalization (McCann & Brown, 2018; Mizock & Dawson Woodrum et al., 2017; Pryor, 2015; Schneider & Dimito, 2010; Woodford, Joslin, Pitcher, & Renn, 2017). Collectively, these disparities have prompted the ANA (2018) to advocate for improved research, education, and practice regarding trans populations, in addition to all gender and sexual orientation minorities identified by the LGBTQ+ acronym. The LGBTQ+ acronym is used to signify lesbian, gay, bisexual, transgender, queer, intersex, asexual, or any other gender or sexual orientation minority identities or their allies.

Problem Statement

Though empirical evidence regarding academic and employment experiences of trans persons has emerged, no known evidence is specific to the experiences of trans persons enrolled in nursing programs. Some researchers have purportedly studied trans persons in health professions or healthcare education; however, in many cases, trans persons were often underrepresented participants lost within the LGBTQ+ umbrella for gender and sexual orientation minorities or misrepresented in light of modern distinctions between gender, sex, and sexuality (Lim & Hsu, 2016; Maruca, Diaz, Stockmann, & Gonzalez, 2018; Merryfeather & Bruce, 2014; Rondahl, 2011). In addition, widespread adoption of the gender binary in survey construction has marginalized or concealed trans voices (Eliason & Chinn, 2018). Therefore, there existed a need to learn about the experiences of trans persons enrolled in prelicensure nursing programs that serve as the gateways into the nursing profession.

Purpose of the Study

The purpose of this phenomenological study was to explore the lived student experiences of trans persons in U.S. prelicensure nursing programs.

Research Questions or Aims

The central question of this research study was, "What are the lived student experiences of trans persons enrolled in U.S. prelicensure nursing programs?" Six sub-questions relating to the central question were delineated:

1. How do trans persons view their trans identities in relationship to admission, progression, and/or graduation experiences in prelicensure nursing programs?

2. How do trans persons describe their classroom/curricular experiences in prelicensure nursing programs?
3. How do trans persons describe their clinical learning experiences in prelicensure nursing programs?
4. How do trans persons characterize their student life, campus culture, and/or extracurricular experiences while enrolled in prelicensure nursing programs?
5. How do trans persons describe their interactions with peers, college personnel, clinical agency staff, and patients while enrolled in prelicensure nursing programs?
6. How do trans persons perceive their trans identities related to their decisions to pursue a career in nursing?

Assumptions

The following assumptions applied to this study:

1. Participants were honest in self-identifying as trans and having been enrolled in a prelicensure nursing program.
2. Experiences of trans persons are unique from cisgender persons enrolled in nursing programs.
3. The majority of faculty and students in prelicensure nursing programs are cisgender; therefore, trans persons are of minority gender status.
4. Experiences of prelicensure nursing students are unique from experiences of college students enrolled in other academic majors, in part because nursing is a gendered profession and because prelicensure nursing programs include clinical education experiences.
5. Participants honestly and openly shared their lived experiences as trans persons.

Delimitations

The researcher implemented the following constraints to this study:

1. Because gender is a sociocultural construct and nursing programs vary significantly in other countries, this study was limited to the U.S.
2. Trans awareness in the general public has increased significantly in the previous five years. Therefore, only participants who were currently enrolled, or who were enrolled in a prelicensure nursing program in the past five years were included.
3. Only prelicensure nursing students were included in this study, as graduate student or baccalaureate-completion student experiences may be quite different.

Definition of Terms

This study employed the following operational definitions:

- *Student experiences* were defined as (a) admission, progression, and graduation experiences; (b) formal and informal classroom and clinical learning experiences, including interactions with college peers, personnel, clinical agency staff, and patients; and (c) experiences related to campus culture and student life.
- *Admission, progression, and graduation student experiences* included all formal and informal processes and interactions encompassing (a) admission to the college/university and/or the nursing division; (b) progression/advancement through the nursing program curriculum; and (c) student experiences when graduating from the college/university and/or the nursing division, which included, but was not limited to, preparing for graduation ceremonies, licensure exams, and nursing employment.
- *Trans persons* were defined as persons self-identifying as transgender. Transgender, trans, or trans* is used as an umbrella term to signify a person whose gender identity does

not align with their assigned sex, which was derived from biological characteristics noted at birth. Cisgender or cis refers to a gender identity that aligns with the assigned sex at birth. Transgender identities is include genderqueer, gender-nonconforming, agender, two-spirit, transsexual, gender fluid, transmale, or transfemale identities, or any other gender identity that is not cisgender.

- *Prelicensure nursing programs* were defined as post-secondary nursing education academic programs of study at U.S. institutions of higher learning, aimed at preparing graduates for licensure as practical nurses (LPNs), vocational nurses (LVNs), or registered nurses (RNs). This included practical/vocational, associate degree, baccalaureate degree, or diploma nursing programs.

Theoretical Framework

The theoretical framework for this research study is the Minority Stress Model created by Ilan Meyer (2003). Meyer's Minority Stress Model was adapted by the PI by replacing general minority descriptors with trans-specific language. The adapted model is shown in Figure 1.

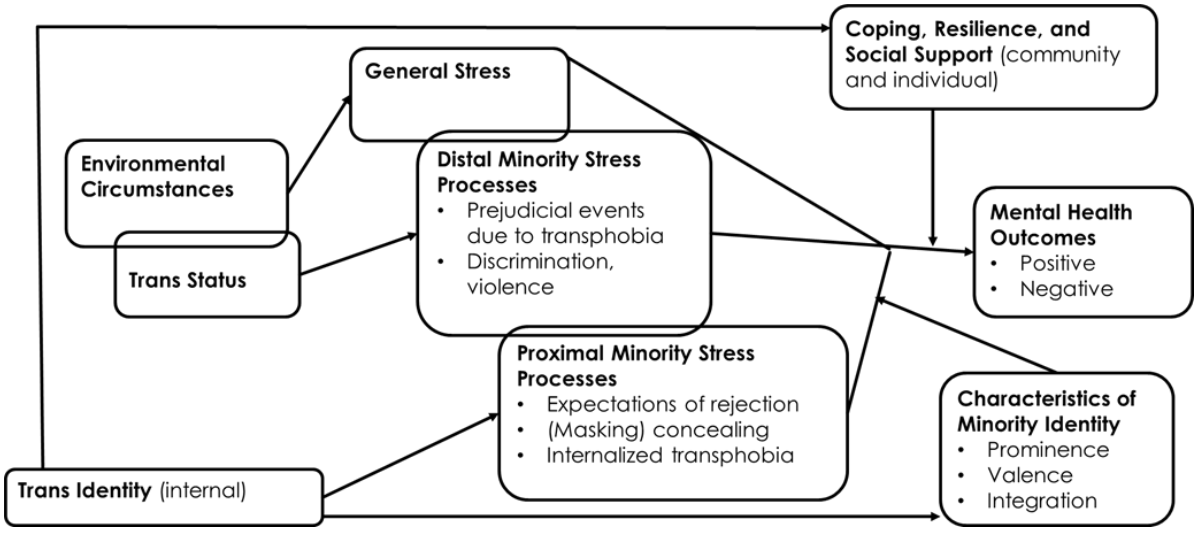

Figure 1. Meyer's (2003) Minority Stress Model, adapted to represent trans persons' minority stress

According to Meyer (2003), minority stress is unique stress experienced by individuals in stigmatized social categories due to their minority status. The concept of minority stress grew from many different theories about the adverse impact of prejudice and stigma, though primarily drew on Dohrenwend's stress model. General stress processes include privileges or disadvantages within the external environment, personal and biological predispositions, prolonged situations, and appraisal and coping (Meyer, 2003). These are important factors foundational to, but not the focus of, minority stress. Rather, minority stress is added to general stress, specific to stigmatized minority status, and a result of both internal and external sources of stress (Meyer, 2003).

Meyer (2003) identified processes of minority stress. Distal stress processes are objective and external to the individual, meaning they are stressors independent of an individual's perceptions or minority self-identifications (Meyer, 2003). For example, a drag queen may not self-identify as trans, but may become a victim of a hate crime due to another individual's transphobia and perception that the drag queen is trans. Proximal stress processes are subjective and dependent on an individual's perceptions and minority self-identifications (Meyer, 2003). These stresses may include hypervigilance and fears of rejection, as well as attempts to conceal the minority identity or the internal decisional conflict determining when to conceal and when to disclose (Meyer, 2003). This may progress to internalized transphobia, directing negative social attitudes towards themselves (Meyer, 2003). Minority stress requires coping and adaptation efforts beyond what is required by others who are not stigmatized and in similar situations (Meyer, 2003). Ultimately, with chronic ineffective coping, the minority stress processes may impact health and contribute to health and/or social disparities (Meyer, 2003).

Though originally designed with sexual orientation minorities in mind, the minority stress model has since been applied to other groups, including ethnic, racial, and gender minorities. Sexual orientation and gender minorities have numerous differences. However, Meyer (2016) noted that sexual orientation and gender minorities "share remarkably similar experiences related to stigma, discrimination, rejection, and violence" (p. 1357). Furthermore, minority stress processes and health disparities consistent with the Minority Stress Model were evident in the literature pertaining to trans persons.

Significance of the Study

This study establishes a foundational understanding of the experiences of trans students in prelicensure nursing programs. Illuminating experiences of nursing students who identify as trans, a historically marginalized and stigmatized sector of the population, holds the power to transform future experiences for trans students. The study informs college personnel how some trans persons have experienced prelicensure nursing education. Specifically, it offers insight for college personnel, nursing students, and clinical agency staff into interactions that positively or negatively influence trans student experiences including sources and influences of minority stress. Nursing program admissions staff and recruiters can learn how trans persons may view their gender in relationship to a future nursing career. This study assists gatekeepers into the nursing profession to become aware of the systems and interactions with potential to influence trans students' experiences. The study findings lead to short-term and long-term recommendations from the course to the institution level. Finally, this study implores the nursing profession at-large to consider the mutual value in actively welcoming gender diverse individuals into the profession.

CHAPTER II: LITERATURE REVIEW

This literature review demonstrated minimal evidence regarding trans persons as members of health professions. Much of the available evidence centered broadly on the LGBTQ+ population, as opposed to trans individuals, specifically. Due to the paucity of research, this review examined LGBTQ+ research pertaining to health professions, academia, and workplaces. Themes relevant to trans students in undergraduate nursing education, described in this review, included (a) gender and the nursing profession, (b) health and safety of trans persons, (c) employment and academic experiences of trans persons, and (d) the influence of knowledge, attitudes, and behaviors regarding trans persons.

Gender and the Nursing Profession

The National Academies of Science, Engineering, and Medicine (2016), formerly known as the Institute of Medicine, assessed the state of the nursing profession five years after its landmark *Future of Nursing Report* recommending diversification of the nursing workforce. Diversification is necessary for the workforce to reflect the demographics of the population it serves. The NASEM's follow-up report indicated little progress has been made to diversify the nursing workforce since the 2010 recommendations, urging enhanced efforts.

Diversification of the nursing workforce has been predicted to enhance the delivery of culturally competent patient care and culturally competent nursing education for increasingly diverse populations (Douglas et al., 2014). Furthermore, evidence has supported that minority healthcare providers are likely to serve populations similar to themselves, thereby improving healthcare access (NASEM, 2016). To this end, the NASEM (2016) report called for gender diversity, as males have continued to be underrepresented in nursing at under 10% of the workforce. Unfortunately, the NASEM report utilized a binary gender framework, embracing

cisnormativity and neglecting true gender diversification of the workforce. Nonetheless, undergraduate nursing education stands as a pipeline to recruit, retain, and adequately prepare all genders for nursing practice.

Nursing is a gendered profession that has embedded the gender binary in curricula, practice and policies (Eliason, 2017). Eliason (2017), a leading advocate and researcher regarding LGBTQ+ persons and healthcare issues, asserted that despite a predominantly female nursing workforce, inequities and gender stereotypes persist due to the patriarchal U.S. healthcare system and continued fixation on the gender binary. U.S. society's patriarchy has defined traits of gender expression and guided gender roles (O'Lynn, 2013). Feminine and masculine traits vary with time and culture. In the U.S., masculinity has been stereotyped as competitive, superior, confident, aggressive, independent, strong, and logical (Martin & Slepian, 2018; O'Lynn, 2013). In contrast, femininity has been stereotyped as vulnerable, dependent, nurturing, warm, sympathetic, sensitive, gentle, and caring (Martin & Slepian, 2018; O'Lynn, 2013). As a result, women traditionally secured jobs in disciplines like primary education and nursing. The purpose of women was once considered to be servants of men; nursing was an extension of this purpose, and it was a woman's duty to serve out of love, not for wages (Olynn, 2013). The impact to social status and salaries lingers today (O'Lynn, 2013).

Patriarchy's grip has made it difficult for individuals who are not viewed as female to enter the nursing profession (O'Lynn, 2013). As an illustration, the word *nurse* conjures images of women; in order for *nurse* to elicit images of men, it requires the qualifier of *male* prior to *nurse* (Carnevale & Priode, 2018; David, 2018). Furthermore, male nurses have often been assumed to identify as a sexual orientation minority due to the profession's feminine image and stereotypes of femininity applied to gay men (Eliason, 2017). Male nurses have also

experienced discrimination and marginalization once in the profession, as well as in prelicensure programs (Carnevale & Priode, 2018; O'Lynn, 2013). National and local programs have actively recruited males into the profession to achieve better gender balance reflective of the society it serves. Yet, paradoxically, male nurses have enjoyed disproportionately higher salaries and moved up career ladders faster than female nurses (Eliason, 2017). Therefore, one must ponder how the complex history of gender and nursing influences the recruitment and retention of trans persons into the profession.

Trans persons in the nursing profession. Trans persons have been mostly invisible in nursing and healthcare literature (Eliason, 2017; Johnson, Smyer, & Yucha, 2012; Kellett & Fitton, 2017; Merryfeather & Bruce, 2014). No identified research publications aimed to study trans nurses or trans nursing students, specifically. Little is known about the experiences of trans health professionals or students. Numerous nursing and healthcare research articles purporting to address LGBTQ+ persons failed to accurately or adequately include persons with trans identities (Merryfeather & Bruce, 2014). This was noted upon review of Lim and Hsu (2016); Maruca, Diaz, Stockmann, and Gonzalez (2018); More, Whitehead, and Gothier (2004); and Rondahl (2011), and this is described in greater detail later in this review.

Due to the paucity of research, this review was broadened to examine LGBTQ+ research pertaining to health professions, academia, and workplaces in general. Still, the few research articles with LGBTQ+ healthcare professionals as participants have significant underrepresentation of trans participants and/or suboptimal research methods. This was illustrated in Eliason, DeJoseph, Dibble, Deevey, and Chinn's (2011) report of data collected in 2006 as part of a survey sent to nurse members of an organization then known as the Gay and Lesbian Medical Association (GLMA). The survey was created by a GLMA member and

Institutional Review Board (IRB) approval was not sought until after data collection, at which time the IRB approved the study as exempt. The authors had no way to calculate a survey response rate as no records were kept about how many surveys were distributed. Only 1.2% of the LGBT nurse respondents identified themselves as trans, limiting interpretation of quantitative findings. However, trans nurses responded to open-ended survey questions highlighting experiences with discrimination. One egregious experience with discrimination involved sharing a trans nurse's medical records with hospital staff where the nurse was employed, leading to workplace hostility and life-threatening circumstances.

Trans persons were better represented in Eliason, Streed, and Henne's (2018) important work examining the coping and experiences of LGBTQ+ healthcare professionals. This mixed methods survey was developed by GLMA members, now known as GLMA: Health Professionals Advancing LGBT Equality. The survey was distributed to more than 6000 members, but the final sample was 277, so the response rate was a mere 4.6%. However, 13% of respondents identified themselves as trans. About 38% of the LGBTQ+ respondents indicated they were not out in the workplace, with the main reason being fear of discrimination. One trans intern stated, "I am worried about being out and transitioning as a trans man and I am nervous that coworkers, supervisors, and patients will not want to interact with me" (p. 566). Of those who reported they were out in the workplace, 41% indicated that being out resulted in discrimination. Examples of discrimination included being misgendered, denial of tenure, loss of patients, delayed promotion, harassment, and denial of a Drug Enforcement Administration (DEA) number that allows for full prescriptive authority (Eliason, Streed, & Henne, 2018).

Greater representation of trans respondents in Eliason and Streed et al. (2018) afforded comparisons revealing differences between gender and sexual orientation minorities in

healthcare professions. For instance, 100% of the trans respondents reported workplace discrimination, compared to 41% of the total sample. Additionally, trans identities were associated with greater degrees of anxiety than sexual identities. One trans male social worker described being outed by a colleague and, subsequently, informed by human resources that his concerns were unwarranted because males could not experience sexual harassment in the workplace. One genderqueer nurse explained the rationale for not coming out completely in the workplace and the related proximal minority stress:

> Being out is a slippery concept in my professional life. I am out as both queer and trans/genderqueer as a general rule, in all aspects of my life, but when I am working with patients, I am more focused on them and what they need than on myself and who I am or am not. Sometimes disclosing more about myself improves care and sometimes it is irrelevant. Sometimes patients treat me with respect and sometimes they don't…I never know how my patients perceive my gender…I have zero idea how I will be perceived / received as I move from room to room. It can be stressful. (p. 566)

The nursing profession's responsibility regarding trans persons. Professional nurses are entrusted to care for a society that is increasingly diverse. Provision 1 of the ANA's *Code of Ethics for Nurses with Interpretive Statements* (2015) urges individualized nursing practice based on the personal attributes—including gender—of clients [or students] or populations including gender expression (Fowler, 2017). In 2016, the ANA expanded the scope and standards of nursing practice by adding an additional standard for culturally congruent nursing practice (Marion et al., 2016). As a component of the social contract between the public and the nursing profession, the ANA defined culturally congruent practice as:

> the application of evidence-based nursing that is in agreement with the affirming cultural values, beliefs, worldview, and practices of the healthcare consumer and other stakeholders…Nurses design and direct culturally congruent practice and services for diverse consumers to improve access, promote positive outcomes, and reduce disparities. (Marion et al., 2016, History of the Revised Standards and New Standard 8, para. 4)

The cultural congruence standard lists 13 demonstrable competencies expected of all registered nurses, at all educational levels, and in all roles or settings. Therefore, the competencies are demanded of new graduates as well as nursing faculty, so they are essential in nursing education. A select list of the competencies most relevant to trans persons are as follows:

- Demonstrates respect, equity, and empathy in actions and interactions with all healthcare consumers
- Participates in lifelong learning to understand cultural preferences, worldview, choices, and decision-making processes of diverse consumers
- Considers the effects and impact of discrimination and oppression on practice within and among vulnerable cultural groups
- Uses skills and tools that are appropriately vetted for the culture, literacy, and language of the population served
- Communicates with appropriate language and behaviors…
- Identifies the cultural-specific meaning of interactions, terms, and content
- Advocates for policies that promote health and prevent harm among culturally diverse, under-served, and under-represented consumers

- Promotes equal access to services, tests, interventions, health promotion programs, enrollment in research, education, and other opportunities
- Educates nurse colleagues and other professionals about cultural similarities and differences of healthcare consumers, families, groups, communities, and populations (Marion et al., 2016, Table 2)

Furthermore, graduate-level prepared registered nurses, including nurse educators and administrators, are charged to demonstrate the following competencies:

- Advances organizational policies, programs, services, and practices that reflect respect, equity, and values for diversity and inclusion
- Develops recruitment and retention strategies to achieve a multicultural workforce (Marion et al., 2016, Table 2).

An individualized approach to culturally congruent nursing practice requires critically self-reflecting on one's existing competencies, developing goals, and gaining insights through formal training about diverse populations (Douglas et al., 2014; Marion et al., 2016). It requires developing knowledge, skills, and attitudes to engage in cross-cultural communication and culturally competent practice, education, leadership, and research (Douglas et al., 2014). It requires advocating for and empowering vulnerable populations (Douglas et al., 2014).

Indeed, the nursing profession has a long history of advocating for and empowering vulnerable populations. Modern nursing practice was born out of subordination and subjugation, primarily due to a female workforce and societal gender inequality (Fowler, 2017). Some of the earliest advocacy by the profession included major influences in women's suffrage and advancement of education for women (Fowler, 2017). Thereafter, nurses continued to unite and fight against social injustices regarding marginalized populations, including causes such as

abolishment of slavery, enactment of child labor laws, housing reform, access to birth control, and quality care for mental illness (Fowler, 2017). However, as a gendered profession with historically feminist political orientations, nursing has encountered a paradox. Feminism drives the profession to advocate for equity among men and women within the profession, ultimately reinforcing the gender binary. Hence, tension surfaces as feminism also motivates the profession to advocate for trans visibility and equity (Fowler, 2017). Therefore, a unified approach by the nursing profession is crucial.

In response to this need for unity, the American Nurses Association released a position statement in 2018 entitled *Nurse Advocacy for LGBTQ+ Populations*. Several recommendations involved nursing education. First, the ANA took a social justice stance, calling nurses to defend human and civil rights of LGBTQ+ persons. Second, it presented the position that nurses in all roles and settings, including education, must provide culturally competent and inclusive care to LGBTQ+ persons. Third, the ANA advocated for research regarding LGBTQ+ persons, including appropriate collection of sexual orientation and gender identity data. The organization charged nurse educators to ensure LGBTQ+ health is part of the formal curricula and to implement strategies that assist students and providers to examine implicit and explicit biases. Finally, the ANA implored nursing program accreditors and state boards of nursing to require LGBTQ+ health content within curricula and evaluation using standardized gender-neutral language (ANA, 2018).

Gender diversification of the nursing workforce is crucial to advancing the profession to serve a diverse society. As a long-standing gendered profession built on feminism and the gender binary, nursing has failed to embrace gender diversity in practice, education, and

research. However, the profession's ethical code and leading national organizations compel nurses to change the tide.

Societal Constructions of Gender and Sexuality

The United States has constructed sex, gender, and sexuality based chiefly on the values and beliefs of White-European, middle-class males (Eliason & Chinn, 2018). One such historical construct of gender in the U.S. is that of the gender binary. Martin and Slepian (2018) assert that gender is the predominant social categorization impacting individuals at the earliest stages in their lives. From birth, society teaches children that the dichotomy of male or female sex assigned at birth determines everything from clothing to hobbies to careers to behavior (Martin & Slepian, 2018). The binary has been viewed by feminists as a mechanism and symptom of gender inequality and female oppression (Monro, 2005); it has historically demanded conformity in gender expression and traditional gender roles in society, including parenting, education, and occupations (Eliason & Chinn, 2018). The binary is based on dichotomous views of sex and gender, and conflation of sex, gender, and sexual orientation as interdependent (Eliason & Chinn, 2018). If one is not male, one is female. If one is not masculine, one is feminine. If one is not heterosexual and/or cis, one is gay or lesbian.

Though feminist gender theory has fought gender oppression, it has also reinforced the gender binary and biology as the sole basis of gender (Monro, 2005). Hence, poststructuralist theories of gender arose in the 1960s and 1970s, emphasizing gender as a social rather than biological construct, and something one performs (Monro, 2005). This theory allowed for nonbinary and fluid views of gender. However, one limitation of poststructuralism is inattention to the influence and limitations of biology in gender construction, along with society's persistent

need to categorize gender (Monro, 2005). In other words, poststructuralism tends to minimize or eliminate the existence of gender (Monro, 2005).

As a result, Monro (2005) proposed an alternate theory of gender called gender pluralism. Born of poststructuralist theory, Monro's gender pluralism is built on the social reality of gender construction and gender fluidity. It also recognizes that biology influences gender construction. For example, social context impacts one's ability to biologically influence gender expression, such as access to sex hormone therapies, which may alter how gender is categorized by others. Finally, unlike some poststructuralist views, gender pluralism resists gender erasure, embracing the existence of gender on a pluralist continuum.

Keo-Meier and Ehrensaft (2018), creators of the Gender Affirmative Model (GAM) of healthcare for trans and all gender diverse individuals, emphasize the complexity of gender and rapidly evolving terminology and scientific knowledge about gender. Like Monroe's gender pluralism, Keo-Meier and Ehrensaft (2018) acknowledge gender as a social construct that is not caused by biology. However, genetic and neuroanatomic influences have been demonstrated in studies of the biologic makeup and brain anatomy of trans persons (Keo-Meier & Ehrensaft, 2018). Rather than labeling variations in gender development as deviations, the "science must recognize the primacy of variations as inherently natural" (Keo-Meier and Ehrensaft, 2018, p. 25). The theoretical basis to the GAM is that (a) no gender identity or expression is pathological; (b) gender presentations are diverse and vary across cultures, requiring cultural sensitivity; (c) gender involves an integration of biology, development and socialization, and culture and context; (d) gender may be fluid, and it is not binary; and (e) any pathology present in trans individuals is caused by cultural reactions to gender diversity rather than innate, internal psychological disturbances (Keo-Meirer & Ehrensaft, 2018, p. 14).

In this literature review, *sex* refers to biological characteristics at birth, sometimes preconceived in utero, that distinguish male, female, and intersex individuals. Variations in biological characteristics involve chromosomes, external genitals, internal reproductive organs, and sex hormones of testosterone and estrogen (Eliason & Chinn, 2018). Intersex persons, formerly referred to as hermaphrodites, have biological characteristics that do not perfectly align with either the male or female sex (Eliason & Chinn, 2018). Healthcare providers may refer to intersex as "disorders of sex development," with some estimating that this impacts as many as 1 in 100 individuals (Eliason & Chinn, 2018).

Rather than a biological construct, *gender* is a social construct that has historically been based on gender markers, that are often biologically influenced, and on socio-cultural norms for gender expression. Gender markers and gender expression are often categorized as feminine, masculine, or androgynous and include characteristics such as body hair and hair style, attire and cosmetic use, posture and mannerisms, vocal quality, and communication style (Eliason & Chinn, 2018; Keo-Meier & Ehrensaft, 2018). Socio-cultural norms dictate how gender markers and expressions are perceived and categorized as feminine, masculine, or androgynous. Gender identity is one's internal sense of self as male or female, both, or neither (Eliason & Chinn, 2018; Keo-Meier & Ehrensaft, 2018).

Historically, cultural norms in the U.S. have been that gender markers, expressions, and identity align with one's sex. A gender identity consistent with one's sex assigned at birth is known as cisgender or cis (Eliason & Chinn, 2018). A person whose gender identity does not align with their assigned sex is referred to as transgender or simply trans* (Eliason & Chinn, 2018). Utilizing the stem "trans" with or without an asterisk is common in the literature, and indicative of the many truncations and identities of binary trans persons, such as transgender,

transman or transwoman (Eliason & Chinn, 2018), as well as nonbinary identities such as two-spirit, genderqueer, gender fluid, gender expansive, and gender nonconforming.

Sexual orientation refers to sexual, emotional, and romantic attraction (Eliason & Chinn, 2018). Though also once viewed as a dichotomy of heterosexual and homosexual, it is now more widely accepted as a spectrum encompassing bisexual, pansexual, asexual, queer, and other sexual orientations. Today, the term homosexual should be avoided, as it is considered offensive by many who identify as a sexual orientation minority, given historical pathologizing of sexual orientation minorities as deviant, psychologically abnormal, and unhealthy (Eliason & Chinn, 2018).

Castleberry (2019) conducted a concept analysis of the gender continuum utilizing Madeline Leininger's transcultural nursing theory. Castleberry (2019) identified four subcategory gender continua as the defining attributes within the gender continuum: identity, expression, anatomy, and sexual and romantic attraction. The author asserts that gender is a culmination of all four defining attributes, and that all people fall somewhere within the subcategory continua. Hence, Castleberry (2019) constructed the following operational definition of the gender continuum:

> Gender is a composition of how a person thinks, feels, and expresses themselves as well as how they relate to and are attracted to others. The gender continuum allows people to present their gender however they feel regardless of the presence of stereotypes or norms. (p. 407).

Castleberry's (2019) concept analysis is admirable in that it recognizes the need to bring awareness of modern conceptualizations of gender to nurse educators and students. The conceptual definition of the gender continuum is also empowering and validating for gender

diverse individuals. Unfortunately, Castleberry's operational definition and defining attributes for gender are misleading, as they conflate sexual and romantic attraction with gender. Though Castleberry utilizes Sam Killermann's (2017) work in the concept analysis, the analysis overlooks Killermann's emphasis that gender and sexuality may be interrelated but are independent of one another. Though intersectionality exists between gender and sexual and romantic attraction, modern scholars of gender and sexuality studies recognize gender as conceptually independent from sexual and romantic attraction (Eliason, 2014).

Castleberry's (2019) conflation of sex, gender, and sexual orientation reflects historical beliefs. Inclusion of both gender and sexual orientation minorities within the LGBTQ+ acronym, meaning lesbian, gay, bisexual, transgender, queer or questioning has contributed to this conflation. The "+" symbol is frequently utilized at the end of the acronym in efforts to capture all sexual orientation and gender minority identities beyond LGBTQ. This literature review used various abbreviated forms of the acronym to accurately identify the specific populations addressed in each study. A full glossary of terms is provided in Appendix A.

Farmer and Byrd (2015) discovered that conflation of sexuality and gender concepts has the potential to generate conflict. The researchers interviewed ten individuals who identified as part of the LGBTQ+ community. Participants described a hierarchy and intragroup oppression within the LGBTQ+ community with white, gay men at the top of the hierarchy and trans persons and nonbinary trans persons at the very bottom of the hierarchy (Farmer & Byrd, 2015). These findings illuminate that not only are sexuality and gender separate concepts, grouping them as related may harm trans persons and impede scientific growth regarding their unique experiences and needs (Eliason, 2014).

Transinvisibility and cisnormativity. The gender binary and cisnormativity render trans persons invisible in society. Cisnormativity is the assumption that people are either cis female or cis male. Cisnormative and gender binary structures have been acknowledged as pervasive and deemed marginalizing and isolating for trans persons (Nicolazzo, 2016; Seelman, 2014). Consequently, it is unknown how many trans persons live in the U.S. Survey instruments, including the U.S. census (United States Census Bureau, 2010), ascribe to the gender binary, excluding many trans persons. In addition, many trans persons assume a binary identity of male or female, so respond to such surveys accordingly (Eliason & Chinn, 2018). For instance, a trans man may identify self as male, rather than as trans. Meerwjik and Sevelius (2017) conducted meta-regression analysis of national survey findings from 2006 to 2016 to offer the conservative estimate of one million U.S. adults identifying as transgender, with 58% being college students. However, they estimated the size of the gender nonconforming population is likely double the size of the population identifying themselves as trans.

Pathologizing trans identities. Castro-Peraza et al. (2019) defined pathologization as "psycho-medical, legal, and cultural practice of identifying a feature, an individual, or a population as intrinsically disordered" (p. 2). Trans individuals have been pathologized since 1980, when *gender identity disorder* was added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (Eliason & Chinn, 2018). This occurred a mere seven years following the removal of homosexuality from the DSM. *Gender dysphoria* replaced the diagnosis of *gender identity disorder* in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) in an effort to relieve stigma with being labeled as "disordered" (Castro-Peraza et al., 2019; Eliason & Chinn, 2018; Kellett & Fitton, 2016). However, by title of the manual, every diagnosis inside of it is considered a disorder. The DSM-5 defines gender

dysphoria as “an individual’s affective / cognitive discontent [and distress] with the assigned gender” (American Psychiatric Association, 2013, p. 451).

The International Classification of Diseases (ICD) is an international coding system for health diagnoses published by the World Health Organization (Castro-Peraza et al., 2019). In the latest edition of the ICD (ICD-11), “transsexualism” and other “gender identity disorders” have been removed from the mental and behavioral disorders chapter. Rather, “gender incongruence” is now listed in the ICD-11 in the “conditions related to sexual health” chapter (Castro-Peraza et al., 2019). ICD-11 codes are necessary for trans individuals to receive health insurance benefits for medical or surgical transition.

As a result of pathological categorizations of trans persons, healthcare providers have been conditioned in their professional education and clinical practice to view trans persons as diseased. This conditioning likely influences the knowledge and attitudes healthcare providers hold regarding trans persons, negatively impacting care. Compounding the issue, health insurance plans will not support gender affirming medical or surgical interventions without the medical diagnosis of gender dysphoria (Kellett & Fitton, 2016).

Contrary to popular belief in the U.S., sex, gender, and sexual orientation are independent constructs. Gender is established by cultural norms and perpetuated by society’s need to categorize individuals in this way. Though many individuals, groups, and systems view gender as binary, contemporary gender theories acknowledge the plurality and fluidity of gender. The gender binary, cisnormativity, and pathologizing of trans persons has led to invisibility and marginalization of trans persons.

The Holistic Wellness of Trans Persons

Research findings have illuminated social and health disparities of trans persons. The findings presented in this literature review were limited to disparities most relevant to academic, rather than clinical settings. Stolzenberg and Hughes (2017) compared the status of 678 first-year trans students from 209 U.S. colleges and universities, with the national norms for all first-year, full-time college students, using data from the Cooperative Institutional Research Program (CIRP) Freshman Survey. Over half of the trans students reported their emotional health to be below average or in the lowest 10% compared to their peers. In contrast, about half of the total sample reported being above average or in the top 10% in emotional health. In addition, 47.2% of trans respondents reported frequent feelings of depression, compared to 9.5% of the total respondents. Furthermore, 54.9% of trans respondents reported feeling overwhelmed, compared to 34.1% of the total sample. Nearly three-fourths of trans students indicated they planned to seek mental health services while in college.

Alongside greater mental health needs, trans college students faced greater concerns about financial wellness (Stolzenberg & Hughes, 2017). Nearly 20% of trans students reported major concerns about funding their education, versus 12% in the overall sample. Trans students were also more likely to report the need to work full time during school (34.9%, versus 28.5% of total sample). However, trans students may also be more resourceful in securing financial assistance. For example, more trans students reported receiving Pell grants, needs-based grants or scholarships, and merit-based financial aid, compared to the total sample.

Messman and Leslie (2018) also utilized data gleaned from a national survey to understand the health experiences of trans college students. Based on the 2013 data of the American College Health Association-National College Health Assessment (ACHA-NCHA)

completed by 32,964 students at 57 U.S. colleges, 0.4% of respondents identified as trans; however, the results may be affected by the limited gender identification options of *male, female,* or *transgender*. Regardless, respondents who identified as trans reported significantly greater rates of anxiety, depression, stress, self-harm, suicidal ideation, and suicide attempts. They reported higher rates of violence, including physical and sexual assault, along with lower perceived safety compared to cis peers. Rates of substance use were also self-reported as higher in trans students. Trans respondents perceived that many of the aforementioned health disparities significantly impacted their abilities to succeed academically. Despite this, the researchers noted that there were no significant differences in the reported grade point averages of trans and cis respondents.

Due to high suicide rates among trans persons, Swanbrow Becker et al. (2017) sought to understand stress, suicidality, and related factors in the college student population. In 2011, the researchers used a cross-sectional design with a stratified, random sample of college students across 73 institutions participating in the National Research Consortium of Counseling Centers in Higher Education. A large sample of 26,292 college students responded to the author-developed survey. Respondents were categorized into one of three gender/sexual identity groups: (a) transgender (n = 47, 0.2%), (b) cis and LGBQ (n = 1759, 6.8%), or (c) cis and heterosexual (n = 23,987, 93%). Again, gender identity options were limited to *male, female,* or *transgender,* which may have impacted gender categorization and subsequent interpretations. Gender and sexual orientation identity were significantly associated with suicidality, as 55% of trans respondents reported suicidal ideation, 34% reported they had attempted suicide, 24% reported suicidal ideation related to stress, and 4.3% reported suicidal attempt related to stress. Regardless of gender identity or sexual orientation, academics was the primary source of stress

students named. However, trans students identified the next leading source of stress as gender identity concerns. Though trans students were significantly less likely than their cis peers to reach out to family, friends, or romantic partners during times of stress, they were significantly more likely to seek help from mental health providers ($x^2[2] = 231.40$, $p < .001$) and academic advisors ($x^2[2] = 18.93$, $p < .001$) (Swanbrow Becker et al., 2017).

Also concerned with self-injury among trans persons, Jackman, Dolezal, Levin, Honig, and Bockting (2018) examined variables associated with non-suicidal self-injury (NSSI). The authors utilized a sample of trans persons, age 16 or over, who spoke English or Spanish and who were enrolled in a longitudinal parent study of transgender identity development called Project AFFIRM. The strong sampling represented racial and ethnic diversity in a nonclinical setting, though data collection via in-person interviews may have been influenced by social desirability, leading to underreporting of NSSI. Despite this, more than 53% of participants reported engaging in NSSI at some point in their lives, with 23.3% reported engaging in NSSI within the previous 12 months. In addition, NSSI was significantly associated with perceived stigma and higher levels of gender dysphoria. With each unit increase in perceived stigma, the odds of NSSI increased by a factor of 2.32 (95% CI 1.55-3.46).

McCann and Brown (2018) conducted a systematic review to determine the vulnerabilities and risk factors for psychosocial health of trans persons. Of the 21 articles that met inclusion criteria, most were based in the U.S. and utilized quantitative methods. Five themes were revealed through thematic analysis of the data: (a) sexual risk and risk-taking behaviors, (b) substance use, (c) psychological vulnerability risk factors, (d) social vulnerability risk factors, and (e) protective factors and behaviors. Sexual risk included engagement in unprotected sex, and morbidity and mortality rates of sexually transmitted infections. Increased

levels of substance use included the use of non-medically prescribed hormones and was noted to often serve as a coping mechanism for anxiety, depression, isolation, and loneliness. Psychological vulnerability risk factors included high rates of suicide attempts, depression, transphobic experiences, and physical or sexual violence. Strong positive correlations were noted between experiencing violence and attempting suicide. In contrast, gender transition was associated with improved mental health. The authors identified inaccessible culturally competent healthcare and workplace discrimination as social vulnerability risk factors leading to unemployment and social isolation. Finally, protective factors encompassed laws and policies protecting the human rights of trans persons, financial supports, stable housing, and competent and accepting healthcare providers. Protective behaviors included building resilience, developing strong support networks, enhancing coping skills, and minimizing risky sexual behaviors.

Clinicians' and students' trans knowledge. Despite a clear, identified need to teach healthcare professionals about the unique health needs of trans persons, a curricular gap persists. In 2019, Rivera contributed significantly to the body of knowledge about trans persons' experiences with nursing care through phenomenology. Via interviews with 11 binary trans persons, four themes emerged: (a) marginalization, (b) uninformed nursing, (c) system factors, and (d) nursing role significance. Nurses' assumptions and discrimination contributed to marginalization. Nurses made assumptions about things related to gender, sexuality, transition, and mental health. Uninformed nursing included perceived lack of training, poor communication, and insensitivity. System factors included electronic health records inhibiting correct name and pronoun identification and failure to distinguish gender from sexual orientation. The theme of nursing role significance related to the participants' identification as

nurses as the most critical, influential caregivers: the ones who could be most helpful but also who could be most harmful. In addition, participants viewed nurses as the most likely change agents, advocates, system leaders, and pioneers in evolving trans healthcare experiences (Rivera, 2019).

Unlike Rivera's (2019) work, the majority of evidence regarding clinicians' trans knowledge comes from self-report by clinicians, rather than by evaluating perceptions of trans persons. Greene et al. (2018) conducted a cross-sectional survey of 388 nursing, 495 medical, and 127 dental students at the University of Pennsylvania. Only 48% of respondents felt their formal training prepared them to treat LGBTQ patients, as only 52% reported LGBTQ health content within their formal curricula. Only 48% of respondents believed their instructors demonstrated LGBTQ health competency, with nursing students more likely to agree their faculty demonstrated competency (OR 1.54, $p < 0.01$) compared to medical students.

Inconsistent with their lack of training, nearly three quarters of respondents in Greene et al.'s (2018) survey reported feeling comfortable caring for LGBTQ patients. Still, most respondents felt additional training would be beneficial, with those respondents identifying as lesbian, gay, bisexual, or queer five times more likely (OR 5.79, $p < 0.001$) to desire additional education. This author-developed survey did not report validity and reliability measures. Furthermore, the survey's gender categorizations of *female*, *male*, and *other* may have constrained the ability to identify trans respondents. As a result, the limited number of "other gender" respondents were excluded from logistic regression model analyses because the sample size of "other gender" category was too small to draw comparisons between cis and "other gender" respondents.

Comparatively, Eliason, Dibble, and Robertson (2011) found training about LGBT health issues lacking within medical education. In their cross-sectional survey of 228 LGBT physicians, 76% reported receiving no LGBT health content in medical school and 79% reported an absence of training during residency. Surprisingly, 46% reported they had not received any continuing education on LGBT health topics. Nearly one third reported never asking patients about gender identity. Despite this, approximately one third of respondents indicated they would feel comfortable working with trans patients.

Directing their attention to the root of curricular inclusion of trans health issues, Lim, Johnson, and Eliason (2015) conducted a national cross-sectional survey of 1,122 baccalaureate nursing faculty to assess their knowledge of LGBT health needs. The 23-item author-developed survey was based on a review of the literature and reviewed for content validity. Survey data demonstrated 75% of faculty respondents were willing to integrate LGBT health content into their curricula, but two thirds reported they lacked awareness of the health content that should be included. Respondents indicated they most frequently included homophobia, human immunodeficiency virus (HIV), sexually transmitted infections, and violence and hate crimes as components of LGBT health issues. Social determinants of health, mental health disparities, minority stress, substance abuse, and the unique reproductive health needs of trans persons were infrequently included in curricula or were not acknowledged by the authors of this article.

Lim et al. (2015) also explored the quantity of time spent teaching LGBT health topics and strategies utilized. The reported range of time spent on classroom teaching about LGBT health topics was 0-10 hours with a mean of 2.12 hours, but more than 500 respondents omitted this item. Open-ended responses to the strategies utilized illuminated perceived barriers in addition to successful approaches. Respondents cited barriers, including (a) needing more

education about the health needs and ways to integrate, (b) limited space in content-laden curricula, (c) lack of institutional support toward LGBT populations, particularly at religious institutions, and (d) lack of integration of LGBT health into NCLEX and accreditation standards. Respondents cited their perceived strategies for inclusion of LGBT health, such as (a) teaching within social justice or cultural competence frameworks; (b) integrating LGBT health into large discussions about diversity, rather than teaching in isolation; (c) incorporating into community health nursing courses as a vulnerable population; (d) including in adult medical-surgical course content on reproductive health; (e) implementing lectures, class discussions, expert guest speakers, and readings; and (f) utilizing LGBT community clinical sites and clinical simulation scenarios.

Manzer, O'Sullivan, and Doucet's (2018) qualitative research of the practice experiences of nurse practitioners suggested that the absence of LGBT health topics may persist into graduate curricula as well. "Efforts to fill knowledge gaps" was one theme uncovered in the data analysis of 22 family/adult nurse practitioner's responses to one-on-one semi-structured interviews. Participants revealed a lack of basic understanding of terminology, such as *cisgender* and *transgender*, and discussed relying on patients to clarify terminology and language that was completely unfamiliar to them. This was felt to hinder their ability to engage in therapeutic communication, as they felt distracted by or anxious in their efforts to select the right words. Some expressed lack of knowledge of resources available to help LGBT patients, while others felt comfortable reaching out to perceived experts for guidance or referrals when needed. Many participants reported the need to engage in internet and literature searching, as well as continuing education opportunities to enhance knowledge of LGBT health.

Though nurse practitioners in Manzer et al.'s (2018) study demonstrated lack of cultural competence, they concurrently exhibited valuing a therapeutic nurse-patient relationship with LGBT patients through awareness, openness, careful use of language, nonjudgmental attitudes, and treating LGBT patients the same as cis or heterosexual patients. For example, they reported self-reflection on personal values and biases and self-awareness of strengths and limitations, striving to be perceived as approachable and nonjudgmental. At the same time, many did not have a process for identifying sexual orientation or gender identity, or did not perceive this to be relevant to care. Institutional processes typically limited gender options on forms to the gender binary. These findings highlighted the most startling theme from Manzer et al.'s (2018) research: pridefully not treating LGBT patients differently. This approach did not represent malice; rather, it reflected lack of knowledge. The majority of nurse practitioner participants failed to recognize LGBT patients as a distinct cultural group needing adaptations in healthcare approaches. Some participants explicitly stated that LGBT patients had the same health needs as everyone else, directly conflicting the nurses' ethical code, as previously described. It also demonstrated a lack of knowledge regarding the unique cultural needs of LGBT patients.

Similarly, Carabez, Pellegrini, Mankovitz, Eliason, and Scott (2015) found that registered nurses (RNs) lacked understanding of basic gender terminology. The authors asked 268 RNs in the San Francisco Bay Area, working in outpatient, inpatient, and community settings in administrative and direct patient care roles, the following question, "Does your organization utilize forms that are gender inclusive?" The primary finding was that 85% of RNs did not understand the question, indicating lack of awareness of the gender spectrum and possibilities beyond a cisgender binary. The second theme was confusion, as 44% of RNs conflated either biological sex or sexual orientation as interdependent with gender identity. Though less than

10% of RNs exhibited discomfort or perceived irrelevance of the issue, this was a notable finding. For example, one RN responded, “Forms that are gender inclusive? It shouldn’t make a difference” (p. 3311).

Conflation of sexual orientation and gender identity surfaced in the literature in unexpected ways, not always in participant responses. Sometimes researchers seemingly misconstrued these two constructs. Maruca et al. (2018) developed a clinical simulation scenario in which student nurses cared for a trans patient, centering the learning objectives on management of anxiety and panic. The authors did not identify the sexual orientation of the simulated patient within the article. Unfortunately, in their pretest-posttest design, the researchers selected a measurement related to sexual orientation, called the Gay Affirmative Practice Scale (Crisp, 2006), a 30-item scale that relates only to gay and lesbian persons; the scale does not mention gender identity, gender expression, or trans concepts. The researchers concluded that the simulation resulted in a statistically significant increase in Gay Affirmative Practice scores following the simulation, demonstrating that the simulation was an effective way to teach trans health concepts. Use of a scale about attitudes toward sexual orientation minorities and concluding that the intervention improved attitudes toward trans patients invalidated the study findings.

Clinicians’ and students’ attitudes and beliefs. Along with knowledge gaps, attitudes and beliefs about trans persons have been disseminated in the literature. Lim and Hsu (2016) conducted a literature review of nursing students’ attitudes toward LGBT persons. Based on their final sample of twelve articles, spanning from 1981 to 2016, the authors concluded that studies published before 2000 showed very negative attitudes toward LGBT persons, indicating some improvement after 2000. The vast majority of articles reviewed focused on homophobia,

failing to mention trans persons. Other studies found correlations among attitudes toward various types of minorities, such as racial minorities and sexual orientation minorities. Similar to other literature discussed in this review, this article consistently utilized the LGBT acronym when the studies clearly only pertained to sexual orientation and not to trans persons. The authors of the review did not acknowledge transinvisibility.

In contrast, a national cross-sectional survey by Brown, Keller, Brownfield, and Lee (2017) specifically examined 265 undergraduate nursing students' attitudes toward trans patients in relationship to their affective transcultural self-efficacy levels and prior contact with trans persons. They also examined correlations between nursing student characteristics and trans prejudice, exploring the variables of openness to experience, empathic concern, perspective taking, and attribution of controllability. The researchers employed robust measurements using six valid and reliable instruments. Two percent of the sample identified as trans or gender nonconforming, and nine percent identified as a sexual orientation minority.

Brown et al. (2017) concluded that affective transcultural self-efficacy was positively correlated with receiving lecture or formal presentation on trans issues ($r = .18$, $p < .01$), viewing films about trans persons ($r = .23$, $p < .01$), and personally knowing trans persons ($r = .14$, $p < .05$). Lee also concluded trans prejudice was significantly inversely correlated with openness to experience ($r = .19$, $p < .01$), empathy ($r = .18$, $p < .01$), perspective taking ($r = .29$, $p < .01$) attribution of controllability ($r = .55$, $p < .01$), and affective transcultural self-efficacy ($r = .20$, $p < .01$). While the conclusions were logical, they do not seem to be fully supported in the correlation matrix, as some appeared to be positive, rather than negative, correlates. Interestingly, multiple regression analysis revealed attribution of controllability was the most influential predictor of trans prejudice ($\beta = -.491$, $p < .001$). This illuminated the need for many

individuals to have a biological, scientific explanation for gender differences to change their attitudes.

Like Brown et al. (2017), Kanamori and Cornelius-White (2016) recognized the importance of unambiguously studying attitudes toward trans persons, though they expanded their study to healthcare workers. In this cross-sectional, national survey, 243 respondents were grouped into three categories: (a) doctoral, which included physicians, pharmacists, dentists, and audiologists; (b) nurses, including nonprofessional assistive personnel and advance practice nurses; and (c) other healthcare providers, such as medical technicians, massage therapists, and pharmacy technicians. Respondents completed the Transgender Attitudes and Beliefs Scale (TABS) developed by Kanamori, Cornelius-White, Pegors, Daniel, and Hulgus (2017). The TABS is a 29-item instrument with demonstrated reliability and validity. It has three subscales measuring (a) interpersonal comfort regarding trans persons, (b) sex and gender beliefs, and (c) human value of trans persons. Kanamori and Cornelius-White (2016) found the mean TABS score was above the midpoint, with females scoring significantly higher than males on all three TABS subscales. There were no significant differences in TABS scores among the three categories of healthcare providers. However, it was questionable to place unlicensed nursing staff and doctorally prepared nurses into one category, which may invalidate these findings.

To draw comparisons with historical findings, Kanamori and Cornelius-White's (2016) survey included three additional items used in studies in the 1960s and 1980s, along with the TABS. These items were as follows:

- "A transgender person is, by definition, morally depraved."
- "Transgender persons would be better off if they gave up their desire for surgery."

- "Sex reassignment surgery is ultimately harmful to the mental health of transgender persons" (Kanamori & Cornelius-White, 2016, p. 171).

Ten percent of respondents agreed with the statement that transgender persons were morally depraved, but this was not significantly more than the 8% who agreed with the statement in the 1960s. However, the latter two historical items included in the survey revealed that healthcare provider attitudes toward gender affirmation surgery were much more positive compared to historical study results from the 1980s.

This review revealed several quality instruments exist to measure attitudes toward trans persons, but there was a notable absence of studies assessing the attitudes of college personnel. However, studies addressing the preparedness of healthcare professionals to care for trans patients painted a bleak picture; there is a lack of social knowledge that presents challenges in basic interactions, as well as a lack of clinical knowledge. It is logical to correlate healthcare professionals' unsatisfactory preparation with faculty knowledge and attitudes about trans persons, though there is no empirical evidence known to support this supposition. It is imperative healthcare professionals and educators become better prepared to address mental health, social vulnerabilities, financial concerns, and the basic safety of trans persons.

Employment and Academic Experiences of Trans Persons

Because of the paucity of literature describing experiences of trans nurses or nursing students, this literature review included experiences of trans persons in academic and employment settings, in general. Seven major themes were noted and will be subsequently described. The themes were (a) masking versus coming out, (b) identity and transition, (c) names and pronouns, (d) discrimination and transphobia, (e) physical spaces, (f) policies, and (g) coping and resilience.

Masking versus coming out. Trans college students discerned when to mask, or conceal, their gender identities and when to "come out," or disclose, as a measure of self-care and self-protection (Goldberg & Kuvalanka, 2018; Nicolazzo, 2016; Pryor, 2015). This was illustrated in one striking participant comment in Goldberg and Kuvalanka's (2018) qualitative study of nonbinary trans college students:

> Entering any situation where the question of my gender comes up…a discussion, or ticking a box, or writing it – it's annoying that I have to think about how, in this moment, do I care more about being truthful and honest, or maneuvering myself through the world easily? (p. 122)

Pryor (2015) examined the lived experiences of five transgender college students at a large, public research university. The theme "coming out" was important as participants expressed this was crucial to living as their authentic selves. The theme emerged as participants clearly described selectively determining whether to mask their trans identities or be open about their identities. Some courses in the social sciences were perceived as safer than others, but students often feared being "outed" by faculty misuse of names or pronouns, or by their personal vocal qualities when asked to speak in class.

In the same manner, trans persons masked their genders to protect against stigma in workplace settings. Mizock and Dawson Woodrum et al. (2017) employed grounded theory design to explore coping strategies of trans persons in their places of employment. Participants reported gender detachment and modifying gender performance as methods of self-protection. For example, they altered gender expression via clothing or vocal tone, or they enhanced feminine or masculine gender performance as needed to conceal trans identities.

Given that clinical learning experiences in health professions uniquely connect education to real workplaces, students are presented with vital opportunities for professional socialization and networking. In clinical settings, LGBT students have masked their sexual and gender identities due to fear, withdrawing and self-isolating in these settings. Rondahl (2011) purportedly interviewed Swiss LGBT persons studying medicine or nursing during 2007; however, this conflicted with the demographic report indicating none of the participants identified as trans. Participants testified to efforts to conceal their sexual orientations when in clinical learning environments. For instance, they avoided informal conversations and "coffee room chat" for fear of outing themselves. Consequently, medical students described their clinical training as lonely, feeling marginalized from conversations about life outside of academia and healthcare. Students were particularly cautious coming out to individuals in positions of authority, such as faculty or clinical supervisors, fearing discrimination.

Identity and transition. Identity navigation is a central focus in the lives of trans persons. Authentic expression of gender identity promotes a sense of relief and strengthened relationships for trans persons (Stewart, O'Halloran, & Oates, 2018). However, according to Austin's (2016) study, the journey of authentic gender identity has been characterized by confusion, invisibility, pain, marginalization, and isolation. Austin used grounded theory methods and individual interviews to determine how youth and young adults experienced their emerging trans identities. The first theme identified involved progressing from uncertainty and confusion about how they were different to eventually knowing themselves to be trans. Goldberg and Kuvalanka (2018) discovered that the college environment was often where this first step occurred. College provided participants of Goldberg and Kuvalanka's (2018)

qualitative study the freedom to explore their gender identities while offering conceptual tools and frameworks to make sense of their gender identities.

Austin's (2016) second theme was recognizing self in others, whereby participants reported feeling validated and hopeful upon meeting and interacting with other trans persons; this was true even of suicidal participants. The process often occurred silently and invisibly via internet sites and social media. Though Goldberg and Kuvalanka's (2018) participants also noted this process of connecting with other trans persons usually began online, they found that college campuses offered additional offline networking opportunities through LGBTQ campus groups.

Third, navigating gender identity involved the theme "finding me," described as, "the powerful experience of seeing and feeling congruence between one's internal and external sense of gender" (Austin, 2016, p. 219). In other words, this involved altering external gender expression to better align with the individual's internal sense of gender, known as *transition*. Martinez, Sawyer, Thoroughgood, Ruggs, and Smith (2017) discussed two facets of this congruence. First, relational authenticity refers to the congruence of one's internal sense of gender with others' perceptions of the individual's gender. Second, action authenticity refers to implementing behaviors that are congruent with one's internal sense of gender. Relational and action authenticity involved some degree of transition, at least in some contexts (Austin, 2016).

Gender transition is an individual process that may be fluid or a defined trajectory to alter one's gender expression. Gender transition consists of social, medical, surgical, and legal facets. Trans persons may choose to transition their genders in some, all, or none of these facets. Social transition refers to altering names, pronouns, and salutations to align with authentic gender (Keo-Meier & Ehrensaft, 2018). Medical transition may involve puberty-blocking medication and

masculinating or femininizing hormones (Keo-Meier & Ehrensaft, 2018). Surgical transition may include facial, chest, and genital alterations (Keo-Meier & Ehrensaft, 2018). Other physical transition includes aesthetic and cosmetic procedures; vocal and speech modification training; and modification of gender expression through mannerisms, attire, cosmetics, or other noninvasive physical transformations (Eliason & Chinn, 2018). Legal transition involves changing name and gender markers on identification and other legal documents (Keo-Meier & Ehrensaft, 2018).

Transition has been associated with many positive outcomes for trans persons, such as improvements in mental health, social relationships, and intimate relationships (McCann & Brown, 2018). Even the initial steps of transitioning have been characterized as coming "out of the depths of despair" (Wells, 2018, p. 1552). Furthermore, a review of the literature supported that the incidence of anxiety and depression, though found to be higher in trans persons pre-transition than in the cis population, equalized following medical transition (Dhejne, Van Vlerken, Heylens, & Arcelus, 2016).

Not only has gender transition impacted psychosocial well-being, it has also been associated with improved professional experiences. Dickey, Walinsky, Rofkahr, Richardson-Cline, and Juntunen (2016) studied the relationship between transition status and career self-efficacy, including vocational selection, perceived ability to obtain career information, goal selection, job searching and resume building, and problem-solving to overcome barriers. Post-transition participants had significantly higher total career self-efficacy scores, compared to pre-transition participants ($t(122)= -3.54$, $p < .05$). Meanwhile, employment status of participants had no significant difference in career self-efficacy, with the exception of higher perceived ability to obtain career information. In contrast, the participants' interview self-efficacy scores

remained low with no significant differences based on transition status. One may surmise low interview self-efficacy stemmed from continued internal conflict related to masking, coming out, and/or passing in their new identities.

While Dickey et al.'s (2016) findings illustrated that transition status may impact perceived ability to select and obtain a career, Martinez et al. (2017) utilized a mixed methods approach to examine the relationship between authentic identity expression and job satisfaction among employed trans persons. Through semi-structured interviews with 17 trans employees, the overall theme was the importance of transitioning; participants viewed transitioning as critical to their professional lives and inevitable regardless of support in the workplace. Martinez et al.'s (2017) quantitative survey data from 199 trans persons indicated the extent of gender transition of each respondent was significantly, positively related to perceived fit with their employing organization and negatively correlated to perceived discrimination. Extent of transition was also positively correlated with job satisfaction, though this relationship was not statistically significant.

Though gender transition has been associated with positive outcomes, the transition process has presented feelings of trepidation. College students considering gender transition reported concern for how others in the college community wouldM perceive and accept the changes (Goldberg & Kuvalanka, 2018). This sentiment was also expressed by trans teachers in primary and secondary education in Wells' (2018) qualitative life history interviews. All three participants were concerned about losing their teaching positions upon presenting an authentic identity in their workplaces, but they viewed the alternative as unbearable (Wells, 2018).

In both college and workplace settings, trans persons also experienced barriers to the transition process. Owens and Wargo (2017) discussed challenges for trans dental students,

including the financial burden of gender transition, and that medical transition may necessitate excessive medical appointments requiring a leave of absence from academics. In fact, some trans persons have felt such a strong desire to medically transition that they have circumvented financial barriers by obtaining hormone therapy from the black market and without any medical oversight, clearly creating additional health concerns (McCann & Brown, 2018; Stewart, O'Halloran, & Oates, 2018).

Similarly, in Wells' (2018) life history interviews of primary and secondary teachers, two participants discussed framing their transitions as a medical necessity in order to garner support in the workplace. One participant readily adopted the psychiatric diagnosis of "gender identity disorder" which allowed her to take a desired leave of absence, fostering incremental transition outside of the workplace. Another participant, who medically transitioned in 2004, utilized a medical framework to secure support from the administrative team, allowing her to move to a teaching position within a new school in the district, resulting in new peers and students post-transition. These approaches may also be useful for transitioning college students, under the protection of federal law.

The fourth theme in navigating gender identity recognized by Austin (2016) was struggling for authenticity. This theme emerged as trans participants discussed ongoing barriers to living as their authentic gender identities. Mizock and Dawson Woodrum et al.'s (2017) work supported this theme as employed trans participants discussed emotional disengagement from gender at work to avoid transphobic experiences and protect against not being affirmed in their identities. Not surprisingly, this coping strategy has demonstrated limited effectiveness. One participant in Simmons' (2017) national qualitative study of trans faculty acknowledged the

impact of suppressing the desire to advocate for trans persons: “I don’t feel like my whole self is really in this space, in this work, and that really, really bothers me and hurts me” (p. 279).

Struggling for authenticity was also evident in Goldberg and Kuvalanka’s (2018) study of nonbinary trans college students, highlighting the complexities of identity authenticity and affirmation. Participants simultaneously felt rejected by both the cis and trans communities, being deemed “too trans” in terms of disrupting the gender binary and “not trans enough” in terms of not pursing a transition to identify as a man or a woman. Within the trans community, the nonbinary individuals reported they were labeled as less legitimately trans. This sentiment was echoed in Simmons’ (2017) qualitative study of trans educators from colleges and universities across the U.S. Some educators discussed feeling pressured to prove an “identity resume” (p. 278) in order to feel included within campus LGBTQ groups.

The final theme that emerged from Austin’s (2016) work was evolving self-acceptance of the trans identity, even within contexts in which individuals were stigmatized. Some educators in Simmons’ (2017) work discussed using their identities to teach students despite microaggressions they frequently experienced in the workplace. One participant commented, “I know I have trans* students in the audience who are looking for any indication that they are okay and that they are loved and accepted…” (Simmons, 2017, p. 277). Another participant described personal stories and identities as educational tools and methods of fostering change.

Names and pronouns. The importance of using gender-affirming names and pronouns of trans persons was a prevalent theme in the literature. Nicolazzo’s (2016) ethnography of trans college students revealed that participants become emotionally exhausted by continually being misgendered, leading to social withdrawal or even substance use. Simply addressing and referring to trans persons by their affirming names and pronouns had a major impact.

Colleges have long-utilized systems and processes that create barriers to utilizing affirming names and pronouns of trans persons (Austin, Craig, Dentato, Roseman, & McInroy, 2019; Goldberg & Kuvalanka, 2018; Pryor, 2015; Seelman, 2014; Woodford, Joslin, Pitcher, & Renn, 2017). For example, records and registration systems, which are integrated with learning management systems, email addresses, and course rosters, required the use of one's legal name and were problematic in outing trans persons during roll call (Linley et al., 2016; Pryor, 2015), in online discussion forums (Pryor, 2015), or in email communications (Woodford et al., 2017). In Austin, Craig, Dentato, Roseman, and McInroy's (2019) study of trans and gender nonconforming social work students, participants cited systems used in higher education with the intention of categorizing students into the gender binary as a form of structural oppression and a microaggression at the institutional level. As a result of such systems, some trans college students felt especially vulnerable in online settings as well as during roll call (Pryor, 2015). In response, trans students strongly recommended efficient and easy processes for students to change their first names within university systems regardless of legal first name, with seamless integration throughout all registrar, learning management, and email systems at the college (Goldberg & Kuvalanka, 2018; Seelman, 2014).

The recommendation by trans students raises the question, "How do educational institutions enable students to identify affirming names, genders, and pronouns within college records and registration systems?" In 2015, an international survey sent to member schools of the American Association of Collegiate Registrars and Admissions Officers (AACRAO) sought an answer (AACRAO, 2015). With a sample of 880 institutions representing 16 countries, nine Canadian provinces, and all 50 states in the U.S., about 10% of colleges reported that they allow students to select affirming pronouns. Though 49% reported allowing students to select their

genders, the options were almost always limited to the male-female binary. About 63% indicated it was possible for a student to select their affirming names through the registrar's office or admission application, though there were vast differences in the locations these names could be displayed, such as students' identification cards, class rosters, transcripts, or diplomas.

College use of gender binary forms, such as the admission application, have been significantly associated with the academic outcomes of trans persons including learning satisfaction, academic challenges, and academic engagement (Woodford et al., 2017). Moreover, Marine (2017) has named the college application as a critical juncture in accessing college, whereby trans students encountering cisnormativity and the gender binary may be compelled to enroll elsewhere. The Consortium of Higher Education LGBT Resource Professionals (2015) recommends all colleges gather information about gender identity and sexual orientation on the admission application as institutions have the responsibility to trend the identities of students applying, gaining admission, enrolling, and graduating. Numerous colleges across the U.S. utilize the Common Application, which asks applicants to identify their sex as either male or female (Marine, 2017). Colleges using this application should supplement custom questions about gender and sexual orientation (Consortium of Higher Education LGBT Resource Professionals, 2015). Furthermore, the Consortium emphasized that gender identity must be treated as a construct separate from sexual orientation, warranting two separate questions that span an inclusive, nonbinary list of labels, along with the options of "additional category/identity" and "prefer not to disclose" (Consortium, 2015, p. 1).

Regardless of the efficiency of systems in capturing authentic gender identifiers, trans college students have reported that faculty and staff in academic settings often refuse, resist, or otherwise fail to utilize gender-affirming names and pronouns (Austin et al., 2019; Goldberg &

Kuvalanka, 2018; Pryor, 2015; Stewart, O'Halloran, & Oates, 2018). This type of microaggression made trans persons feel marginalized, as did faculty adherence to binary views of gender (Pryor, 2015). In Goldberg and Kuvalanka's (2018) qualitative study of nonbinary trans college students, additional challenges with proper pronoun use were evident. Most of the participants affirming "they" or "them" pronouns, but they noted the grammatical conflicts this generated in English language. Furthermore, one participant indicated it was often easier to simply accept the pronoun and name others assigned to avoid egregiously inappropriate follow-up questions and comments, sometimes related to private anatomy.

On the other hand, participants felt validated and safe when faculty utilized gender-affirming names and pronouns and intervened when trans prejudice was apparent in the classroom (Linley et al., 2016; Pryor, 2015;). Linley et al. (2016) analyzed a subset of qualitative data from a large mixed-methods, national study that included 900 quantitative surveys and 60 semi-structured interview transcripts of LGBTQ undergraduate and graduate students. Faculty support of LGBTQ college students emerged as an important theme, which included both formal and informal interactions. Use of gender-inclusive language and avoidance of the gender binary were simple and meaningful demonstrations of support in the classroom. Not only did participants discuss the validation felt when faculty utilized affirming names and pronouns, they also reported that it was supportive when faculty sought to learn students' affirming names and pronouns. Based on the data, the simple gesture of asking for affirming names and pronouns of students created a safe space, conveying acceptance of gender on a spectrum and rejecting a cisnormative learning environment.

Discrimination and transphobia. Discrimination, stigma, harassment, and microaggressions stemming from transphobia have been reported by trans persons as prevalent

problems in education and employment. McCann and Brown's (2018) systematic review of trans persons' vulnerabilities revealed that approximately 70% of trans persons have been victims of transphobia ranging from microaggressions and stigma to acts of violence. Transphobia is defined as feelings or expressions of discomfort, disapproval, disgust, fear, anger, or hatred toward people who do not conform to societal gender norms (Eliason & Chinn, 2018). Commonly, trans persons perceived they were negatively regarded in society as freaks, imposters, sexual deviants or predators, and mentally ill individuals (Rood et al., 2017). Because of these perceptions, trans persons often internalized the stigma (Rood et al., 2017).

These negative perceptions and experiences of trans persons begin at a young age. Ullman (2017) surveyed 704 LGBTQ high school students in Australia; 7% identified as trans. Nearly 90% of trans students reported witnessing transphobic language in school, compared to 57% of their cis peers ($x^2(1,669)=19.49$, $p < 0.001$). This variance may be indicative of cis privilege and cis students' inattention to transphobic language. In contrast, the variance may be indicative of trans students' minority stress processes (Meyer, 2003). In Ullman's (2017) study, trans students were significantly less likely to report that their teachers were supportive of gender diverse students, with 43% of trans students reporting their teachers were never positive or supportive. Witnessing transphobia and the perceived level of teacher support were explained variances in the participants' feelings of connection to their schools. Comparatively, Pryor's (2015) qualitative study of trans college students revealed that lack of support, microaggressions, and overt harassment were common experiences, leading to withdrawal from classes, academic majors, and student organizations. Furthermore, students chose not to enroll in courses or majors that are inherently gendered or known for gender stereotypes, gravitating toward majors and coursework known to be more open-minded.

Schneider and Dimito (2010) sought to gain deeper understanding of how discrimination influenced the academic and career choices of LGBT persons. They recruited 119 survey respondents via a research booth at Campus Pride events for LGBT students. Graduate students comprised 28% of the sample, undergraduate students 59%, and high school students 12%. Respondents conveyed high levels of discrimination and violence as 68% reported they had been verbally abused, and 61% reported they had been physically assaulted due to their LGBT identities. Respondents who reported the greatest impact of discrimination were most likely to seek out LGBT-positive settings, including universities regarded as LGBT-friendly ($F(2, 118) = 10.29$, $p < .001$) and careers regarded as LGBT-friendly ($F(2, 118) = 20.14$, $p < .001$). Additionally, they were more likely to report selecting colleges and careers based on their reputations as LGBT-friendly.

Indeed, college and vocational settings vary in their acceptance of trans persons. Freitas (2017) surveyed 184 college students attending five different educational institutions, one of which was an all-women's college. Approximately 10% of respondents identified as trans. Cis respondents reported greater institutional support and overall satisfaction with their learning experiences than did trans respondents. Therefore, it is not surprising that trans students reported significantly higher rates of discrimination compared to cis students ($t(182)=4.19$, $p <0.001$, two tailed). Of interest, students attending women's colleges reported significantly more positive experiences than trans students at co-ed colleges. The authors attributed this finding to the historically feminist missions of women's colleges, "which call for deconstruction of oppressive gender norms…. challenging normativity" (Freitas, 2017, p. 306).

In contrast, experiences of transphobia in the female-dominated health profession of social work were prevalent, according to Austin, Craig, and McInroy's (2016) mixed methods

study. They analyzed responses from 97 trans students, which was a subset of 1,310 social work student survey respondents in the U.S. and Canada. The parent study was called "Social Work Speaks Out" and included both quantitative and open-ended qualitative items. Unfortunately, 43% of respondents indicated they had experienced transphobia within their school of social work, and 40% perceived their faculty as transphobic. However, 55% felt the majority of faculty were supportive of trans issues. Notably, clinical learning experiences were most problematic as 60% reported gender-related conflict in those settings.

Austin et al. (2016) used grounded theory methods to glean themes from the qualitative data, which included transphobic microaggressions and intentional harm. Microaggressions were more common, and examples included lack of trans-specific education in the curricula and lack of trans support structures. Microaggressions by faculty included lack of responsiveness to evidence of transphobia and incompetence in teaching trans content. Respondents testified the pathologizing of trans persons occurred as gender dysphoria was discussed strictly as a DSM-5 diagnosis alongside paraphilias.

Intentional harm was perceived by student respondents when they felt victimized or intentionally discriminated against. For example, one respondent reported that faculty showed a transphobic video to students for amusement. Other students reported that faculty and clinical staff were resistant to using their affirming names, pronouns, or gender-neutral pronouns. Additionally, one respondent experienced clinical staff making transphobic comments based on the student's gender expression (Austin et al., 2016).

It is not surprising that trans health professionals remain susceptible to discrimination after entering the workforce. Eliason, Dibble, and Robertson (2011) surveyed 228 LGBT physicians, only 1% of whom identified as trans. One-third of physician respondents conveyed

they had witnessed discrimination of LGBT peers in their workplaces, and 15% reported personally experiencing harassment by colleagues. The majority of respondents personally experienced discrimination in the work place; for example, 65% overheard negative comments about LGBT identities, and about one-third witnessed discriminatory care of LGBT patients or their partners. Some respondents believed their LGBT identities negatively impacted their career trajectories. They identified the following impacts: termination of employment (3%), denial of employment (8%), denial of admission to an education program (5%), and denial of patient referrals (10%).

Because of workplace discrimination, one manner in which trans persons coped was to avoid such settings. For example, trans persons have reported electing self-employment or leaving a discriminatory workplace in favor of a trans-affirming environment (Mizock & Dawson Woodrum et al., 2017). In other instances, workplace discrimination has led to unemployment of trans persons (McCann & Brown, 2018). Likewise, due to the pervasive harassment and discrimination in education settings, trans college students have been compelled to withdraw from their educational institutions (Stewart et al., 2018).

Transphobic experiences also negatively impact the holistic health of trans persons. Feelings of anger, frustration, sadness, fear, anxiety, and marginalization have been reported (Rood et al., 2017; Stewart et al., 2018). Subsequently, self-concept and self-worth deconstruct, leading to loneliness, social isolation, and self-harm (McCann & Brown, 2018; Rood et al., 2017; Stewart et al., 2018).

Physical spaces. Accessibility of gender-inclusive physical spaces, such as restrooms and residential housing has been associated with trans college students' academic outcomes (Woodford et al., 2017). In Woodford et al.'s (2017) study of microaggressions on college

campuses, trans students reported that the efforts to hide their trans identities within gender binary spaces was so stressful that they wanted to transfer to different colleges. Trans college students have indicated that consistently grouping gender minorities with sexual orientation minorities has not always felt safe, as sexual orientation minority spaces may be viewed as binary. Specifically, housing environments were noted as potential exposure of trans identities (Seelman, 2014). For example, one participant in Woodford et al.'s (2017) study noted her request to be assigned a dormitory room with another trans student resulted in the college assigning a gay cis male to be her roommate. While she appreciated that her roommate seemed trans-friendly, the college apparently lacked understanding of gender-inclusive housing.

According to participants in Goldberg and Kuvalanka's (2018) study, it is imperative college campuses integrate gender-inclusive or gender-neutral restrooms throughout campus while still retaining some female-only or male-only restrooms to promote a sense of safety. When present, gender-inclusive restrooms have been noted to frequently lack accessibility due to inconvenient and segregated locations (Woodford et al., 2017). Trans college students and faculty recommended single occupancy, gender-neutral restrooms, along with changing the signage so it does not reflect the gender binary (Seelman, 2014). With this in mind, a simple graphic of a toilet would be appropriate signage. Furthermore, trans persons have stressed the importance of implementing gender-inclusive spaces in a way that does not out individuals (Seelman, 2014).

Policies. Trans faculty and students have explained the importance of policy development to protect against discrimination. Specifically, colleges need to include trans persons in non-discrimination policies (Case, Kanenberg, Erich, & Tittsworth, 2012; Seelman, 2014). Case, Kanenberg, Erich, and Tittsworth (2012) conducted participatory action research in

order to describe the challenges, strategies, and influences of privilege and power encountered during the process of adding gender identity to one university's nondiscrimination statement. Their research team consisted of one trans student in the field of social work and three faculty allies. The main challenges they overcame were conceptualizations of gender and misunderstanding that nondiscrimination statements should be limited to protections mandated by law. To overcome these barriers, the change agents educated stakeholders about gender and trans persons, dispelling myths. A second strategy was to focus on relationship building using open and therapeutic communication techniques, such as clarifying and reflecting statements when interacting with individuals displaying transphobia. Finally, they saw value in "burning gender-inclusive language into the university's history and life" (Case et al., 2012, p. 155) through discussions within university committees, ensuring documentation in official university minutes.

Once nondiscrimination polices address gender diversity, it is essential for colleges to hold people accountable to the policy (Seelman, 2014). Ignorance and incompetence cannot be excuses for discrimination (Seelman, 2014). Trans persons have recommended that colleges designate a specific point person on campus to whom they can report discriminatory experiences (Goldberg & Kuvalanka, 2018; Seelman, 2014). Moreover, such nondiscrimination policies should permeate college practices, including recruitment and retention of trans students, faculty, staff, and administrators (Goldberg & Kuvalanka, 2018).

Coping and resilience. In light of pervasive discrimination, coping and resilience of trans persons have received attention in the literature. Trans persons have reported resilience strategies to overcome negative social messages (Rood et al., 2017). Some reach a state of acceptance in which they have felt unaffected by discrimination and stigma (Rood et al., 2017).

To achieve this, some trans persons expressed they needed to develop personal coping strategies, including a strong support network such as membership in LGBTQ groups (McCann & Brown, 2018; Stewart, O'Halloran, & Oates, 2018). Another strategy trans persons have used is self-education about approaches to securing employment, and accessing health and other support services (Stewart et al., 2018).

Nicolazzo (2016) employed an ethnographic approach to illuminate the resilience of trans college students and the gender norms they encounter. The researcher observed nine trans student participants, two to three days per week, over the course of 18 months, in addition to a one-on-one interview each semester. The participants practiced resilience repeatedly and in various contexts in response to cisnormativity and gender binary discourse, though they did not always recognize this in themselves. There were notable differences in degree programs, limiting participants' abilities to practice resilience in some settings. One way in which resilience was practiced was by not living on the college campus due to pervasive gender binary discourse. Resilience was tested by intersectionality of gender and another identity vulnerable to discrimination. For example, one participant was diagnosed with fibromyalgia, taxing her coping skills and normal resilience strategy of escaping campus.

Nicolazzo (2016) also found kinship networks fostered resilience. Close-knit groups of like-minded peers were accessible in physical and virtual spaces, serving as refuges from cisnormative and gender-binary thinking. Some were drawn solely toward virtual kinship networks, with one participant stating, "I exist primarily on the internet, you know? That's pretty much my hometown" (Nicolazzo, 2016, p. 552). Most participants had more than one kinship network, and not all individuals in these networks were trans. Some participants felt

their academic departments and classrooms offered kinship, while others held the opposite viewpoint. However, it was noted that trans-only spaces were valuable in offering support.

Mizock and Dawson Woodrum et al. (2017) reported different coping strategies trans persons utilized in the workplace in response to transphobia. First, participants discussed efforts to preserve relationships, such as attempting to understand the perspectives of those demonstrating transphobia, or through intentional selectivity of when to self-advocate based on their perceived ability to impact change. Second, they mobilized external resources after internal resources, like supportive supervisors and human resources, failed to promote positive change. However, participants avoided internal resources if they were perceived as unsupportive. Third, participants worked even harder and self-sacrificed to try to overcompensate for workplace discrimination, or, at times, they intentionally focused on work details to distract from transphobia. Fourth, some participants coped by taking calculated risks to enhance their abilities to impact change through advancing education or pursuing leadership roles. On the other hand, they also understood that trans advocacy in the community could negatively impact their employment.

In addition to the positive strategies listed, some trans persons adopt maladaptive coping strategies. In the workplace, trans persons have described using maladaptive coping like self-isolation, suppression of resentment, and avoidance in response to transphobia (Mizock & Dawson Woodrum et al., 2017). While Mizock and Dawson Woodrum et al. (2017) noted these strategies may have short-term benefits, they likely result in long-term consequences. For example, McCann and Brown (2018) reported that substance use was a maladaptive coping strategy utilized by trans persons in response to self-isolation and loneliness.

Living as their authentic selves is key to the health and wellbeing of trans persons. Coming out and gender transition are perceived as risky, yet necessary, for an authentic identity; however, the alternative of masking identity is stressful and involves fear of being outed. Once out, trans persons face a great deal of discrimination in academic and workplace settings. Ensuring use of affirming names and pronouns, offering gender-neutral spaces, and implementing gender-inclusive policies are simple and meaningful ways institutions can support trans persons. These types of supports may very well impact recruitment and retention of trans students and employees, though this was not explicitly discovered in the literature review.

Influencing Knowledge, Attitudes, and Behaviors Regarding Trans Persons

The literature pointedly indicated the need to educate college faculty, staff, and students regarding contemporary conceptualizations of the gender spectrum and trans identities. Nonbinary trans persons recommended that faculty and staff specifically receive mandatory education about nonbinary identities and appropriate ways to solicit affirming names and pronouns of students (Goldberg & Kuvalanka, 2018). In order to ensure all students on college campuses and the members of U.S. society broaden their conceptualizations of gender, some trans persons feel that gender studies courses should be required within undergraduate curricula (Goldberg & Kuvalanka, 2018).

Burden to educate others. The call to educate about the gender spectrum and trans identities partly stems from the burden and exhaustion trans persons experience from continuously educating as a measure of self-advocacy (Austin, 2016; Austin et al., 2016; Goldberg & Kuvalanka, 2018; Nicolazzo, 2016; Pryor, 2015). Being undesirably placed in the position of gender expert has resulted in trans persons feeling tokenized and objectified (Austin et al., 2016; Goldberg & Kuvalanka, 2018; Nicolazzo, 2016; Pryor, 2015). They have testified to

"demands to witness, explain, and defend their gender [identity and expression]" (Goldberg & Kuvalanka, 2018, p. 122). This burden to educate has resulted from direct pressure, such as faculty using the trans student as an example in class, or indirect pressure due to faculty ignorance about gender and trans health (Austin et al., 2016). In addition to exhaustion, trans persons have expressed that the burden to educate made them vulnerable to marginalization and harassment (Pryor, 2015).

Methods of education. Ameliorating bias is daunting, and more research is needed to determine effective methods. However, a few authors offer guidance to influence knowledge and attitudes toward trans persons. Parent and Silva (2018) conducted a cross-sectional survey of 282 college students to determine relationships between critical consciousness, transphobia, and voting behavior. Critical consciousness refers to empathy toward marginalized and minority groups, and the social justice efforts aimed to mitigate sociopolitical oppression. College students responded to two valid and reliable instruments designed to measure critical consciousness and transphobia: (a) the Contemporary Critical Consciousness Measure and (b) the Transphobia Scale. They also answered one item about whether they would vote in favor of a fictitious legislative bathroom bill discriminating against trans persons. Higher Transphobia Scale scores were associated with about five-times greater likelihood of voting in favor of the bathroom bill and a three-times greater likelihood of abstaining from voting. Conversely, for every one unit increase in participants' critical consciousness scores, the odds of voting against the bathroom bill increased by two. Because critical consciousness was found to mitigate the relationship between transphobia and voting behavior, the authors concluded that interventions aimed at growing critical consciousness may foster trans-inclusive behaviors.

With this intention, Tunac De Pedro, Jackson, Campbell, Gilley, and Ciarelli (2016) implemented a series of sociocultural learning activities regarding trans persons. They aimed to determine whether the activities impacted the critical consciousness of education major college students. The first intervention involved critical reflection on evidence of transphobia and cis privilege in filmed interviews of prominent trans persons. The second intervention was designed to stimulate each student's sense of political efficacy through formulating examples of institutional reinforcement of transphobia and cis privilege. This was followed by a gallery walk of the examples. The final intervention was role-playing strategies for crafting and enacting trans-inclusive institutional policies. Following the activities, students engaged in critically reflective writing assignments analyzed by the course faculty, who asserted the reflections demonstrated evidence of critical consciousness. The anecdotal article included interesting strategies and instruments that could be used with a pretest and posttest intervention design.

Similarly, Baker, Hurula, Goodreau, and Johnson (2018) described integrating humanities to influence undergraduate teaching candidates' attitudes and knowledge regarding trans students. The authors used autoethnographic research methods to study poetic inquiry teaching and learning strategies to investigate issues of trans and intersex communities. They found that the art-based activities provided a safe space for the teaching candidates to evolve in their understanding and approach regarding gender diversity. Specifically, analysis of the creative works of teaching candidates revealed students evolved regarding: (a) confusion of terminology, (b) awareness of cis privilege, (c) understanding what advocacy might look like, and (d) understanding future challenges of trans persons within educational systems.

Mizock and Hopwood et al. (2017) employed a pretest and posttest interventional design using an author-developed transgender awareness webinar to influence 305 undergraduate

students and 158 mental health providers. Study participants responded to the Transphobia Scale before and after the webinar to measure influence on transphobia. In both participant groups, there was a significant decrease in transphobia scores, indicating the webinar was effective. Interestingly, the research also supported the notion that repeated education may have a lasting impact as the undergraduate students who reported they had prior education on trans topics had lower transphobia scores both pretest and posttest.

Comparatively, Walters and Rehma (2013) utilized an experimental design to examine whether viewing a film about the experiences of a trans child and the emergence of trans identity would influence knowledge and attitudes toward trans persons. The researchers randomly assigned 120 students at a single university to one of three conditions: (a) control group with no intervention, (b) treatment group that included 14 minutes of video, or (c) treatment group with the same 14 minutes of video, plus an additional 14 minutes of a different video. They used three psychometrically solid instruments to measure empathy, gender beliefs, and transphobia, along with one author-developed tool to measure trans knowledge.

Based on analysis of their data, Walters and Rehma (2013) discovered transphobia and extreme gender beliefs were positively correlated ($r = 0.69$, $p < .001$), while both measures were inversely correlated with empathy ($r = -0.29$, $p < .001$; $r = -0.43$, $p < .001$, respectively). Furthermore, transgender knowledge scores were negatively correlated with transphobia ($r = -0.33$, $p < 0.001$) and extreme gender beliefs ($r = -0.31$, $p < 0.001$). Transgender knowledge score means were statistically significant, with lowest scores in the control group and highest in the treatment group watching 28 minutes of video ($F(2,117) = 6.53$, $p < 0.002$).

Healthcare professionals, as well as college students and personnel, need education about gender pluralism and trans persons as a cultural group. Thus far, the burden to educate has fallen

to trans persons. Knowledge, attitudes, and behaviors toward trans persons may be influenced by film, sociocultural learning activities, critical reflection, and developing empathy and critical consciousness. However, little is known about the most effective methods or the duration of their impact.

Summary

Upon examining literature that focuses on trans college students or employees, and LGBTQ+ healthcare professionals or students, themes emerged. The first theme was that there are social and health disparities within the trans community, including mental illness, self-harm and suicidality, financial stress, and experiences with harassment and assault. Second, the academic and employment experiences related to individuals' trans identities are largely negative due to discrimination, but trans persons have demonstrated resilience and effective coping behaviors. Finally, healthcare professionals, students, and nursing faculty have demonstrated opportunities for growth in knowledge and attitudes toward trans persons.

Due to the prevalent use of the gender binary in survey research, the number of U.S. nurses or nursing students identifying as trans is unknown. No research publications addressed the recruitment or retention of trans persons into the nursing profession. Additionally, no research publications described the experiences of trans nurses or nursing students. No studies describing faculty attitudes toward trans students were found in this literature review. Meanwhile, leading national organizations have called for diversifying the nursing profession and improving cultural competence of healthcare providers serving trans patients. This literature review has established the need to begin filling the literature gap regarding trans persons as students in nursing programs.

CHAPTER III: METHODS AND PROCEDURES

This chapter presents the methods and procedures used for this phenomenological study. In addition, participant sampling, ethical considerations, data collection and analysis procedures are described.

Research Design

This qualitative study utilized a phenomenological research design: it sought to explore trans persons' experiences as students enrolled in prelicensure nursing programs. Phenomenology is useful in exploring the essence of common lived experiences shared by multiple individuals (Creswell, 2013). Due to the paucity of evidence on the topic, it was important to develop understanding of how trans students experience their nursing programs. Phenomenology combines subjective individual experiences of participants with the discovered common experiences of participants. Subsequently, the common experiences become objective experiences (Creswell, 2013). The principal investigator (PI) for this study engaged in private, individual, semi-structured interviews of participants to discover their experiences. Interviews were conducted using web-based videoconferencing using the Skype platform.

Population and Sample

The PI recruited participants using purposeful and snowball sampling methods. Purposeful, criterion sampling methods are necessary to recruit participants who have experienced the phenomenon being explored (Creswell & Creswell, 2018). Snowball sampling is a widely used method to recruit participants who are difficult to reach (Creswell & Creswell, 2018). Because there were no clear, direct channels for recruiting trans persons who have been enrolled in prelicensure nursing programs, and because evidence suggested trans persons often have kinship networks that include other trans persons, snowball sampling methods were

warranted. However, snowball sampling was not known to lead to participants in this study.

Phenomenology design requires a small heterogeneous sample to achieve the goal of discovering the universal essence of the phenomenon. While absolute sample size for phenomenology has not been established, Creswell (2013) recommends a range of three to 10, or up to 15 participants. Therefore, a minimum of three participants were sought for this study. The PI pre-determined that data collection would cease when one of the following conditions were met: (a) ten participants were interviewed; (b) at least three participants were interviewed, and no new themes were emerging from the data; (c) at least three participants were interviewed, and there were no additional prospective participants; or (d) at least three participants were interviewed, and the date was October 1, 2019. Data collection ceased on October 1, 2019, with a total of four participants.

Demographics

The following inclusion criteria applied to the sample: (a) age 19 or older; (b) read and spoke English; (c) self-identified as transgender, including, but not limited to trans male, trans female, gender-nonconforming, gender fluid, genderqueer, agender, two-spirit, or any other gender identity that does not align with the sex assigned at birth; (d) also self-identified as transgender while enrolled in a prelicensure nursing program; (e) enrolled in a U.S. prelicensure nursing program for at least one academic term between 2014 and 2019; (f) enrolled in at least one clinical nursing course between 2014 and 2019; (g) was able to either transport self to a mutually agreed upon interview site, or access and utilize videoconferencing technology for an online interview; and (h) had a cellular phone. Prospective participants were excluded if their prelicensure nursing programs were fully online. Online prelicensure nursing programs were excluded because they would not reflect the full range of lived student experiences this study

intended to explore. The range of characteristics of the participants and their nursing programs are depicted in Figure 2.

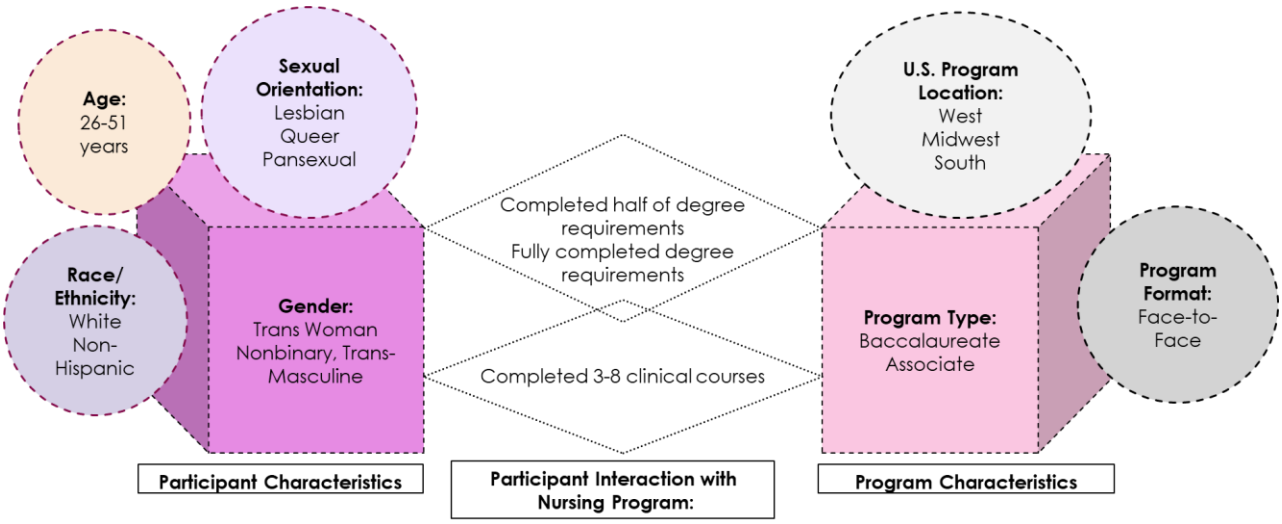

Figure 2. Participant and U.S. Prelicensure Nursing Program Characteristics. The range of participant characteristics appears in the left portion of the figure. The range of characteristics of the pre-licensure U.S. programs attended by the participants appears in the right portion of the figure. The central portion of the figure represents the range of interaction between the participants and their respective prelicensure nursing program.

Description of Setting

Recruitment settings for the study included health care clinics, academic resource centers, national consortia, support groups, and other community-based groups that serve LGBTQ+ individuals and groups. The principal investigator (PI) generated a list of 46 prospective recruitment partners through social networking, internet browsing, and professional organization membership benefits. The PI sent a letter of inquiry (Appendix B) to prospective recruitment partners the week of February 25, 2019, inquiring about their willingness to assist in distributing and/or advertising research recruitment information to prospective participants following IRB approval. A follow-up contact occurred the week of March 4, 2019, for prospective recruitment partners who did not respond to the first inquiry. Very few prospective partners declined, but several did not respond to the inquiry. The list of 17 recruitment partners who agreed to assist with recruitment flyer distribution are shown in Appendix D. This list

includes two national consortia; two state-wide LGBTQ+ resources; four therapists; two private businesses; one national LGBTQ+ speaker; two LGBTQ+ community-based groups; one trans community-based group; one campus LGBTQ+ group; one LGBTQ+ health center; and one speech, language, and hearing clinic.

Procedure

Following study approval by the Institutional Review Board of the PI's learning institution, the PI distributed participant recruitment flyers (Appendix C) to the agreeable recruitment partners, as well as to listservs and forums of national organizations as shown in Appendix D. The recruitment flyer directed prospective participants to contact the PI if interested in joining the study. Upon being contacted by prospective participants, the PI requested a telephone conversation to allow for dialogue following the telephone script in Appendix E.

The script opened with an explanation of the study purpose and a series of questions to determine whether the prospective participant met the study criteria. Those who met the inclusion criteria were invited to participate in an individual interview, in-person or using Skype videoconferencing technology. The interview modality, location (if applicable), date, and time were mutually agreed upon by the prospective participant and the PI as guided by the telephone script. When videoconferencing interviews were planned, the script also provided instructions for the prospective participant to establish a private environment with high-quality sound transmission. Additionally, the PI collected some basic demographic information of each prospective participant: (a) full name, (b) cellular phone number, (c) personal email address, and (d) city and state of residence. This personal information was recorded in a separate master list, and, henceforth, each participant was identified by a randomly generated three-digit code. The

PI explained how all information would be protected and utilized, including generation of an individualized *Adult Consent Form* for each participant. As part of the IRB requirements, each consent form provided specific emergency and emotional support services within a reasonable geographic distance of each participant. At the end of the phone conversation, the PI explained the use of an individualized encrypted Dropbox, unique to each participant to confidentially access the *Rights of Research Participants* as well as the *Adult Consent Form* prior to the interview. The PI sent an encrypted email to each prospective participant with the link to their unique Dropbox.

Data collection procedures. The PI obtained each participant's informed consent prior to collecting data. Participants selected a pseudonym for use during the interview and then provided basic demographic information, including (a) age; (b) gender; (c) ethnicity; (d) race; (e) sexual orientation; (f) prelicensure nursing program type, delivery format, and geographical location; (g) number of academic terms enrolled; and (h) number of clinical courses completed (Appendix F). Next, the PI followed an interview protocol (Appendix G) to ask a series of open-ended, semi-structured questions during the interviews:

1. Describe how you view(ed) your gender identity in relationship to your decision to pursue a career in nursing.
2. Tell me about your experiences as a trans person in terms of admission to the prelicensure nursing program.
3. Talk about the feel of the campus and your experiences outside of the classroom as a trans person in the prelicensure nursing program.
4. How would you describe your classroom (in-person and/or online) experiences as a trans person in the prelicensure nursing program?

- Prompt if needed: Describe your interactions with student peers and college personnel (faculty, staff, administrators) as a trans person enrolled in the nursing program.

5. Tell me about your experiences as a trans person in terms of progressing through various levels (e.g. courses, quarters, semesters) of the prelicensure nursing program.
6. How would you describe your clinical learning experiences as a trans person in the prelicensure nursing program?
    - Prompt if needed: Describe your interactions with clinical agency staff (nurses, physicians, etc.), patients, and patients' visitors as a trans person during clinical learning experiences.
7. (If applicable) Tell me about your experiences as a trans person when preparing to graduate from your prelicensure nursing program.
8. What else, if anything, should I know about your experiences as a trans person while enrolled in a nursing program?

Interviews were predicted to last approximately 60 to 90 minutes. Actual interview length ranged from 30 to 60 minutes, plus about 15 minutes to discuss participant rights and obtain consent. Upon conclusion of the interview, the PI provided each participant with a $5 Amazon electronic gift card as a token of appreciation for their time. The interviews were audio-recorded using two digital recorders. The digital files were provided to a hired transcriptionist, using an encrypted electronic Dropbox. Once each audio file was transcribed, the transcriptionist submitted the text files in the Dropbox. Transcripts were identified by each participant's three-digit code. The PI assigned each participant a new pseudonym in the transcripts and de-identified any specific individuals or places named.

Analytical procedures. The PI employed a systematic, iterative approach to phenomenological data analysis, as described by Creswell (2013). The PI read each transcript, as it was received from the transcriptionist, and subsequently identified significant statements. The PI winnowed the data using a two-cycle coding method (Saldaña, 2016). Through the coding process, the PI identified themes of *what* and *how* participants experienced the phenomenon (Creswell, 2013). At that time in the data analysis, the PI applied the validation strategy of member checking, asking for participant feedback on the PI's initial interpretations. The PI sent each participant an encrypted email with a link to a unique encrypted Dropbox containing the preliminary interpretations of themes and descriptions, requesting participant feedback. This strategy enhances the credibility of the interpretations of the data (Creswell, 2013).

Creswell (2013) recommended qualitative researchers use a minimum of two validation strategies in each study. In addition to member checking, the PI utilized three more validation strategies in the data analysis. First, the PI clarified personal bias through the process of reflexive journaling (Creswell, 2013; Saldaña, 2016). The PI engaged in reflexive journaling prior to and throughout data collection and analysis, allowing the PI to reflect deeply on personal experiences related to the phenomenon of trans persons enrolled in nursing school. The reflexivity also involved identifying assumptions, biases, and identities that shaped the PI's approach and interpretations. Furthermore, it served as a record of the cognitive and metacognitive processes involved in coding and analyzing the data (Saldaña, 2016). Second, Creswell's (2013) data analysis method led to thick, rich description of the phenomenon, through both textural and structural description, "interconnecting the details, using strong action verbs, and quotes" (Creswell, 2013, p. 252). Thick, rich description enhances validity because it allows readers to develop a sharp sense of the findings and the contexts (Creswell, 2013).

Finally, the Dissertation Committee Chair conducted an external audit of the research process and accuracy of findings. An external audit enhances validity by determining that the described process was followed and that the data supported the PI's findings and interpretations (Creswell, 2013).

To maximize study reliability, the PI employed two strategies described by Creswell and Creswell (2018). First, the PI listened to each interview's audio file while reading each transcript, ensuring transcripts were error-free. Second, the PI recorded emerging codes in a separate codebook, creating rules about each code's meaning (Creswell & Creswell, 2018). Specifically, the codebook included the code name, a brief definition, inclusion and exclusion criteria, and typical and atypical exemplars (Saldaña, 2016).

Ethical considerations. Participants' rights were protected at all times in this study. Participants were provided a copy of the *Rights of Research Participants* (Appendix H) as well as the *Adult Consent Form* (Appendix I) via an encrypted electronic Dropbox prior to the interview. To mitigate risk related to emotional distress, the PI individualized each participant's consent form by providing contact information of specific support agencies in the geographic area of the participant. The PI provided participants the opportunity to ask questions about the documents or any other questions regarding the study. The PI also assured each participants that participation was voluntary and they were able to withdraw from the study at any time without impacting their jobs, student status, or their relationships with the PI and the PI's institution.

The PI took numerous measures to protect the confidentiality and privacy of participants. Participant contact information was stored on a distinct master list on a password-protected computer on a private drive and was destroyed upon study completion. The experienced transcriptionist signed a confidentiality agreement upon hire (Appendix J). Pseudonyms were

used in the audio files of the interviews and changed to new pseudonyms in the transcribed interviews as a second layer of de-identification. All raw electronic data and transcripts were named as each participant's randomly assigned three-digit code and stored on a private drive on a password-protected computer and on an encrypted USB drive. The USB drive, digital recorders, and all paper copies of demographic, consent, and interview protocol forms were transported in a locked computer bag, and were stored in a locked box to which only the PI has access. The locked box was stored inside a locked cabinet maintained in a locked office. The PI carefully selected direct quotes and composite stories during data analysis to protect participant identity. The PI also de-identified specific individuals, groups, or places named in transcripts, as needed, to protect identities. The PI will securely maintain study materials and raw data for up to five years, after which it will be permanently deleted from electronic storage and disposed of by a commercial, confidential document destruction agency.

Summary

This chapter explained the phenomenological design used to answer the research questions. Through purposeful and snowball sampling methods, participants who met the inclusion criteria were recruited to participate in semi-structured interviews, which were audio-recorded and transcribed. Data analysis was iterative and involved clustering significant statements into themes, writing textural and structural descriptions, and revealing the essence of the phenomenon. Rigor was assured by four validation and two reliability strategies. Finally, this chapter described numerous measures taken to ensure protection of participants' rights, including upholding participant confidentiality and privacy.

CHAPTER IV: RESULTS

This chapter discusses procedures used to analyze the data and significant findings. Findings are categorized into themes and subthemes. Examples of participant statements offer rich description of the participants' experiences.

Data Analysis

The PI employed a systematic, iterative approach to phenomenological data analysis, as described by Creswell (2013). The PI identified significant statements and then winnowed the data using a two-cycle coding method (Saldaña, 2016). With the second cycle, the PI clustered emergent themes and examined the themes to write textural and structural descriptions of participant experiences (Creswell, 2013). Finally, the PI synthesized textural and structural descriptions to arrive at the essence of the phenomenon (Creswell, 2013) of experiencing a prelicensure nursing program as a trans student.

Results

Data analysis revealed six themes in the lived experience of trans persons enrolled in U.S. prelicensure nursing programs: (a) language is a barometer for respect and safety, (b) traversing deep-rooted assumptions about gender and nursing, (c) the burden of altruism as default educators and advocates, (d) navigating transition and coming out, (e) pride in nursing, and (f) personal gender experiences enhanced nursing care. The themes and exemplar participant statements are presented in Table 1.

Table 1

Themes and Exemplar Statements by Participants

Theme	Exemplar
Language is a barometer for respect and safety	"Pronouns are an easy way to figure out if someone is going to be able to respect you. I sorta use pronouns, in general, as a barometer of how close or safe I can be with people."
Traversing deep-rooted assumptions about gender and nursing	“At first when I started getting hit on by patients, I was over the moon because I was passing. As it continued to happen then, eventually, I was just so frustrated and annoyed… It was something that I just never would have even conceived of happening when male passing, so it really, really was a very stark view into how different genders are treated so differently, especially in a profession like nursing.”
The burden of altruism as default educators and advocates	“I have really been forced…into this [trans] advocacy role at the school… I started nursing school and I was like *the* [with emphasis] trans person… It's like that is who I am now… I have started choosing my battles more with professors and peers… I am just kind of burned out. I just want to do school and graduate. I don't really want to always engage on that stuff.”
Navigating transition and coming out	“I couldn't just get out and proclaim it all in one day and that was it. I really had to find who had experience on the unit and experience in school, who would defend me and speak out for me too… You can be discriminated against for being trans and denied employment… You wait [to transition/come out] until, if you get disowned, you will still be able to protect yourself… It wasn't until actually getting hired on after graduation and passing NCLEX, that I felt comfortable enough to come out completely… My experience [in nursing school] was primarily in the closet because I had no idea how people would react, and I needed to rely on that kind of systemic privilege."
Pride in nursing	“If people want to knock me down, that is fine… I had skills basically that I could attest to and my own individual experience that was really valuable.”
Personal gender experiences enhanced nursing care	“Having been able to be a binary trans individual, first identifying as male, it really provides insight to a lot of different kind of cultural conceptions through a first-person lens of experience, not maybe someone's rule, but maybe a slice of what that is like. And I think that just can be so instrumental in being able to approach people where they are.”

Findings

Theme 1: Language is a barometer for respect and safety. Participants identified correct pronoun use as salient and affirming, but they frequently experienced misgendering in formal and informal interactions with faculty and, less often, with clinical staff. Participants discussed gender affirming pronoun use as a fundamental communication element that demonstrated respect. They emphasized affirming pronoun use as an early indicator of whether they could expect support and acceptance from an individual.

Faculty often failed to use the participants' affirming pronouns. Primarily, participants viewed this misgendering as ignorant and unintentional, rather than malicious. They expressed tolerance for effort and intolerance for lack of effort. One participant elaborated on faculty misgendering them and apparent effort: "You can tell when someone is trying [to use affirming pronouns] or not, and it is not like I need people to be perfect. I just want them to try and to think about it." When this participant perceived others as not trying, they "kind of keep those folks at arm's length." Meanwhile, another participant expressed frustration with a faculty member "constantly" misgendering her. This participant deduced that the language choice was calculated, given the discordance between the simplicity of correct pronoun use and the educational and experience levels of the faculty member:

> I am sorry. You have been a doctor; you have a PhD, and you have worked here for more than a decade. You don't do that at this university with its political structures and climates without being shrewd… You have the authority to prescribe medications. If you can't take care of this fairly fundamental way to respect a human being, I question your ability to perform your job well.

In this particular situation, when the participant discussed with the nursing program director that she was experiencing frequent misgendering by the faculty member, the participant did not receive administrative support. Instead, "[the nursing program director] basically told me to suck it up and deal with it, because 'you will probably have to deal with this a lot in practice.'"

Though participants rarely discussed misgendering by patients, they encountered misgendering by the clinical staff. One participant described that this typically occurred with the nurse aid staff, rather than other members of the healthcare team. The participant remembered that younger, less-educated, male members of the healthcare team were most likely to misgender her. The participant acknowledged that misgendering was likely related to binary, cisnormative assumptions about certain aspects of her gender presentation, stating, "I think it is kind of a lazy excuse, but it is what it is."

Instances in which participants were gendered correctly were affirming to participants. One participant whose pronouns were *she/her/hers* described a situation in which a patient was questioning her gender. The participant recounted how the preceptor she had been working with that day advocated for the patient to use the correct pronoun when referring to the participant. The preceptor did this by vocally emphasizing the pronoun *she* when referring to the participant during patient interactions. The participant highly regarded the preceptor. Similarly, when faculty advocated for correct pronoun use by others, it affirmed the participants' gender identities. One participant recalled a faculty member advocating for affirming name and pronoun use at a preceptored clinical site. The need for advocacy resulted from institutions' systems identifying the participant by her dead name (legal name assigned at birth) and incorrect pronouns. Despite the faculty member's conventional misunderstanding of gender, faculty advocacy for affirming name and pronoun use by clinical staff fostered mutual respect:

> It did increase my respect for her [the faculty member] because even though she does not agree with—as she views it—my 'lifestyle,' she viewed it as her job as a clinical instructor, as a professor at a university that, 'These are our policies, and this is my student. I might not agree with my student, but they are my student. And I will protect them to the greatest extent that I can.'

In summary, pronouns and many names are parts of English language that are associated with a gender category in the U.S. Participants identified names and pronouns for themselves that would promote categorization of their genders in alignment with their gender identity. Correctly identifying individuals by names and pronouns was deemed a fundamental way to show respect to the individual. Therefore, participants gauged whether faculty and clinical staff were safe individuals with whom they could interact, based on the pronouns and names those individuals chose to use when referring to the participants. Faculty and clinical staff often used incorrect pronouns and dead names for participants, categorizing their genders in a way that reflected cisnormative, binary assumptions about gender.

Theme 2: Traversing deep-rooted assumptions about gender and nursing.

Participants encountered stereotyping and discrimination by faculty, clinical staff, and patients. These experiences were primarily based on cisnormative, traditional, binary assumptions about gender, gender roles within the healthcare context, and the image of nursing. Participants discussed simultaneously gravitating toward and steering away from nursing based on the image of nursing as a caring and feminine profession, reflecting ambivalence about their gender identities in the context of the gendered images of nursing and other healthcare professions. As a trans person, one participant was drawn toward the profession due to the image of nurses as

caring advocates. Another participant discussed feeling like a minority within the female-dominant profession:

> I remember thinking about how many females were in nursing, especially cisgender females, and how I was a minority in a weird way… I noticed there was a much more, maybe stereotypical, female presence—just with all the females in general.

Though the female presence did not dissuade another participant from pursuing a career in nursing, the peer demographics were noted to be marginalizing once enrolled in the nursing program. The participant felt they were unable to connect with their nursing student peers because peers were "much younger white women who have been in sororities."

In contrast, one participant initially pursued a career in medicine while avoiding the nursing profession due to the image of nursing as a predominantly female profession. Prior to transitioning from male to female, the participant viewed the nursing profession as a potential source of life-ending, gender-related psychological distress. As a result of this view, the participant waited to pursue nursing until she had started to pass as female. She described her initial resistance to a career in nursing in the following way:

> I knew it was a field full of extremely intelligent, very tough, badass women… I thought it would be a constant reminder of everything that I thought I was never going to be able to be, and I knew that I would wind up ending my life early.

Because participants had all lived as more than one gender, they experienced nursing education and healthcare through unique lenses. They encountered first-hand the binary nature of gender in healthcare, including role stereotyping based on male or female gender expression. Patients frequently assumed one student nurse participant to be the doctor when expressing gender as male, but this ceased once the participant transitioned to female. Participants also

received a clear, consistent message that it was advantageous to their nursing trajectory to be perceived by others as cis male because the pathways, expectations, and opportunities advantaged males within the profession. They were encouraged into nursing and leadership trajectories when perceived and assumed to be cis male. One participant described encouragement received from a nursing director to pursue nursing leadership when she was perceived as a cis man. She reflected on giving up the nursing career advantages she may have had living as a man, and how this interplayed with her unwavering female gender identity and others' misperceptions of gender identity as a choice:

> She [the nursing director] had said that I would probably be promoted faster than everybody, and I would end up running a department. And as myself, being myself [expressing authentic gender of female] um, I have a feeling I would just have to kind of go through the years of everything else [to be promoted]. Unfortunately, I have had to explain that to people. It is like, you wouldn't willingly do something that puts you in a really—and I feel bad for saying this—like, in a lower social strata kind of thing so you are going to make less money.

Clinical staff offered different clinical opportunities to participants based on their perceptions of the participants as male or female. One participant described feeling empowered by an assumed competence which she attributed to her male gender expression at the time. This participant transitioned from male to female during her prelicensure nursing education. Hence, the participant compared and contrasted her clinical education when perceived as cis male versus cis female:

> [When perceived as a cis male nursing student], attention was paid to me by nurses wanting to help teach me different skills… I was the first to try a lot of different technical

> procedures… I think there was just a lot of misogyny in general, and I benefitted from that very much… [Once I started to transition to female], all of a sudden, people didn't want me really on the front lines… I cleaned up more poop as a female, too.

This same participant experienced profound differences in how patients treated her pre- and post-transition. She attributed the differences to patients' binary assumptions of her as cis male or cis female. The participant recalled frequent romantic and sexual advances by patients after transitioning from male to female, as supported by her statement in Table 1. She recounted an incident in which a mental health patient removed his pants in an implicit proposition for a sexual encounter with the participant. The participant and the clinical staff interpreted this as a sexual misconduct by the patient, directed toward the participant because she was perceived as cis female. As a result, the clinical staff altered the participant's patient assignment and told the participant not to enter the patient's room. The participant described how such encounters generated cognitive dissonance, as an overwhelming desire to pass as female competed with a strong desire to be treated with basic human respect.

Being trans within the gendered profession of nursing presented challenges in how the participants viewed and experienced their gender identities due to how they were treated by patients and nurses. One participant discussed the difficulty in being in touch with her authentic gender due to constant assumptions about her gender identity. She also recognized that being treated differently, based on assumptions that she was cis female, was reinforcing the worldviews that she was trying to combat. Participants felt varying degrees of discomfort in different patient spaces and interactions based on the patients' perceptions or uncertainty of the participants' genders:

> [I experienced] a few times where patients don't want a male nurse and preceptors are like, 'I don't know what to do! Can you go in there?' I don't [go into the patient room] because they might be confused, and I would have to have that conversation.

Another participant remembered her discomfort when she believed her gender expressions unintentionally outed her. In this particular situation, she recalled responding in stereotypical masculine ways to an aggressive patient, and his subsequent behaviors: “He kept trying to mess with me in different ways. It kind of made me stand out to the people that were not sure about me as…a trans person."

One participant experienced overt gender discrimination by faculty and administration, which the participant attributed to her trans identity. Faculty would not allow for the participant to have artificial or painted nails, though this was commonplace among her cis female peers. She was also told she must cut her hair to a shorter length. The participant was overtly held to a different standard in regard to the dress code.

The participant felt she was discriminated against financially as well. She noted that a peer had the same student loan balance as she did, but the peer had a lower loan payment. At the time of the interview, she was seeking legal counsel due to not receiving the same level of support as other students in the nursing program and feeling she was “pushed out” of the program due to her trans identity. She indicated that other students who did not meet passing standards were allowed to continue in the program, while she was not. She talked about her inability to join a new cohort within the nursing program, feeling financially vulnerable, and her general mistrust of the nursing program:

> [A student services staff member] was trying to explain that there are certain people they won't take [for readmission]… Even if, like, they did come back to me and say, ‘Hey,

> you know, there is a spot open'—whatever, it is like, can I trust you? You know, in a for-profit [university] are you just doing this to get more money out of me and still kick me out?

In summary, participants traversed assumptions about gender and nursing that were deeply rooted. Given that gender was critical to participant identity, this led to a uniquely complex dynamic between participant and the nursing profession. The dynamic was characterized by bias, stereotypes, and discrimination toward nurses, females, and trans persons.

Theme 3: The burden of altruism as default educators and advocates. Participants felt burdened and were marginalized as the default educators on trans health in classroom settings and as default advocates in student life. Students felt "forced" or compelled to teach and speak up about trans health as a form of altruism for the trans community, as they simultaneously felt burnt out and burdened with this responsibility. Participants were the default educators and advocates due to three factors determined to be subthemes: (a) faculty were unprepared to teach trans students and to teach trans health concepts; (b) the formal curricula on trans health were inadequate, cisnormative, and pathologizing; and (c) transinvisibility was common on campus.

Unprepared faculty, inadequate curricula, and transinvisibility resulted in burdening the participants as the default educators on the topic of trans health and as default advocates for trans students. Participants were altruistic in serving as default educators and advocates. This was not a role that participants expected or wanted to be filling, and it generated some ambivalent feelings about serving their trans community, while desiring their transness to be just one part of their whole identity. One participant expressed grappling with these ambivalent feelings in the following way:

> In a way, it is nice to have something to contribute and be an expert, so to speak, to help

> but… I kind of want to be on the other end of it where it is like, that is not what I am seen as. But then again, I guess that is just what I am. And maybe that is finding a way to embrace that.

Another participant was less ambivalent, but they talked more about feeling tokenized. The participant explained that their transness was their predominant identity while in the nursing program, as the sole representation of trans persons. Tokenization and the pressure to educate and advocate subsequently led to the participants feeling burnt out, as illustrated in Table 1.

One participant reported starting an LGBTQ group for nursing students because of lack of a group accessibility and availability on campus. However, this resulted in some role stress, as the participant stated, "It really felt like I was the one keeping that afloat." Another participant examined the burden of trans advocacy and activism in relationship to the general stress of being a nursing student. The participant emphasized that adequate and accurate information about trans health in nursing curricula would ease the burden:

> [Ideally], nursing students don't have to be relied on to teach, especially those that are trans identified. Instead, they can get what they really need which is the support and the comradery. And maybe they choose to be activists and advocates, but it shouldn't be the main pathway for them.

As the default educators for trans health and advocates for trans students, participants came out to entire cohorts of peers, which sometimes resulted in marginalization and social isolation for participants. In a situation in which a faculty member was providing inaccurate and incomplete information about trans health, the participant gave an impromptu presentation to the class, coming out to the class by way of the presentation. Subsequently, the participant observed being marginalized by peers, stating, "No one directly attacked me physically and

interpersonally… They would just like not talk to me [in the classroom]… There were a couple people I could tell were just turned off…got a little bit more 'not cool' with me."

Serving as default educators and advocates drew attention to the participants' trans identities. In spaces where participants felt they had positive relationships with peers and a general sense of acceptance, or at least tolerance, they still felt like outsiders. One participant, who had transitioned from male to female, described feeling accepted yet socially isolated as a trans person in the nursing programs:

> I wasn't necessarily invited to all of the things that all of the people in my class were going to, and when almost everyone is female-identified…that sting is felt… Even in places where you are accepted, it can still be a lonely experience.

Subtheme A: faculty were unprepared to teach trans students and to teach trans health concepts. Faculty were not attentive to the needs of the participants as trans nursing students, as one participant commented with sarcasm, "It certainly was fun trying to get some of the older professors to understand [my trans identity]." Another participant reflected on her experience in which a faculty member did not respond to the participant's psychological distress, even after a peer alerted the faculty that the participant may be suicidal. The participant identified the situation as "one of the key things that would not make me want to go back to that program even if they begged me to and said the rest of it was free."

In the classroom, faculty were awkward about language, struggled with appropriate terminology, and did not present accurate or culturally sensitive information related to trans health care. Some faculty acknowledged their lack of preparation. Faculty made statements such as, "I don't know anything about that [trans health]." In contrast, one participant expressed frustration that some faculty would sometimes attend "one lecture on trans identity and go, 'I

know it all.'"

Due to their lack of knowledge but general openness to include trans health content in the curriculum, faculty and administrators frequently defaulted teaching about these concepts to the participants. Upon recognizing an absence of trans health in the nursing curriculum, one participant advocated for inclusion by involving the nursing program dean who stated, "'Oh well, we are not doing a good job, and we really don't know how, but if you help us, we want to do it.'" As a result of unprepared faculty, all participants became guest student lecturers on trans health concepts.

Subtheme B: the formal curricula on trans health were inadequate, cisnormative, and pathologizing. The amount of trans health concepts within the formal curricula was minimal, and in some cases was pathologizing and reinforcing stigmas about trans persons. For instance, one participant remembered, "What she [faculty] was teaching and what was in the book was kind of getting me a little upset because of it being so inaccurate…You are a deviant, a transsexual… You're a crossdresser. You're a freak." More often the absence of curriculum content was marginalizing, as one participant verbalized, "I feel totally invisible in the classroom and feel like my [trans] community is not being talked about or represented at all."

The lack of inclusion of trans persons in informal course learning activities also exemplified cisnormative and heteronormative curricula that marginalized participants, as illustrated in this participant's reflection on her classroom experiences:

> Seemed like it was very, very heteronormative…and cisnormative… Kind of assumed the patient and the partner was [sic] male and female, and if they weren't, it was a special unit… All of a sudden trans or LGBTQ in general becomes a…'special unit'…that doesn't integrate the rest of care… When you set a population aside, how do you integrate just

caring for human beings in general?

Subtheme C: transinvisibility was common on campus. Participants experienced a lack of visible and easily accessible formal and informal LGBTQ+ support unless they were involved in campus or community LGBTQ+ centers. Some participants expressed a desire for nursing programs to welcome faculty and students from marginalized groups to become a part of their community. One participant stated, “I think a lot of professors might have been LGBTQ, but I don't think they felt comfortable enough to come out too, and so without that visibility, it was difficult for LGBTQ students to feel supported." Even if faculty did not identify as LGBTQ, those who talked about authentic personal experiences with trans persons decreased the feelings of marginalization for participants. One participant described the faculty who "felt really safe were…the ones who had real experience with LGBTQ students…the ones who did LGBTQ care…the ones who had lived in San Francisco…the ones who have LGBTQ kids of their own."

Participants also noted that it was difficult to find LGBTQ nursing students who were out. Though LGBTQ+ centers were important to some participants, one participant described challenges accessing them. The participant highlighted the nature of nursing education, particularly on a larger campus, presented a barrier for the participants to become involved in the campus LGBTQ center. First, the nursing school was geographically segregated from the campus LGBTQ center. Second, the nature of nursing student course schedules was different from other undergraduate students due to nursing students’ clinical education.

In summary, nursing faculty were unprepared to teach trans students or trans health concepts. Formal curricula were cisnormative and were either pathologizing or did not address trans health concepts. Furthermore, participants generally described transinvisibility on campus. As a result of these factors, participants were placed in positions as the sole individuals willing

or able to educate regarding trans health and to advocate for the trans community. Serving as educators and advocates was altruistic because it frequently resulted in marginalization and feeling burnt out.

Theme 4: Navigating transition and coming out. Participants gave careful consideration to the timing of coming out and the timing of gender transition in relation to admission to, progression in, and graduation from the nursing program. They navigated social, medical, surgical, and legal transition. Participants were intentional about when they masked their authentic gender identity and when they were out, such as masking at admission interview, being out at graduation but wondering how they would be perceived, or masking until employment secured. One participant described masking during her nursing program admission interview by presenting herself as more gender neutral. She expressed feeling wary about how her gender was perceived and whether admission interview questions were directed toward her differently as a result, because "it is not something you stop and ask people during the interview, 'Hey, what [gender] do you think I am?'"

Another participant discussed waiting to come out until she had graduated from the nursing program, passed the licensing exam (NCLEX), and obtained employment. The decision to mask her trans identity related to her recognition of cis privilege in the nursing program, fear of financial insecurity, and fear of employment discrimination. However, throughout the nursing program, she was on alert for allies, as described in Table 1.

Each participant timed their transition to minimize disruption to the participant's social or academic life. Participants planned social, surgical, and/or initial medical transitions during academic breaks. Social transition was chosen at times that they would be meeting new people because identifying affirming name and pronoun use was easier for most people if the individual

was not previously known to them. One nonbinary participant described their social transition to using *they/them/their* pronouns, "I used nursing school and my move to start doing that because it seemed easier…introduce yourself only with these pronouns. You don't have to make a switch."

Another participant discussed departing the medical program in which she had been enrolled, in part due to being trans, and realizing she wanted to pursue nursing. She determined the optimum time to transition was during this academic break, so she delayed application to a nursing program until she felt more secure in her female gender expression. She felt this would allow her to socially transition more smoothly, as illustrated by her explanation for her delay:

> I knew I did not pass [as female], and so any program that I applied to would be dealing with my name change at some point. They would be dealing with my changing [gender] presentation over the course of the program.

Legal transition, including navigating NCLEX and licensing with correct names and pronouns, required many steps without clear pathways or guides. One participant was proactive and intentional in the timing of taking these steps to successfully navigate this transition:

> So by the time that I was submitting all of this kind of stuff [legal documents] to hospitals for employment, things [legal identifiers and documents] were increasingly all congruent with each other… I had so aggressively pursued that at the beginning of the program, getting my legal name changed and stuff.

In contrast, some participants identified incongruence between the name on their nursing licenses and their affirming names. They discussed that there was not a clear pathway to change names for the NCLEX exam, from which the licenses are subsequently issued. One participant described the irony of beginning the nursing program as their authentic self and gender, yet the

nursing license was issued with the participant's dead name. Another participant elaborated that legal transition was an onerous process that she could not endure at the time of graduation, due to the stress and time commitment in preparing for the NCLEX.

Participants experienced psychological and physiological distress when not living as their authentic genders as prelicensure nursing students. This distress impacted their concentration, motivation, and general wellness. One participant summarized the impact in the following way:

> All the repressions kind of started coming up. It really became psychologically difficult for me to do things like pay attention, even at times noticing my heart rate accelerating very, very high; feeling just like nothing felt real. And I actually had to get up out of class at times and take a walk outside, just to kind of center myself… I think it just became difficult to take care of myself… There were a lot of experiences, especially depersonalization and derealization, so feeling outside of my body and feeling as if the world around me was a dream or fake. It is really hard to care about classwork when that psychological experience happens.

Though living as the gender assigned at birth, rather than one's authentic gender, created distress, the process of medically transitioning through hormone therapy presented its own challenges. One participant was medically transitioning from male to female later in life, while enrolled in her nursing program. The hormonal changes impacted her learning, and she surmised they may have caused her to fail a midterm exam. She ruminated about whether hormonal adjustments resulted in academic failure, which, in turn, resulted in tremendous stress and suicidal ideation:

> Your second puberty is kind of like tough…this is like really difficult… Am I hormonally off? Did I change medicines? Did I mix something wrong? You know, I was just kind of

> spinning!… And I think it was not working and the family relying on me…the expenditure was high and the pressure was there, and then whatever was happening, I just…I was losing it… One of her [my peers'] daughters had been kind of suicidal and she [my peer] is like, 'I am seeing the pattern [in you].'

Post-transition, participants experienced positive psychological and physiological effects. The positive effects, in turn, were recognized as positively influencing one's ability to learn, in addition to one's overall wellness. One participant described the change in self following medical transition, "You know, being able to be my own self, my attention is better, my cognition is better, my memory is better, my reliance on substances went down to like zero, whereas, before it was horrible."

In summary, participants navigated coming out to others as trans and social, medical, surgical, and legal aspects of transition. Their navigation involved careful consideration of timing in relation to admission to, progression in, and graduation from their prelicensure nursing programs. Participants coped with gender-related psychological distress prior to transitioning that impacted their ability to learn. On the other hand, hormonal modulation during medical transition also challenged academic success. Participants handled or avoided nebulous legal transition processes in anticipation of nursing licensure.

Theme 5: Pride in nursing. All participants were proud to be on a career trajectory in nursing, taking pride in their clinical nursing skills. Overall, they described positive clinical experiences that affirmed their decisions to pursue nursing and feelings of belonging in the nursing profession. Though participants did not mention faculty interactions as a source of pride in their nursing skills, they received compliments from clinical staff and patients that were affirming. Encouraging comments by clinical staff and preceptors, such as requests for the

participant to work with them in the preceptor-student relationship or recommending the participant apply for employment within their departments, impacted their feelings of belonging. When reflecting on her clinical experiences, one participant expressed this sense of pride in regard to the patient and family perspective about her care:

> Usually, what patients and patients' families would be saying about me was pointing out that either I had taken the extra time to try and listen or kind of went above and beyond what one might expect someone to do in a student role.

Most participants had an intrinsic sense of pride and belonging in nursing that was less dependent on external feedback. These participants recognized qualities like empathy and strong communication skills as characteristics they possessed that enhanced their nursing skills.

Some participants explicitly identified reciprocity between their comfort and confidence with nursing skills and with their gender identity. As self-efficacy in nursing skills grew, so did confidence in their trans identities. In part, this was due to the financial security and social capital associated with their trajectories to join a virtuous profession that offered job security, as depicted in this participant's words:

> The more I felt like I had a grip on the curriculum and my own understanding of nursing in general, the more confident I felt about coming out… Money and respect in your profession really can give you the confidence to do a lot of things… The more privilege you have in society, unfortunately, the more comfortable you feel about speaking out.

In summary, being on a trajectory of a career in nursing was a source of pride for participants. They took pride in their clinical nursing skills. Positive feedback from patients, families, and clinical staff enhanced their pride and feelings of belonging. Participants

associated privilege with the nursing profession, including financial stability and social respect. In this way, feeling secure in nursing skills influenced feeling secure in gender identity.

Theme 6: Personal gender experiences enhanced nursing care. Participants' personal gender experiences positively influenced their clinical abilities to approach all patients with empathy and cultural humility. This was explicitly communicated by some participants, while it was implicitly evident with others. For example, one participant discussed that experiencing personal hardships related to gender allowed her to develop a deeper sense of empathy because she understood overcoming something really difficult in her life. She was able to apply this empathy to patients experiencing different hardships.

Participants also described approaching patients without any assumptions or judgments, expressing compassion and empathy for vulnerable patient populations. One participant talked about her empathy for inmate patients due to their vulnerability for sexual and physical violence. Another participant recalled her experience caring for a patient who self-identified as a Neo-Nazi. Though the participant was initially fearful of how the patient would treat her as trans-female, she approached the patient with an openness to difference and grew in her cultural humility as a result:

> There was no attention that he paid to me being trans, and I don't even think that he knew… It made me realize: wow, this is just another person—horrible beliefs, but another person who needs help. So, it really helped me to see less of the labels that exist and more the fluidity of the human experience and how to care for all people.

Patients rarely knew the participants to be trans unless the participants chose to disclose this to trans patients in a way intended to enhance the patient's outcomes. Regardless, all participants understood their personal gender experiences promoted their abilities to provide

culturally congruent, gender-affirming care. One participant pursued the nursing profession with this understanding already firmly in place stating, "I just knew it was for my [trans] community always; that is why I went into nursing." In contrast, another participant's understanding of her value in the nursing profession evolved over the course of her nursing education:

> What I see is that it [my gender experience] can benefit others so they don't have to go through all the things that I did to get there… I am pleasantly surprised that there is more of a benefit that I can offer…whereas I thought it might have been more of a liability… Some people see it [becoming a trans nurse] as more of a benefit than I thought… I 'poo-pooed' it.

In conclusion, some participants explicitly acknowledged that their personal gender experiences enhanced their abilities to provide quality nursing care to patients of all backgrounds. All participants also described approaching patients with empathy and without assumptions or judgments, implying cultural humility. While some participants pursued nursing because they recognized their personal gender experiences would enhance care of trans patients, other participants grew in their understanding of this during their nursing education.

Results Summary

Using standard processes for rigorous analysis of data collected from four participants, six themes emerged. The themes represent the essence of the experience of being a trans person enrolled in a U.S. prelicensure nursing program. Descriptions of participants' experiences and descriptions of the contexts of their experiences were supported by excerpts of the participants' statements.

CHAPTER V: DISCUSSION AND SUMMARY

The purpose of this phenomenological study was to explore the lived student experiences of trans persons in U.S. prelicensure nursing programs. This chapter will synthesize the study's purpose, research questions, theoretical framework, and interpretation of the findings. The synthesis will lead to an examination of the implications for nursing education and future research.

Research Questions and Interpretation

The central question of this research study was, "What are the lived student experiences of trans persons enrolled in U.S. prelicensure nursing programs? Six sub-questions relating to the central question were answered through a phenomenological research design. The six research sub-questions were:

1. How do trans persons view their trans identities in relationship to admission, progression, and/or graduation experiences in prelicensure nursing programs?
2. How do trans persons describe their classroom/curricular experiences in prelicensure nursing programs?
3. How do trans persons describe their clinical learning experiences in prelicensure nursing programs?
4. How do trans persons characterize their student life, campus culture, and/or extracurricular experiences while enrolled in prelicensure nursing programs?
5. How do trans persons describe their interactions with peers, college personnel, clinical agency staff, and patients while enrolled in prelicensure nursing programs?
6. How do trans persons perceive their trans identities related to their decisions to pursue a career in nursing?

Answers to the six sub-questions are interwoven in the interpretation of the six themes: (a) language is a barometer for respect and safety, (b) traversing deep-rooted assumptions about gender and nursing, (c) the burden of altruism as default educators and advocates, (d) navigating transition and coming out, (e) pride in nursing, and (f) personal gender experiences enhanced nursing care. Figure 3 depicts relationships among the major themes and subthemes.

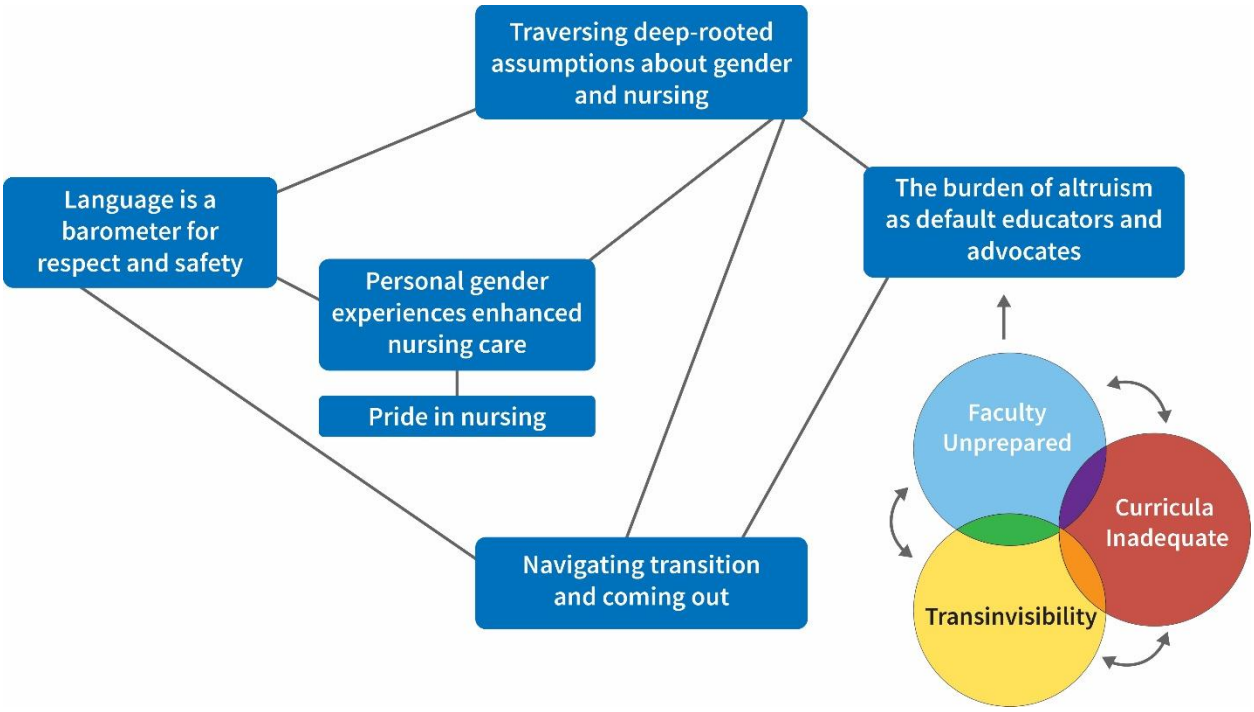

Figure 3. Interconnectedness of the six major themes and three subthemes

Language is a barometer for respect and safety. The theme of language as a barometer for respect and safety contributed significantly to answering research sub-question five, regarding interpersonal interactions. Participants identified appropriate pronoun use as salient and affirming, viewing it as a fundamental communication element that demonstrated respect. Participants also appreciated effort in use of correct pronouns, extending grace for individuals who showed they were trying but made pronoun mistakes. Faculty frequently misgendered participants by using incorrect names and/or pronouns, but participants expressed

gratitude and respect for faculty and clinical staff who advocated for correct pronoun use. Though clinical staff sometimes misgendered participants, participants were rarely misgendered by patients and did not mention being misgendered by peers. This was an interesting, unexpected finding.

Misgendering students is not unique to nursing education, as this type of microaggression was prevalent in the literature regarding the experiences of trans social work students and trans college students in general (Austin et al., 2019; Goldberg & Kuvalanka, 2018; Pryor, 2015; Stewart, O'Halloran, & Oates, 2018). Some authors have discussed the cis bias and privilege in systems that underscores incorrect name and/or pronoun use by individuals (Austin et al., 2019). Faculty who ask for pronouns and affirming names help to negate cisnormativity and make trans students feel visible, while misgendering and failing to ask for pronouns and affirming names has a marginalizing effect that renders trans students invisible (Austin et al., 2019).

Participants of this study asserted affirming pronoun use as an early indicator of whether they could expect support and acceptance from an individual, meaning they were a "safe" person. Frequently experiencing misgendering by faculty, participants generally gave faculty the benefit of the doubt that these microaggressions were unintentional and not with malice. However, for some participants there was doubt and uncertainty in the motives of highly educated faculty, who repeatedly failed to use appropriate pronouns for participants.

The participants' common experience of using correct pronoun use as a barometer for respect and safety has been supported in the literature. First, correct name and pronoun use has been recognized by trans college students outside of the nursing major as an indicator of whether faculty are safe individuals (Linley et al., 2016; Pryor, 2015). Second, Patev, Dunn, Hood, and Barber (2019) found that an individual's negative attitude toward trans persons was associated

with the individual's perceived difficulty using gender-inclusive language. This validates the argument for using language as a barometer for respect and safety. Third, the ANA identified appropriate language and terminology as one critical competency of culturally congruent practice expected of all nurse educators and nurse graduates (Marion et al., 2016). Therefore, using the correct pronouns for trans students, and familiarity with the use of nonbinary pronouns, including the use of singular "they," should be an expectation for faculty, clinical preceptors, and nursing student peers.

If language is a barometer for respect and safety for trans nursing students, it implies that first impressions can be a gauge of whether peers, college personnel, and clinical agency staff can be trusted. The nature of using the correct name and pronoun when identifying a student seems simplistic on the surface; however, participants briefly eluded that college learning management systems created barriers. College learning management systems often drive first impressions and first opportunities for name and pronoun use, even in face-to-face coursework. For example, electronic college enrollment and learning management systems may be used for roll call on the first day of class, or for online introductions even in a face-to-face class. Though participants in this study briefly eluded to challenges in affirming name and pronoun use due to electronic enrollment and learning management systems, cis privilege built into such systems received greater emphasis by participants in studies by Goldberg, Beemyn, and Smith (2019), Goldberg and Kuvalanka (2018), and Seelman (2014).

Countries around the world are expanding beyond the gender binary to allow individuals to legally label selves within a third category. Examples of countries legally identifying a third gender include the following: Australia, Austria, Bangladesh, Canada, Malta, Nepal, New Zealand, and Pakistan (Castro-Peraza et al., 2019). Within the past three years, several states in

the U.S. have legally adopted a third gender for state-issued identification: Arkansas, Oregon, Minnesota, Maine, Utah, Colorado, California, Indiana, Nevada, and Vermont (Lam, 2019). It is unclear how these legal changes may improve institutional systems' abilities to use the affirming names and pronouns of trans college students. The exchange of federal financial aid at the institutional level requires use of legal names. However, previous authors have asserted that institutional systems cannot serve as an excuse for misgendering (Austin et al., 2016). Regardless of state or federal changes, cis allies can advocate for a change in systems at institutional levels.

Traversing deep-rooted assumptions about gender and nursing. The theme of traversing deep-rooted assumptions about gender and nursing arose from research sub-question three, regarding clinical learning experiences; sub-question five, regarding interpersonal interactions; and sub-question six, regarding the decision to pursue a nursing career. Participants experienced stereotyping and discrimination by faculty, clinical staff, and patients, primarily based on each participant's image measured against cisnormative, traditional, and binary views of gender and gender roles in healthcare. The deep roots of gender beliefs and biases intertwine with the cis female-dominant profession of nursing situated within a patriarchal healthcare context. Hence, complex gender experiences as a trans person pursuing the nursing profession were anticipated findings. However, complex male-female binary experiences based on the cisnormative assumptions of others were not expected to be discussed in depth by participants. All participants had lived as two or more of the following: male, female, and nonbinary trans-masculine, leading to a unique lens into gender discrimination in nursing education and healthcare.

The first deep-rooted gender assumption was that doctors are male and nurses are female (Fletcher, 2007). As of 2016, about one-third of physicians with active medical licenses were categorized as female, while over 90% of nurses were categorized as female (NASEM, 2016; Young et al., 2017). Though both professions have slowly diversified gender in the binary sense, medicine remains male-dominant and nursing remains female-dominant, contributing to the assumption identified by Fletcher (2007). Gender stereotypes also contribute to the assumption that male physicians are dominant while female nurses are subordinate (Clow, Ricciardelli, & Bartfay, 2014). The participants who had clinical education experiences, both when perceived as cis male and cis female, noted that patients assumed them to be the doctor when expressing gender as male and assumed them to be the nurse when presenting as female.

The second deep-rooted gender assumption was the existence of innate traits that characterize male and female nurses. This assumption resulted in discrimination by faculty and clinical staff, causing participants to express a sense of misogyny and male privilege in the clinical setting. When perceived as cis male, participants were offered advantages and opportunities that they were no longer offered once perceived as cis female. For instance, when they were perceived as cis male, they were encouraged into leadership positions, assumed to be competent, and offered opportunities to practice technical skills. In contrast, participants indicated that those opportunities vanished after transitioning to female. Moreover, after passing as female, they were assigned less-desirable nursing cares, such as toileting patients. It is worth emphasizing that participants attributed this discrimination to being perceived as cis female, not to being perceived as trans.

The literature abounds with reports of complex gender inequities in the nursing profession. For example, men are underrepresented in the nursing workforce yet are

paradoxically overrepresented in higher paying, leadership nursing positions (Clow, Ricciardelli, & Bartfay, 2014). Male registered nurses are paid 27.9% more than female registered nurses, which possibly relates to upward mobility advantaging males (Wilson, Butler, Butler, & Johnson, 2018). The literature review by MacWilliams, Schmidt, and Bleich (2013) underscored both advantages and disadvantages male student nurses experience versus female counterparts. The experiences of participants being urged into leadership when perceived be cis male are consistent with Clow et al. (2014), Wilson et al. (2018), and MacWilliams et al.'s (2013) literature review. The participants in the present study offered a valuable perspective of different treatment of nursing students based on deep-rooted binary gender assumptions. This perspective resulted from their unique positions to compare their personal experiences presenting as different genders.

The third deep-rooted assumption participants traversed was the image of female nurses as sexual objects (Price & McGillis Hall, 2014). This image related to more egregious forms of discrimination participants faced, as one participant recounted unwanted sexual and romantic advances by patients when perceived as cis female. It is important to emphasize that in these instances, the participant was passing as female; therefore, she attributed the patient misconduct to being perceived as cis female rather than to being perceived as trans.

A review of the literature suggested that one in four nurses worldwide experience sexual harassment in the workplace, most often with patients as perpetrators (Spector, Zhou, & Che, 2014). The rate of one in four participants reporting sexual misconduct in this study mirrors this previous work. In a recent Medscape survey of 6,235 physicians, nurses, nurse practitioners, and physician assistants, 11% of nurses, nurse practitioners, and physician assistants reported experiencing sexual misconduct in the workplace (Kane & Levy, 2018). Of those who reported

experiencing sexual misconduct, 94% identified themselves as female and 91% identified themselves as nurses. It was not reported whether trans was a gender option for this particular survey. Most often, patients were perpetrators of misconduct directed toward nurses. Nearly all victims of sexual misconduct ranked the experience as upsetting, and more than two-thirds reported that it interfered with job performance, but 61% of victims did not report the misconduct (Kane & Levy, 2018).

Aligning with the literature, the study participant who experienced unwanted sexual and romantic advances from patients was identifying as female and was upset by these interactions. However, the participant discussed an additional layer of distress unique to her transness: the patient misconduct validated her female gender identity at a critical time in her transition. This resulted in cognitive dissonance, as the participant's strong desire to pass as female competed with her strong desire to feel safe and be treated with basic human respect. Though she was "over the moon" to feel validated as female, such advances quickly became upsetting, particularly as they occurred more frequently. The participant reflected on the personal values conflict and tension generated by such encounters.

The fourth deep-rooted assumption participants traversed was the gendered image of nursing within a cis binary framework. Some participants sought a career in the female-dominant nursing workforce because of their transness and some in spite of it. The female dominance of the nursing profession was sometimes intimidating and uncomfortable, causing participants to feel like a minority, marginalized and isolated. One participant discussed that her positive perception of nurses as strong, intelligent females caused her to avoid pursuing a nursing career, as she predicted immersion in nursing would intensify psychological and emotional

gender-related distress prior to gender transition. She perceived this would create such intense distress, it would lead to suicide.

One component of the gendered image of nursing relates to physical appearance and dress as a symbol of professionalism. Feminine expectations related to the physical appearance of the nurse has been one barrier to gender diversification in nursing. It was one participant's experience that nursing faculty held rigid, deep-rooted, gendered images of the nurse, in which the trans participant did not fit. These deeply held beliefs led faculty to demand the participant cut her hair and leave her nails unpainted, despite different expectations for her cis female peers. In the 2018 qualitative study about the nursing uniform and professional image, Daigle writes, "An increase in male nurses has also forced creation of a uniform that is gender neutral" (p. 556). Notably, Daigle (2018) does not acknowledge gender beyond the binary and has chosen to use the word "forced" in describing the evolution of the nursing uniform to accommodate gender diversification of the profession.

Another participant sought a career in nursing due to the feminine, caring image of the profession. The pervasive image of nurses as caring advocates (Fletcher, 2007) led the participant to conclude that nurses would be accepting of her trans identity. Though clinical staff were generally accepting, nursing faculty behaviors that seemingly contradicted the caring image of nursing were particularly distressing for the participant. In this particular case, the participant was intensely affected by the faculty member's lack of responsiveness to the participant's emotional and psychological distress that had escalated to the point of suicidal thoughts.

Discrimination in academic and employment settings has been commonly experienced by trans persons (Austin, 2016; Austin, Craig & McInroy, 2016; Eliason & Dibble et al., 2011; Mizock & Dawson Woodrum et al., 2017; Pryor, 2015; Schneider & Dimito, 2010). One

participant in this study felt she experienced overt discrimination by faculty and administrators in the nursing program due to her transness. The participant suspected she was dismissed from the nursing program because she did not receive the same level of support and equitable treatment compared to her cis peers. This suspicion was compounded by comments from college personnel that the participant would be denied readmission. Additionally, the participant suspected she experienced financial discrimination regarding her student loan terms, when compared to her cis peers. Consistent with Pryor's (2015) finding that perceived discrimination led to avoidance of the academic setting, this participant subsequently planned to avoid future enrollment in the university. However, she planned to continue to pursue a career in nursing. The participant primarily seemed to attribute her mistreatment to individual faculty members' transphobia and the values of the for-profit institution, rather than generalizing this mistreatment to nurse educators or the nursing profession as a whole.

Though all participants reported some degree of gender discrimination, none of the participants mentioned Title IX protections. Title IX of the U.S. Educational Amendments of 1972 is a civil rights law designed to protect students, faculty, and employees from sex-based or gender-based discrimination in the learning environment (Seals & Gonzales, 2019; Weiss & Lasky, 2017). It is unknown whether participants were aware of Title IX protections or how those may have been applied in the situations described.

The burden of altruism as default educators and advocates. Participants felt burdened by their altruism as default educators and advocates. This theme arose from research sub-question two, regarding classroom and curricular experiences, and sub-question four, regarding student life on campus. Burden to educate others was a theme in the literature review regarding trans college students (Austin, 2016; Austin et al., 2016; Goldberg & Kuvalanka,

2018; Nicolazzo, 2016; Pryor, 2015). Similarly, the participants in the present study felt burdened, tokenized, and marginalized due to direct and indirect pressure to educate others. However, in contrast with the previous literature, in which students carefully discerned when to educate and when to stay quiet as a resilience measure (Nicolazzo, 2016), participants in the present study clearly expressed altruistic motivations to educate and advocate. Participants recognized it was critical for their peers to receive accurate information about trans health, so they would be prepared to provide gender-affirming care; thus, altruism compelled participants to speak out despite potential negative personal consequences.

Negative personal consequences for participants included tokenization, marginalization, and social isolation. These findings are similar to Nicolazzo's (2016) and Pryor's (2015) findings of trans college students in that the burden to educate made the students vulnerable to marginalization and harassment. There were three clear subthemes that contributed to participants' burden to educate: (a) faculty were unprepared to teach trans students or teach trans health concepts; (b) the formal curricula on trans health were inadequate, cisnormative, and pathologizing; and (c) transinvisibility was common on campus. All three subthemes can be labeled as covert discrimination or microaggressions against trans students, according to Austin et al. (2016).

Nurses and nursing faculty lack basic understanding of gender terminology, trans health needs, and trans health disparities (Carabez et al., 2015; Goldberg, Beemyn & Smith, 2019; Lim et al., 2015; Rivera, 2019). All participants in this study experienced this first-hand. In most cases, faculty were open to including information about trans health but did not know what to include. Openness was demonstrated by (a) allowing or inviting participants to present on trans concepts, and (b) asking for participants to guide integration of trans health in the curriculum.

These findings were consistent with Lim et al.'s (2015) national survey results of baccalaureate nursing faculty: the majority of faculty demonstrate an openness to curriculum integration but express feeling unprepared to teach about trans health.

Participants' accounts implied nursing faculty were also unprepared to teach trans students. First, their nursing faculty seemed to lack awareness of the burden, tokenization, and marginalization resulting from relying on participants to teach trans health concepts. A second example was their lack of familiarity with basic terminology and inattention to correct name and pronoun use, which further served to marginalize students. A third example was the failure to recognize cis privilege in dress code policies and subsequent inequitable implementation of such policies. A final striking example was the faculty member who did not reach out to the participant with severe emotional and psychological distress to the point of suicidal ideation. Failure to reach out to a student when critically distressed was clearly neglectful and ethically irresponsible regardless of the student's gender. It remains unknown whether the faculty member's knowledge, skills, and attitudes regarding trans students contributed to her unresponsiveness.

Consistent with the work of Carabez et al. (2015), Eliason et al. (2011), Green et al. (2018), Lim et al. (2015), and Manzer et al. (2018), participants in the present study cited the formal nursing curricula as problematic in relationship to trans health concepts. The problems ranged from absence of trans health to cisnormative bias to pathologization of trans persons. Castro-Peraza et al. (2019) asserted that depathologization of trans identities is a basic human right, summating, "Defining gender diversity as an illness or otherwise abnormal is unfounded, discriminatory and without demonstrable clinical utility. The fact that only gender diverse people are pathologized constitutes unequal treatment, resulting in a violation of the right to non-

discrimination" (p. 986). Moreover, Castro-Peraza et al. (2019) labeled depathologization as both a healthcare and legal issue. Like the explorations of trans social work students' experiences (Austin et al., 2016), the trans nursing students in the present study indicated that pathologizing trans identities intensified participants' feelings of stigmatization and marginalization. Therefore, depathologization is also an education issue.

Cisnormativity within the formal curricula also contributed to marginalization of participants. This was experienced in relationship to patterns of assumption that individuals were cis and aligned within binary gender categories. For example, general case studies of patients and families assumed the actors to be cis and straight. Lacking integration of trans individuals in teaching materials limited curricular inclusion to a "special unit…that doesn't integrate the rest of care." One participant's description of "setting the population aside" suggested marginalizing the population within the formal curriculum. In addition to trans health topics, participants noted a lack of theoretical basis of gender in the nursing curricula. This finding was echoed in Goldberg et al.'s (2019) mixed methods survey of trans college students' needs. With regard to curricula, respondents in Goldberg et al. (2019) urged for broader thinking about curricular inclusion, such as including scholarship written by trans individuals.

Finally, the participants in the present study felt burdened as the default advocates on campus due to transinvisibility. Kinship networks are important for the effective coping and resilience of trans college students (Nicolazzo, 2016). Often times, LGBTQ groups have contributed to the kinship networks of trans college students (McCann & Brown, 2018; Stewart, O'Halloran, & Oates, 2018). Of concern in the present study was that participants discussed some difficulty establishing kinship networks within the nursing program. This was due to transinvisibility on campus, noting the absence of visible LGBTQ+ faculty and nursing students.

Additionally, participants found that the LGBTQ+ campus centers were not readily accessible or available to students due to the unique learning schedules for nursing students. Transinvisibility in student life compelled the participants to engage in advocacy, such as by starting and attempting to maintain an LGBTQ+ group for nursing students. Once again, this was a role that became burdensome.

In contrast, transvisibility was affirming when present. Transvisibility came in the form of knowledgeable faculty who had authentic experiences with trans persons, whether on a personal or professional level. Though participants noted an absence of visible LGBTQ+ faculty, they asserted that would have been affirming. Participants who did have access to an LGBTQ+ center on campus noted that positive kinship network developed as a result.

Navigating transition and coming out. The theme of navigating transition and coming out arose from (a) participants' explanations about the timing and pathways of their transitions and coming out, and (b) the impact of transition on wellness and academics. Thus, research sub-question one correlated with the admission, progression, and graduation experiences of the participants. Similar to the findings of Goldberg and Kuvalanka (2018), Nicolazzo (2016), and Pryor (2015), the participants in the present study carefully discerned when to come out as trans, as a measure of self-care and protection. For example, one participant masked her trans identity when attending the interview for admission to the nursing program. She feared her gender identity may result in discrimination and denial of admission. In contrast, another participant delayed application to the nursing program until she felt confident that she could pass as female. This participant masked her trans identity throughout her nursing program until after graduation. Yet another participant chose to disclose her trans identity upon seeking admission to the prelicensure nursing program. This participant had the unique experience of achieving a

previous non-nursing degree from the same university, but had since undergone extensive medical/surgical and social transition, including name and gender markers. She had pre-established relationships and knowledge about campus culture that afforded her a sense of security. Therefore, her particular strategy when seeking admission was to disclose her trans status and push a narrative of gender diversity.

In addition to self-protection, the participants chose to mask their trans identities and to time transition to minimize social disruption. In part, they sought to reduce the discomfort of cis individuals in the educational environment. Participants carefully timed medical, surgical, and/or social transition to academic breaks whenever possible. They felt this would make it easier for others to use the correct name and pronouns. For some, this was during a summer break; for others, the goal was to complete a component of transition prior to engaging in direct patient care in the clinical learning environment. One participant used a gender-neutral bathroom in a separate building on campus as a way to mask her trans identity and to avoid causing discomfort for others. Another participant described her prelicensure nursing program experience as being mostly "in the closet" because of fear of how others would respond. She was also fearful of discrimination in attaining employment and being financially disowned by family; therefore, she waited to fully come out after she had attained employment at the time of graduation.

Navigating transition involved coping with the health and academic effects of medical transition, as well as distress from gender incongruence pre-transition. Participants discussed accelerated heart rates, difficulty caring for selves, struggling with a "second puberty," depersonalization, dysphoria, feeling hormonally imbalanced, and maladaptive coping such as substance use. The academic effects participants discussed included placing greater importance

on transition than learning; difficulty with attention, cognition, and memory; and the sense that hormonal imbalance caused poor exam performance and subsequent dismissal from the nursing program. Previously published research on the possible impact of gender incongruence and/or medical transition on the cognition of trans college students was not discovered.

Navigating legal transition held unique implications for participants in the pursuit of nursing licensure. Use of legal names for nursing licensure is reasonable for protection of public safety, but simultaneously presents challenges for trans nursing students approaching graduation. Participants were unable to identify clear pathways to gain consistency in the names appearing on legal and educational documents required for licensure. It is unclear whether enhancements in legal gender identification at the state level, as described by Lam (2019), might generate clear pathways.

Pride in nursing. Though no known studies discuss professional pride among minority nurses or nursing students, Sorenson and Hall (2011) found that the ability to "see the big picture" in nursing practice was a source of human and professional pride. Adapted from Sorenson and Hall's (2011, p. 2289) definitions, the participants' pride in the present study related to their personal human dignity and feelings of value as a human being within the nursing profession, including appreciating what one brings to the profession. They were able to see the big picture.

Participants were proud to be on a career trajectory in nursing and took pride in their nursing skills. This correlated to their description of clinical learning experiences, which was research sub-question three. Overall, participants characterized their clinical experiences as positive and frequently received compliments from clinical staff and patients. Nursing faculty were notably absent from participants' descriptions of clinical experiences. It is unknown

whether this was due to clinical education models or due to negligible faculty influence on participants' clinical experiences. Positive clinical experiences with patients and clinical staff impacted each participant's sense of value and belonging as an impending member of the nursing profession. However, most participants also seemed to have an intrinsic understanding of their value to the nursing profession, such as the ability to empathize with patients or demonstrate strong communication skills.

Some participants explicitly identified reciprocity between their comfort and confidence with nursing skills and with their gender identity. As self-efficacy in nursing skills grew, so did confidence in their trans identities. This may be partly due to the financial security and social capital offered by being on a trajectory to join a virtuous profession known for job security. This was an interesting finding that deserves further study.

Personal gender experiences enhanced nursing care. Personal gender experiences were springboards for participants to approach their nursing care with empathy and cultural humility for patients of all walks of life. The participants reported approaching patients without assumptions or judgments, especially when working with vulnerable populations. Some mentioned respect for human differences, even in academic settings outside of their clinical education. However, this theme predominantly related to nursing care in the clinical setting, correlating with research sub-question three.

Though participants did not use the term "cultural humility," the descriptions of their approach to patient care aligned with the concept. Foronda's (2020) grand theory of cultural humility provided the following definition:

> Cultural humility refers to the recognition of diversity and power imbalances among individuals, groups, or communities, with the actions of being open, self-aware, egoless,

> flexible, exuding respect and supportive interactions, focusing on both self and other to formulate a tailored response. Cultural humility is a process of critical self-reflection and lifelong learning, resulting in mutually positive outcomes. (p. 9)

Approaching others with an open, flexible mind-set was something demonstrated in participants' narratives about caring for patients who identified as neo-Nazis or who were incarcerated. They reflected on these cultural encounters and discussed how they grew in their understanding of others. Cultural humility is valued in nursing education and practice. Foronda (2020) suggested that cultural humility may "improve communication, satisfaction, empowerment, partnerships, respect, optimal care, health, and wellness" (p. 11).

In addition to cultural humility and empathy for all patients, participants recognized their abilities to provide gender-affirming care to trans patients, given their personal experiences and knowledge. Some participants pursued a career in nursing with the goal of providing gender-affirming care to trans patients. For others, the recognition of their abilities to provide gender-affirming care unfolded as they progressed through their clinical experiences. Therefore, the theme that personal gender experiences enhanced nursing care also related to research sub-question six, regarding participants' pursuit of nursing careers.

As described in theme three, participants' personal gender experiences included continuously traversing assumptions about gender and nursing during their prelicensure nursing experience. Additionally, participants discussed approaching others without assumption. It is logical that their personal gender experiences with traversing assumptions contributed to the importance they placed on approaching others without assumption. Approaching patients without assumption has been shown to be important in gender-affirming nursing care. In Rivera's (2019) study of trans patients' lived experiences with nursing care, trans patients

identified informed nursing care to be pivotal to feeling comfortable accessing healthcare. Cultural humility is a necessary approach in providing gender-affirming care to trans patients (Bell et al., 2019). Nurses who approached care with assumptions fueled anxiety and frustration in trans patients and compounded marginalization (Rivera, 2019).

Theoretical Framework and Interpretation

The theoretical framework for this research study was the Minority Stress Model developed by Ilan Meyer (2003). According to Meyer, minority stress is unique stress experienced by individuals in stigmatized social categories due to their minority status. Minority stress occurs in addition to general stress.

Prelicensure nursing students are known to experience high levels of general stress. In Boulton and O'Connell's (2017) national survey of 4,033 members of the National Student Nurses' Association, students reported a moderate degree of stress. Student nurses reporting higher levels of stress were more likely to report misuse of substances (Boulton & O'Connell, 2017). In Reeve, Shumaker, Yearwood, Crowell, and Riley's (2013) mixed methods study of 107 undergraduate nursing students enrolled at one private university, respondents reported high levels of anxiety, worry, and depression related to stress. Sources of stress within their clinical experiences included feeling rejected by faculty, clinical staff, and patients; and feeling inadequate, unprepared, and overwhelmed in clinical experiences and as a learner in general.

In addition to general stress experienced by all student nurses, the present study provides insight into how the Minority Stress Model may apply to student nurses who are trans. The relationships among this study's findings and the Minority Stress Model are graphically represented in Figure 4. Participants experienced distal minority stress processes at institutional and individual levels. Distal minority stress processes are objective and discriminatory (Meyer,

2003). At the institutional level, one example of distal stress processes was inadequate and/or misinformed trans health topics in the nursing program curricula. Inadequate curricula resulted in students feeling burdened as the default educators and advocates. Along with the general nursing student stress of learning in the classroom, the participants coped with the additional stress of altruistically educating and advocating for the sake of the trans community.

Another example of distal minority stress processes at the institutional level was binary, cisnormative institutional systems. All prelicensure nursing students nearing graduation likely experience general stress as they encounter license application processes, preparing for the licensure exam (NCLEX), and securing employment. However, participants in this study discussed additional minority stress during this already generally stressful timeframe as they were navigating legal gender transition processes.

At the individual level, distal stress processes included discriminatory application of the student dress code, differential learning opportunities based on perceived gender, and unwanted sexual and romantic advances. Participants also demonstrated evidence of proximal stress processes. This was apparent, for instance, in the theme of navigating transition and coming out, feeling like trans identity was a "liability," and fearing discrimination during clinical experiences or in securing employment. As a protective strategy related to this proximal stress, participants used language as a barometer for respect and safety.

Meyer's (2003) Minority Stress Model asserts that integration of the minority identity as one component of an individual's entire personhood will result in optimal health outcomes for the individual. Prominence and valence impact the pathway to integration. Prominence is the understood importance placed on the minority identity. According to Meyer (2003), in coming out, individuals risk the minority identity becoming their prominent identity while other personal

and social identities are ignored. Valence is the self-evaluation of the minority identity as positive or negative. More positive valence corresponds with diminished internalized transphobia, improving mental health (Meyer, 2003).

Two themes in this study may interact with prominence, valence, and integration: (a) pride in nursing, and (b) the burden of altruism as default educators and advocates. For some participants, valence trended toward more negativity at the time of admission in the nursing program. Uncertainty about the trans identity within the context of nursing changed over time, as participants began to regard their trans identities as more positive within the context of nursing. As they progressed through their prelicensure nursing programs, participants' pride in nursing increased and this positively influenced the valence of their trans identities.

The burden of altruism as default educators and advocates may have impacted both prominence and integration for participants. Serving in educator and advocate roles increased the prominence of trans identities, which may have otherwise been concealed. Each participant expressed feeling that the trans identity was the prominent identity in how faculty and peers viewed them. Moreover, participants seemed to be desiring integration of the trans identity, but found that serving as default educators and advocates inhibited integration progress.

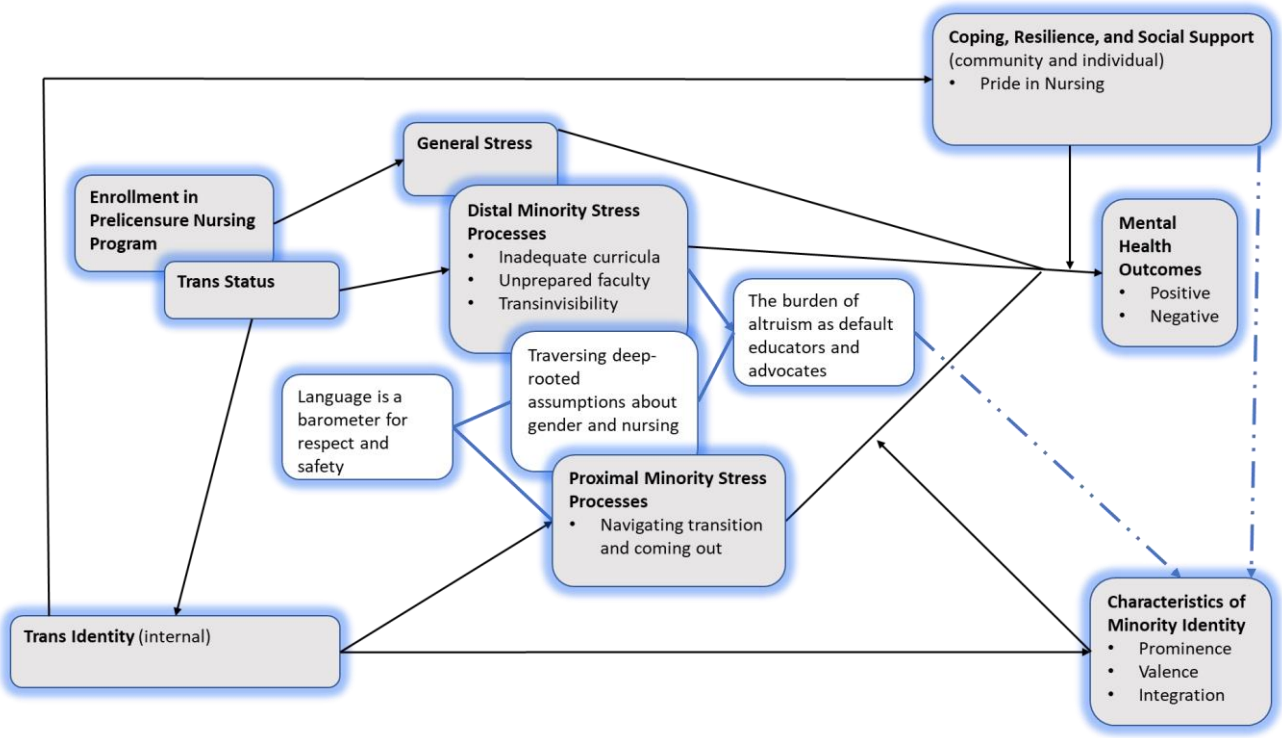

Figure 4. Theme relationships to the Minority Stress Model

Limitations of the Study

Few studies have explored experiences of trans students seeking to enter a gendered profession that also serves trans persons. Still this study had limitations to consider. Creswell (2013) recommends a sample size of at least three participants for a phenomenological study. Though this goal was met, a larger sample may have enhanced heterogeneity. The sample was fairly homogenous: all participants identified as white, non-Hispanic, sexual orientation minorities. Lack of racial, ethnic, and sexual diversity in the sample does not allow one to consider intersectionality of identities. Only one participant identified as nonbinary trans and described themselves as trans-masculine, with the remaining three participants identifying as trans female. With research suggesting nonbinary trans individuals have additional challenges living in a society that embraces the gender binary, it is likely that nonbinary trans individuals have additional challenges in nursing programs as well. Additionally, there was no participant

inclusion criteria related to degree of transition or degree of outness. Both variables likely influenced the study results. Finally, though the PI bracketed personal bias, the PI's identification as a cis female nurse educator may have influenced the research findings.

Implications/Recommendations for Education

Trans persons have the right to receive a quality education in nursing as their authentic selves and to join the workforce without discrimination. Nurse educators have a responsibility to implement recruitment and retention strategies aimed at diversifying the workforce. The educational journey of all prelicensure nursing students should be characterized as inclusive and respectful. This study promotes understanding of the experiences of trans persons in their prelicensure nursing programs, shedding light on how those experiences might be enhanced. Furthermore, the study findings suggest there is mutual value in actively recruiting trans persons to join the nursing workforce. Trans persons could positively influence gender-affirming nursing care while a career in nursing could offer security and social capital for trans persons.

Given the comparison of the study findings to the Minority Stress Model (Meyer, 2003), perhaps the most urgent implication for prelicensure nursing programs is easing trans nursing students' burden to educate and advocate. This begins with revising program curricula and preparing nurse educators to teach trans health and to teach trans students. Nursing program faculty and administrators need to critically evaluate cisnormativity, gender binary, and gender assumptions and stereotypes often embedded in formal curricula.

Faculty can swiftly implement changes in individual nursing courses. Prior to the next teaching semester, faculty can evaluate course documents and assignments for gender bias, including the representation of gender diversity in language and images. Furthermore, all college personnel should be using affirming names and pronouns for students. Due to the limitations of most institutional systems in identifying students by names other than their legal

names, it is prudent for faculty to privately identify each student's affirming name and pronouns. Small, basic changes in language can make a profound impact.

Ensuring trans health concepts are formally integrated throughout curricula will be a more involved, collaborative process for faculty and administrators. Rather than one lecture on trans health issues, findings of the present study have suggested that trans health concepts should be incorporated with each topic as appropriate. For instance, when teaching the patient interview in the health assessment, nursing faculty could include information about asking for pronouns and affirming name. Curricular integration is necessary to prepare future nurses to care for gender diverse patients and to establish gender-inclusive learning environments for trans students.

Before major curricula changes can occur, nursing faculty need professional development on the topic of trans health. Professional development will take time. In the interim, faculty could invite trans health topic experts into classrooms. Simultaneously, professional development of nursing faculty could begin through film, novels, autobiographies, professional conferences, and journal clubs. One way to begin to reform implicit bias among nursing faculty is to engage in activities that increase self-awareness of cis privilege. Baker et al. (2018) described use of poetic inquiry pedagogy to increase awareness of cis privilege among undergraduate teaching students. This strategy may be useful with nursing faculty as well. Developing faculty knowledge on the topic of trans health is essential in easing the burden felt by trans students.

Along with trans health concepts, faculty have opportunities to grow in their knowledge of the needs of trans students. Terminology has been identified as an area of potential faculty development. Trainings from an area LGBTQ+ campus or community center may be used to

promote knowledge of terminology. Typically, such trainings are labeled as “Safe Space” or “Safe Zone” trainings. If nursing programs are not aware of area programming for Safe Space trainings, administrators can contact organizations such as Campus Pride (campuspride.org) to bring Safe Space training to campus. Many trainings also discuss how to respond to biased or prejudicial comments in the classroom, how to support students who come out, the signs of psychological distress and suicidal ideation, and the importance of connecting students with campus services in these situations. Such development will allow nurse educators to recognize and respond to the holistic needs of trans students in partnership with student health services.

In preparation for graduation and obtaining licensure, senior nursing students provide documents to state boards of nursing. Documents vary by state, but may include birth certificates, criminal background checks, and official college transcripts. Therefore, administrators may help trans students by exploring ways to alleviate some of the name incongruence among documents. In September 2019, more than 50 universities in the U.S. were allowing students to change their genders, names, and pronouns on some campus documents and systems (Johnson, 2019). According to Johnson (2019), most institutions in higher education required the use of student’s legal names for financial aid documents and on grade transcripts, but diplomas were able to display the students’ chosen names. Administrators can learn from these model institutions. Additionally, faculty and administration can ensure nursing students receive information early in the nursing program about legal requirements for licensure, as well as resources to assist with the legal name change process in their particular state. Showing students pathways for legal transition early in their nursing education could affirm students’ gender identities and minimize minority stress.

Another legal consideration is that Title IX prohibits gender discrimination. Per federal law, all institutions should adopt and enforce zero tolerance policies for gender discrimination and sexual misconduct. The law is ambiguous but implies that unwanted sexual or romantic advances made toward students during clinical education experiences are subject to Title IX. Therefore, sexual misconduct like the experience of one participant in this study should be investigated. Institutions must understand the obligation and implications of mandatory reporting of any gender or sex discrimination (Weiss & Lasky, 2017). Trans students may benefit from receiving information about Title IX as part of campus application and admission processes.

A final legal consideration is the impact of health on learning. It has been clearly established that trans identities should not be pathologized. However, anxiety, memory problems, and difficulty concentrating that may arise from gender incongruence and/or the medical treatment for gender incongruence, call for an examination of these health effects within the framework of the Americans with Disabilities Act (ADA). "A disability is a physical or mental impairment that substantially limits one or more of a person's major life activities" (Singh, 2019, p. 244). Major life activities include, but are not limited to, caring for one's self, concentrating, sleeping, and memorizing (Singh, 2019); hence, the physiological effects of gender incongruence and its medical treatment may qualify as disabilities as defined by the law. Trans students should be made aware of their educational rights in relation to the ADA and how to access related campus services.

Trans nursing students have expressed the benefit of transvisibility, including LGBTQ+ personnel and campus centers. Large campus LGBTQ+ centers may consider whether they are accessible, given the unique learning schedule of nursing students. On small campuses, trans

students could be connected to community or online resources and supports. Institutions should support gender-inclusive environments that welcome and retain trans personnel. This will be a difficult task within the colleges of nursing without first embracing efforts to recruit and retain trans nursing students.

For true gender diversification of the nursing profession and to subsequently improve culturally congruent care for trans patients, trans persons should be actively recruited into the profession. The participants in this study demonstrated advanced cultural humility, empathy, and gender-affirming approaches to care. It is unknown whether these attributes are generalizable to trans nursing students, but they are acknowledged as desirable attributes in nursing. It is possible that welcoming more trans nurses to the workforce could advance gender-affirming patient care and help shift the nursing profession from cisnormative approaches to gender-inclusive approaches in education, practice, and research.

Future Research

One impetus for this study was the national call for diversification of the nursing workforce. Theoretically, diversification of the healthcare workforce will improve minority access to healthcare, enhance patient satisfaction, and improve outcomes. This is logical, but there is no known empirical evidence to demonstrate that diversifying the healthcare workforce improves health equity and reduces health disparities. Though participants freely spoke of their contributions to gender-affirming care for trans patients, this warrants future research. Is there a measurable difference in the gender-affirming nursing care provided by trans nurses versus cis nurses? Designing such a study would require careful development of measurement methods to be used with a small, controlled sample.

Though there has been research regarding the employment experiences of LGBTQ+ health care providers, there is a paucity of evidence regarding the employment experiences of trans nurses. Understanding the assumptions about gender and nursing revealed in the present study, trans nurses likely have experiences unique from sexual orientation minority health care providers. Continuing to add to the body of literature about trans persons as healthcare providers has the potential to aid in recruiting and retaining trans persons in the healthcare workforce.

This study points to the need to influence the knowledge, skills, and attitudes of faculty and clinicians working with trans patients and trans students. Specific strategies that change faculty behaviors deemed microaggressions are not evident. Therefore, interventional, longitudinal studies would be valuable in identifying effective strategies.

Finally, there is a need to continue to add to the body of evidence regarding the experiences of trans nursing students. It is critical for future research regarding trans nursing students to examine intersectionality of trans and other identities. Additional exploration of the influence of medical and surgical transition on learning needs and abilities of trans students may be beneficial to identify ways to support academic success.

Summary

A phenomenological approach was used to answer the research question, "What are the lived student experiences of trans persons enrolled in U.S. prelicensure nursing programs?" Creswell's approach to data analysis revealed six themes: (a) language is a barometer for respect and safety, (b) traversing deep-rooted assumptions about gender and nursing, (c) the burden of altruism as default educators and advocates, (d) navigating transition and coming out, (e) pride in nursing, and (f) personal gender experiences enhanced nursing care. Three subthemes contributed to the burden of altruism as default educators and advocates: (a)

faculty were unprepared to teach trans students and to teach trans health content; (b) formal curricula were inadequate, cisnormative, and pathologizing; and (c) transinvisibility was common on campus.

This study promotes understanding of the experiences of trans persons in their prelicensure nursing programs, including how these experiences integrate with the Minority Stress Model (Meyer, 2003). This allows college personnel to recognize potential sources of minority stress for trans students and strive to mitigate them. The most urgent implication for prelicensure nursing programs is to ease trans nursing students' burden to educate and advocate. Faculty and administrators can begin by eliminating gender bias in the classroom and ensure threading of accurate, depathologized trans health concepts throughout curricula. Simultaneously, nursing faculty need professional development on the topics of trans health and trans students.

Institutions can examine binary, cisnormative systems trans students must traverse. For nursing students, such systems are also encountered when preparing for licensure exams. Additionally, institutions must adopt and enforce zero tolerance policies for gender discrimination and sexual misconduct.

Finally, the trans persons participating in this study demonstrated advanced levels of cultural humility and empathy. Participants felt pride and a sense of belonging in nursing that had a reciprocal effect on positive valence of their trans identities. Therefore, there is mutual value in actively recruiting trans persons to join the nursing workforce, benefitting both trans persons as future nurses and the future recipients of their care.

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APPENDIX A
Glossary

Cisgender: category of individuals whose gender identity and expression aligns with their sex.

Cisnormativity: the assumption that individuals are cisgender.

Gender: a sociocultural categorization based on gender markers and gender expression. Gender may or may not align with sex.

Gender binary: the dichotomous view of gender in which there are only two options: male or female, as determined by an individual's biological sex

Gender expression: external display of gender, contextually and culturally influenced and interpreted, often on a continuum of masculine to feminine.

Gender dysphoria: a diagnosis of mental illness in which an individual experiences distress related to incongruence between gender identity and assigned sex.

Gender identity: self-determined, internal sense of gender. Gender identity can statically exist or fluidly move on a continuum encompassing, male, female, both, neither, or something else.

LGBTQ+: an acronym meaning lesbian, gay, bisexual, transgender, queer or questioning. The "+" symbol is frequently utilized in efforts to capture all sexual orientation and gender minority identities beyond LGBTQ. The acronym may be shortened to identify specific gender identity or sexual orientation minorities.

Sex: a biological categorization assigned at birth, based on characteristics that distinguish male, female, and intersex individuals. Biological characteristics include chromosomal composition, external genitalia, and internal reproductive organs.

Sexual orientation: sexual, emotional, and romantic attraction, primarily categorized according to binary views of gender.

*Trans** or *trans*: widely used to signify an abbreviation of transgender, along with all of the possible truncations and identities that fall under the trans umbrella, such as transsexual, transman, etc.

Transgender: an umbrella term for persons who are not cisgender. Transgender individuals identify and/or express gender differently from their assigned sex.

Transphobia: feelings or expressions of discomfort, disapproval, disgust, fear, anger, or hatred toward people who do not conform to societal gender norms.

Transinvisibility: the lack of attention, awareness, and acknowledgement of trans persons in society due, in part, to cisnormative and gender binary conceptualizations and structures.

APPENDIX B
Letter of Inquiry to Potential Recruitment Partners

Dear (Recipient Name):

I am a doctoral candidate in the EdD program, with emphasis in nursing education, at Bryan College of Health Sciences. I am reaching out due to our common interest in advocating for, supporting, and serving trans persons. I am specifically inquiring about your interest in partnering with me to recruit prospective trans participants for my proposed dissertation research study. The purpose of my research study will be to explore the college student experiences of trans persons who have been enrolled in nursing programs. I anticipate your role in recruitment would involve distributing or advertising an official invitation to participate in my study, after I receive approval from Bryan College of Health Sciences' federally-registered Institutional Review Board. I project I will receive approval, allowing participant recruitment to begin in early summer.

I would appreciate a response, regardless of your interest in partnering with me, and completely understand if you decline. If you decline, I will remove you from my contact list. If you have not responded within the following week, I will reach out to you a second time. If you have questions, please contact me by phone or email. I appreciate your time in considering my request.

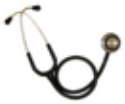
Sincerely,

Jenna Dubas, MSN, RN (she/her/hers)
EdD Candidate
Bryan College of Health Sciences
1535 S. 52nd St.
Lincoln, NE 68506
jenna.dubas@bryanhealthcollege.edu
402-481-3906

APPENDIX C
Recruitment Flyer

Do you identify as trans*?

Have you pursued a career in nursing?



Participate in a study about **Trans Persons as Students in Nursing Programs** to give a voice to your experiences

- I am looking for trans persons who have been enrolled in a practical/ vocational nursing, RN diploma, associate, or baccalaureate (bachelor) degree nursing programs who would like to anonymously participate in individual interviews about their student experiences.
- Participants need to meet the following criteria:
    - Age 19 years or older
    - Currently self-identify as trans
    - Self-Identified as trans while enrolled in a U.S. prelicensure (LPN/LVN or RN) nursing program
    - Enrolled in the prelicensure nursing program for at least one academic term (quarter, semester, or other) any time between the years 2014-2019, including at least one clinical course.
    - Read and speak English
    - Ability to meet with me face-to-face or using Skype videoconferencing for approximately 60-90 minutes.

- Participants will receive a $5 Amazon e-gift card at the conclusion of the interview, as a token of thanks.

To learn more about the study or to volunteer to participate, please contact:

Jenna Dubas, MSN, RN, doctoral candidate (she/her/hers):
jenna.dubas@bryanhealthcollege.edu
402-481-3906

*For this study, *Trans* respectfully includes any gender identity different from the sex assigned at birth, including, but not limited to transmale, transfemale, gender-nonconforming, gender fluid, genderqueer, agender and two-spirit.

Images credit: Wikimedia Commons at https://commons.wikimedia.org

APPENDIX D
Recruitment Partners, Forums and Listservs

Location	Organi-zation	Details	Contact Name	Contact Info	Flyer Distribution		
					Elec-tronic	Mail	Hand
National	Consortium of Higher Education LGBT Resource Professionals	My individual membership allows me to post within the research forum which all institution consortium members have access to. In addition, I can email all individual members (733 institutional memberships listed; 798 total memberships in directory)			x		
	CenterLink	National Community of LGBT Centers—They directed me to select specific centers and email them the recruitment flyer, as there is not a way to do an email blast because they are inundated with research requests. I will select some centers in large cities that specifically identify themselves as physical centers offering support for trans people, such as in San Francisco, Birmingham, DC, NYC, Chicago, Miami, Denver, Minneapolis, Seattle, Houston, LA, Philadelphia		Email from website at https://www.lgbtcenters.org/ContactUs	x		
Nebraska-wide	OutNebraska (formerly OutLinc)	Brand new statewide expansion.	Waylon Werner-Bassen, board member Executive Director: Abbi Swatsworth	See OutLinc and Drag Queen Story Hour abbi@outlinc.org			

Location	Organi-zation	Details	Contact Name	Contact Info	Flyer Distribution		
					Elec-tronic	Mail	Hand
	Nebraska AIDS Project		Lacie Bolte	laciet@nap.org			
Lincoln	Lincoln Bike Kitchen	Women and trans open shop—1st and 3rd Tues. of each month	No name	lincolnbikekitchen1@gmail.com			x
	Star City Pride	Festival / Parade: June 7-8, 2019—probably won't work due to timing of festival		info@starcitypride.org			
	LGBTQA Resource Center at UNL		Pat Tetreault	lgbtqa@unl.edu			
	Allison Bitz	Counseling / therapy for trans persons	Allison	contact@drallisonbitz.com			
	BlueSky Therapy	Counseling / therapy for trans persons	Tauni Waddington	tauniwaddington@aol.com			
	Ryan Sallans, Inc.	National LGBTQ+ speaker	Ryan Sallans	ryan@ryansallans.com			
	Collaborative Transitions Coaching			gseiste@gmail.com			
	Drag Queen Story Hour		Waylon Werner	dragqueenstoryhourne@gmail.com			
Omaha, NE	UNO speech, language, and hearing clinic	Vocal modification for trans persons	Jill Kumke, clinic coordinator	402.554.3528 jkkumke@unomaha.edu			
	One World Community Health Centers—LGBTQ+ HC at 8 clinics in Omaha area	https://www.oneworldomaha.org/lgbtq-health-care/	Clara Fynbu—NP there	clara.fynbueggert@doane.edu			
	River City Gender Alliance		Katherine 'Kate' Parrish	president@rcga.co			

Location	Organi-zation	Details	Contact Name	Contact Info	Flyer Distribution		
					Elec-tronic	Mail	Hand
			president@rcga.co kate8parrish@gmail.com 402-541-5792				
	Insight Wellness	Therapy/counseling for trans persons	Michelle Wieme Paige Vorderstrasse	Glica4@gmail.com 402-661-4149			

APPENDIX E
Telephone Script
For Use with Prospective Participants

Introduction

Thank you so much for contacting me about your interest in participating in this study. The purpose of the study is to explore the experiences of trans individuals who have been enrolled in nursing programs. Participation in this study is completely voluntary and involves a one-on-one interview estimated to last 60-90 minutes. The interview can occur in-person or using Skype, whichever is geographically reasonable and affirming.
Are you still interested in participating?

Yes--- *Wonderful. Before we schedule a time for an interview, let's make sure that you meet the participant criteria required for the study*. Proceed to **Inclusion/Exclusion Screening Criteria.**

No—*Thank you so much for reaching out regarding this study. If you know of others who may like to participate, I appreciate you providing them with my contact information. Thanks again.*

Inclusion/Exclusion Screening Criteria

Inclusion Criteria:

1. *Are you age 19 or older?*
   Yes_____ No_____

2. *For my study, I have defined trans as any gender identity that does not align with the individual's sex assigned at birth. Do you identify as trans?*
   Yes_____ No _____

3. *For my study, I have defined a prelicensure nursing program as vocational/practical nursing programs, associate's degree, diploma, or baccalaureate programs designed to lead to initial licensure as an LPN/LVN or RN. Have you been enrolled in a prelicensure nursing program for at least one academic term between 2014 and 2019?*
   Yes_____ No _____

4. *Did you identify as trans during your enrollment in a prelicensure nursing program?*
   Yes_____ No _____

5. *Have you been enrolled in a clinical course in your nursing program?*
   Yes_____ No _____

6. *Are you able to use Skype or to travel to a public library in the Lincoln and Omaha area?*
   Yes_____ No _____

Exclusion Criterion:

1. *Was your prelicensure nursing program fully online?*
   Yes_____ **No** _____

2. *Are you willing to provide your full name, cell phone number, and city and state of residence?*
   Yes_____ No_____

Does prospective participant meet criteria?

Yes—*You meet the study criteria, so let's talk about the interview.* Proceed to **Interview Scheduling**

No—*Unfortunately, you did not meet all of the criteria required to be in the study. Thank you so much for reaching out regarding this study. If you know of others who may like to participate, I appreciate you providing them with my contact information. Thanks again.*

Interview Scheduling

Would you prefer to meet in a private study room at a public library in the Lincoln or Omaha area for the interview or prefer to hold the interview using Skype?

Public Library—*Okay. Let's select a location that is convenient for both of us.* Proceed to **Public Libraries**

Skype—*Okay. Let's discuss use of Skype.* Proceed to **Skype Interviews.**

Skype Interviews

Preparing for Skype

- *In preparation of the Skype interview, please make sure you have a personal Skype account that is current and that you remember your password.*
- *You might consider creating a new account with a fake name that is linked to a personal email.*
- *My Skype account can be found by using my email: jenna.dubas@bryanhealthcollege.edu*

Protecting your privacy and confidentiality

- *For the interview, please select a private location that will allow you to speak freely, while protecting your identity and confidentiality.*

Ensuring good sound quality

- *I will be using a digital audio recorder to record your responses during the interview. The recordings will be used to transcribe your responses to a written format, so sound quality is essential.*
- *For the interview, please select a very quiet environment that is free from background noise.*

Public Libraries

- *We will select a library that has private study rooms, as a measure to protect your privacy and confidentiality. Would you prefer a library in Lincoln or Omaha?*

Lincoln	Omaha
Southeast: Gere Branch	**Elkhorn: Bess Johnson Elkhorn Branch**
2400 S. 56th St. Lincoln, NE 68506 (402)441-8560 Mon-Thur: 10a.m.-8p.m. Fri.-Sat: 10a.m.-6p.m. Sun: 12p.m.-8p.m.	2100 Reading Plz. Elkhorn NE 68022 402-289-4367 Mon-Thurs: 9a.m.-8p.m.; Fri-Sat: 9a.m.-6p.m.
Downtown: Bennett Martin	**Millard Branch**
136 S. 14th Street Lincoln, NE 68508 (402)441-8500 Mon-Thurs: 10a.m.-8p.m. Fri-Sat: 10a.m.-6p.m. Sun: 12p.m.-6p.m.	13214 Westwood Ln. Omaha NE 68144 402-444-4848 Mon.-Thurs: 9-9; Fri-Sun.: 9-6
Northwest: Eiseley Branch	**Northwest: Saddlebrook Branch**
1530 Superior St. Lincoln, NE 68521 (402)441-4250 Monday – Thursday: 10 a.m. – 8 p.m. Friday – Saturday: 10 a.m. – 6 p.m. Sunday: 12 p.m. – 8 p.m.	14850 Laurel Ave. Omaha NE 68116 402-444-5780 Tue-Thur: 8-8; Fri: 8-5; Sat: 9-4
Southwest: Bess Dodson Walt Branch	**Southeast: South Omaha Library**
6701 S. 14th St. Lincoln, NE 68512 (402)441-4460 Monday – Thursday: 10 a.m. – 8 p.m. Friday – Saturday: 10 a.m. – 6 p.m. Sunday: 12 p.m. – 8 p.m.	2808 Q St. Omaha NE 68107 (402) 444-4850 Mon-Thurs: 7:30-9; Fri-Sat: 9-6
	Northeast
	Charles B. Washington Branch 2868 Ames Ave. Omaha NE 68111 402-444-4849 Mon-Wed: 9-8; Thur-Sat: 9-6
	Florence Branch 2920 Bondesson St. Omaha NE 68112 402-444-5299 Tue-Wed: 10-8; Thur-Sat: 10-6
	North Central: Milton R. Abraham Branch
	5111 N. 90th St. Omaha NE 68134 402-444-6284 Mon-Thurs: 9-9; Fri-Sat: 9-6; Sun: 1-6

Interview Date/Time

The interview is estimated to take 60-90 minutes. What day and time would work well for you to be interviewed?

Date: **Time:**

Contact Information

I need to gather some essential contact information for my records. I need your full name, cell phone number, personal email address, and city and state of residence. I will use your city of residence to create an individualized consent form that lists local support services, should you need them. I will use your personal email address to send you an encrypted link to access some of the study documents. Upon completion of your interview, I will also use the email address or cell phone number to send you an Amazon e-gift card. I will keep all of your identifying contact information confidential and will destroy it upon completion of my study. However, I need to make you aware that I am required to follow standard protocols for emotionally-charged research. This means I would be obligated to share your name, phone number, and city of residence with emergency personnel if intent to harm self or others was expressed to me. Are you comfortable providing me your name and contact information at this time? **(Record info on separate contact information spreadsheet)**

Participant Rights & Consent

Your name will appear on a consent form that you will need to be signed before beginning the interview. Your email address will be used to email you a link to an encrypted Dropbox to which only you and I have access. You do not need to have a Dropbox account to access the documents I share with you via a personalized link in encrypted email. You can expect to receive the email with the link to access DropBox from me within 1-2 business days. In the Dropbox, you will find the consent form and another document called the "Rights of Research Participants." I encourage you to read these in advance of the interview. Keep in mind that participation in this study is voluntary and you can withdraw at any time. After you read through these documents, if you decide that you no longer wish to participate, please notify me that you would like to cancel the interview. Choosing not to participate or withdrawing from the study will not damage your relationship with me or Bryan College of Health Sciences, but advance notification is greatly appreciated.

I will email you the day before your scheduled interview, to confirm date/time/place. Upon meeting for the interview, I will give you an opportunity to ask any questions about the study, the informed consent, and the "Rights of Research Participants." After answering your questions, and you would like to proceed, I will get your electronic signature on the informed consent in the DropBox at that time. Then, we will be able to proceed with the interview questions.

Closing

What questions do you have at this time?

Please reach out to me if any questions or concerns arise in advance of the interview, or if you need to reschedule your interview time.

Thank you, again, for contacting me! I am looking forward to meeting you and hearing your story. I will see you at/via__(location/Skype)_____ on ___(date)____at__(time)__

Prospective Participant 3 digit code:_____ (assigned from contact sheet)

APPENDIX F
Demographic Data Collection

1. **Age**
2. **Gender**
3. **Sexual Orientation**
4. **Race**

Alaska Native	Asian	American Indian
Black or African American	Multiracial:	Native Hawaiian
Other Pacific Islander	White	Other:

5. **Ethnicity**

Hispanic or Latino	Non-Hispanic / Non-Latino

6. **Prelicensure program type**

associate	baccalaureate
diploma	practical/vocational

7. **Number of academic terms enrolled**

8. **Approximate number of clinical courses**

9. **Format of prelicensure nursing program**

Face-to-Face	Hybrid

10. **Geographic region of prelicensure nursing program**

www.worldatlas.com

APPENDIX G
Interview Protocol

Date:
Time:
Physical Location:_____or Skype:_____
Interviewer: Jenna Dubas, I use the pronouns she/her/hers.
Participant Pseudonym: _____pronouns:_____3-digit code_____
Icebreaker question: How have you (will you) spent(d) the day?
The Institutional Review Board at Bryan College of Health Sciences has approved this study. The purpose is to explore the experiences of trans persons enrolled in nursing programs. The study intends to support trans persons who pursue a career in nursing. Participation in this study is voluntary. You may end the interview at any time. Your decision to participate or withdraw from this study will not affect your relationship with me or Bryan College of Health Sciences. This interview will be audio recorded and transcribed. I will also write notes as you are speaking.
One risk of participating may include emotional distress, such as anger, anxiety, or stress upon describing your experiences. You may take breaks or ask to end the interview at any time. If you were to share plans to harm yourself or others, I would be obligated to notify emergency personnel of those plans. Another risk of participating is loss of confidentiality or privacy. However, I will take steps to lower that risk. During the interview, I will refer to you using a fake name you select. As you talk, please try not to name specific colleges and geographic locations, as measures to protect your identity. All interview data will be stored securely using password protected and encrypted devices, as well as physical locks. Research findings will be shared with the faculty at Bryan College of Health Sciences and may be presented in professional journals and settings. The interview consists of 10 questions and I estimate it will last about 60-90 minutes. You will be sent a $5 Amazon e-gift card at the conclusion of this interview, as a token for your time spent with me.

Do you have questions about the "Rights of Research Participants" or adult informed consent I sent you? Your agreement to participate in the study will serve as informed consent and I will be happy to answer questions at this time.

Ensure adult informed consent form has been signed.
Thank you very much, _____, for taking the time to share your experiences with me today.

First, we will complete the separate demographic form.

Prompts that the interviewer may use as needed throughout the interview:

- "Tell me more about…."
- "I need more detail about…"
- "Could you explain your response in more depth?"
- "What does _____ mean?"

******Turn on recorders**

Let's begin with my first interview question.

1. Describe how you view(ed) your gender identity in relationship to your decision to pursue a career in nursing.

2. Tell me about your experiences as a trans person in terms of admission to the prelicensure nursing program.

3. Talk about the feel of the campus and your experiences outside of the classroom as a trans person in the prelicensure nursing program.

4. How would you describe your classroom (in-person and/or online) experiences as a trans person in the prelicensure nursing program?

    a. Prompt if needed: Describe your interactions with student peers and college personnel (faculty, staff, administrators) as a trans person enrolled in the nursing program.

5. Tell me about your experiences as a trans person in terms of progressing through various levels (e.g. courses, quarters, semesters) of the prelicensure nursing program.

6. How would you describe your clinical learning experiences as a trans person in the prelicensure nursing program?

    a. Prompt if needed: Describe your interactions with clinical agency staff (nurses, physicians, etc.), patients, and patients' visitors as a trans person during clinical learning experiences.

7. (If applicable) Tell me about your experiences as a trans person when preparing to graduate from your prelicensure nursing program.

8. What else, if anything, should I know about your experiences as a trans person while enrolled in a nursing program?

Conclusion

This will conclude the interview. Thank you, once again, for your time participating in this study. Again, I will take all appropriate measures to ensure your privacy and confidentiality.

- May I contact you if needed to clarify certain points? _____yes_____no
- May I send you an encrypted email with a secure link to a Dropbox folder with the initial list of themes I identify as I analyze the interview data, in order to check that I have accurately reflected your viewpoints?_____yes_____no

I would like to confirm the personal email address/cell number on file is the one to which I should send the $5 Amazon E-Gift Card

APPENDIX H
Rights of Research Participants

Bryan COLLEGE OF HEALTH SCIENCES

Institutional Review Board (IRB)

THE RIGHTS OF RESEARCH SUBJECTS

AS A RESEARCH PARTICIPANT YOU HAVE THE RIGHT:

- **To be told everything you need to know about the research before you are asked to decide whether or not to take part in the research study.**
  - The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.
- **To freely decide whether or not to take part in the research.**
- **To decide not to be in the research, or to stop participating in the research at any time.**
  - If you are a patient, this will not affect your medical care or your relationship with your healthcare worker(s), the Medical Center, or Bryan College of Health Sciences.
  - If you are a student, this will not affect your education/evaluations/grades or your relationship with Bryan College of Health Sciences or faculty of the college.
  - If you are an employee, this will not affect your relationship with your employer or Bryan College of Health Sciences.
- **To ask questions about the research at any time.**
  - The investigator will answer your questions honestly and completely.
- **To know that your safety and welfare will always come first.**
  - The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.
- **To privacy and confidentiality.**
  - The investigator will treat information about you carefully, and will respect your privacy.
- **To keep all the legal rights you have now.**
  - You are not giving up any of your legal rights by taking part in this research study.
- **To be treated with dignity and respect at all times.**

The IRB is responsible for assuring that your rights and welfare are protected. If you have any questions about your rights, contact the IRB at 402- 481-3967.

(Adapted and modified with permission from University of Nebraska Medical Center IRB)

APPENDIX I
Adult Consent Form

ADULT CONSENT FORM

IRB protocol #:

Formal Study Title: The Lived Experiences of Trans Persons as Students in U.S. Prelicensure Nursing Programs

Participant Study Title: The Experiences of Trans Persons Enrolled in Nursing Programs

Study Personnel:
Jenna Dubas
1535 S. 52nd St.
Lincoln, NE 68506-1398
Work: (402)-481-3906
jenna.dubas@bryanhealthcollege.edu
www.bryanhealthcollege.edu

- **Key Study Information**:
- Individuals age 19 or older are eligible for this study.
- This study will require one individual interview approximately 60 to 90 minutes.
- A brief summary of the procedures includes:
    - The interview will involve a series of questions and will occur either in-person or using Skype video call. You will select a fake name for use during the interview to protect your identity.
    - The investigator will digitally audio-record the interview and handwrite notes.
    - The interview recording will be transcribed into an electronic text file.
    - The investigator will analyze the transcripts for themes in participants responses.
    - The information from this study may be published in professional journals or presented at professional conferences, but your identity will be kept strictly confidential.
- The risks to this study include potential emotional distress, loss of confidentiality or privacy, and loss of time. The researcher will take many steps to lower these risks.
- For compensation of your time, you will be provided a $5 Amazon e-gift card at the conclusion of the interview.
- You will be given a copy of this consent form.
- Your participation is voluntary and you may freely stop participating at any time without any consequences to you.

Invitation: You are invited to participate in this research study. The information in this form is written to assist you with deciding whether or not to participate. If you have questions, please contact me prior to the interview.

Why are you being asked to be in this research study? You are being asked to participate in this study because you have been enrolled in a nursing program while identifying as a trans person.

What is the reason for doing this research study? A diverse nursing workforce is needed to improve care of a diverse society. Though research has been published about the experiences of trans college students, little is known about trans persons in the nursing workforce or in nursing programs. Trans persons are often underrepresented in studies about LGBTQ+ persons. Research suggests trans persons have avoided or left school and work settings due to harassment, discrimination, and stigma. The purpose of this study is to explore the student experiences of trans persons in nursing programs. Bringing light to these experiences is intended to foster positive learning experiences for trans persons enrolling in nursing programs.

What will be done during this research study? If you choose to be in this study, you will sign this Adult Consent Form. Then the researcher will interview you either in-person or using Skype, as mutually greed upon. At the onset of the interview, you will be asked to provide some basic information about yourself and the nursing program you attended. You will select a fake name to be used during the interview. The interview will consist of a series of questions about your student experiences as a trans person who was/is in a nursing program. The interview should last about 60-90 minutes. The researcher will digitally audio record the interview and write notes. The notes will not be shared and will be stored securely. The digital recordings will be shared securely with a transcriptionist who has signed an agreement to keep information confidential. The transcriptionist will create a text file of the interview and securely share the file (transcript) with the researcher. To further protect your identity, the researcher will assign you a new fake name and will change the names of any specific people or places in the transcript. The researcher will review transcripts of all study interviews and identify themes. Next, the researcher will securely share the themes with you using a secure electronic Dropbox. You will be asked to respond if you have additional information or corrections to share. The Committee Advisor will review this process and the study findings.

How will my data/samples/images be used? General information about your age, gender, sexual orientation, race, and ethnicity will be grouped together with the information about all participants and included in the research findings. None of your personal information will be linked to you or your interview responses. Your name will not be shared with anyone. Your personal email will be used by the researcher to send an Amazon e-gift card after completing the interview. The researcher will also send encrypted email to your personal email address with links to a unique folder created for you within Dropbox. Your Dropbox folder will be identified by a random three-digit code assigned to you. Documents that will be shared with you in your

unique Dropbox folder include this Adult Consent Form, the a document about your rights as a research participant, and the themes sent to you for feedback, as previously described. Your interview transcript will be identified by your fake name and your three-digit code, and will not be shared with researchers other than the Committee Advisor. Your interview data will also be shared with a transcriptionist. Your interview data will be securely retained by the researcher for up to five years, and will not be used for any purpose other than this study. All of your identifying information will be destroyed upon completion of the study.

What commercial benefits will I get from research conducted on my data/samples/images? You will not receive commercial benefits by participating in this research.

What will happen to my data/samples/images once the study is completed? Once the study is completed, all electronic data will be stored on a password-protected personal computer and an encrypted flash drive. The encrypted flash drive and all paper copies of forms and interview notes will be stored inside a locked box to which only the researcher has access. The locked box will be stored inside a locked cabinet that is inside a locked office. These steps will be taken to further protect your privacy. All of your identifying information will be destroyed upon completion of the study.

Will I be notified of the findings from the research study? You will be notified of preliminary themes of the research study. You will not be notified of the final findings.

What are the possible risks of being in this research study? One risk of being in this research study is possible emotional distress, such as feeling anxious, angry, or stressed while you reflect on past experiences. To lower this risk, you may take a break at any point during the interview or end the interview at any time without impacting your job or school status, nor your relationship with the researcher or with Bryan College of Health Sciences. You could also experience a loss of privacy and confidentially, which could negatively impact your social status, your education, or your job. Every effort will be made to protect your privacy and confidentiality. If you reveal plans to physically harm yourself or others, the researcher will be obligated to notify emergency personnel of those plans

If appropriate, what is the approximate number of participants in this research study? Approximately three to ten participants are expected for this research study.

What are the possible benefits to you? There are no known direct benefits to you by participating in this research study; however, you may find personal benefit in telling your story. You may also benefit emotionally in feeling you are helping the trans community.

What are the possible benefits to other people? Trans persons enrolling in nursing programs may benefit from this study. Bringing light to trans persons' experiences when enrolled in nursing programs may enhance the ability of college personnel, cis nursing students, and clinical agency staff to provide supportive learning environments.

What are the alternatives to being in this research study? The alternative to participating in this study is not participating in this study.

What will it cost you to be in this research study? There are no known direct costs to participate in this research study. You could incur costs related to transportation and loss of personal time by participating in this study. Should you need professional follow-up care for emotional distress, you could incur personal financial costs related to such services.

Will you be rewarded or compensated for being in this research study? As a token of thanks, you will receive a $5 Amazon e- gift card at the conclusion of the interview. The gift card will be delivered using the personal email or cell phone number you have provided.

What should you do if you have a problem during this research study?
Your welfare is a major concern of the researcher. Every effort will be made to lessen emotional distress. You may request a break or end the interview at any time. Should you need follow-up care related to emotional distress, some reasonably accessible options are listed for you. An individualized consent form will be requested from the IRB that contains local resources for emotional distress. The local resources will be identified based upon the participant's city of residence.
If you experience severe emotional distress or are thinking of harming yourself or others, you are urged to seek immediate professional help. Reasonable options include:

- call 911
- contact local law enforcement
  will provide address and phone number of local law enforcement
- visit your nearest emergency room. Emergency room locations include:
  will provide location and phone number of nearest emergency room(s)
- call the National Suicide Prevention Lifeline: 1-800-273-8255. The Lifeline will connect you with the crisis center nearest you, based on your phone's area code.

If you experience mild to moderate distress, you may need professional follow-up care. Appropriate options for you may include:

- Employee Assistance Program
- Student Health Services
- Your Primary Healthcare Provider
- Local or regional support groups, such as
  Will provide 1-2 local or regional LGBTQ+ or trans organizations

If you reveal plans to physically harm yourself or others, the researcher will be obligated to notify emergency personnel of those plans. Physical safety is of utmost importance.
You will assume any financial costs related to follow-up care, should you need it.

How will information about you be protected?

The researcher will take steps to protect your privacy and confidentiality. Your contact information--your name, phone number, personal email address, and city and state of residence--will be stored in a separate file on a password-protected computer. Fake names will be used during the recorderd interview and changed to new fake names in the interview transcripts, as an additional layer of protection. All electronic data will be stored on a private drive on a password-protected computer, on an encrypted flash drive, and in your unique folder in an encrypted Dropbox. The digital recorders, flash drive, computer, and all paper forms will be transported inside a locked computer bag. All paper forms, interview notes, and the encrypted flash drive will be stored inside a locked box to which only the researcher has access. The locked box will be stored in a locked cabinet that resides in a locked office. The researcher will carefully select quotes to protect your identity. If needed, the researcher will use fake names for specific people or places in the interview transcript.

Confidentiality will not extend to plans to physically harm yourself or others. If you reveal plans to physically harm yourself or others, the researcher will be obligated to notify emergency personnel of those plans. Physical safety is of utmost importance.

What are your rights as a research participant?

You have rights as a research participant. These rights have been explained within this consent form. You have also been given the Rights of Research Participants brochure. If you have any questions concerning your rights or complains about the research, contact the investigator or the Institutional Review Board (IRB):

Bryan College of Health Sciences
Institution Review Board Chair
Telephone: 402-481-3801
Email: IRB@bryanhealthcollege.edu

What will happen if you decide not to be in this research study or decide to stop participating once you start? You can decide not to be in this research study, or you can stop (withdraw) being in this research study at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your job or school status, nor your relationship with the researcher or with Bryan College of Health Sciences. Completing the interview is necessary to receive compensation. If you decide to withdraw from the study after receiving compensation, you will not lose the compensation that was provided to you.

Documentation of Informed Consent

You are freely deciding to participate in this research study. Signing this form means that:

1. You have read and understood this consent form.
2. You have had the consent form explained to you.
3. You have had your questions answered.
4. You have decided to be in this research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep for your records.

Participant's signature: _____

Date: _____ Time: _____

My signature certifies that all the elements of informed consent described in this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research study and is voluntarily and knowingly providing informed consent to participate.

Signature of Person Obtaining Consent: _____

Date: _____ Time: _____

Authorized Study Personnel

Principal Investigator:
Jenna Dubas, MSN, RN
Bryan College of Health Sciences
1535 South 52nd St. Lincoln, NE 68506
402-481-3906
jenna.dubas@bryanhealthcollege.edu

Co-investigator OR Committee Advisor:
Marcia Kube, EdD, RN, CNE
Bryan College of Health Sciences
1535 South 52nd St. Lincoln, NE 68506
402-481-8845
marcia.kube@bryanhealth.org

Research Team Member(s), if applicable:

APPENDIX J
Transcription Confidentiality Agreement

Transcription Confidential Disclosure Agreement

This Agreement is entered into this ____ day of _____, 20__ by and between _[transcriptionist]_____ (hereinafter " Recipient") and __[researcher]_____ (hereinafter "Discloser").

WHEREAS Discloser possesses certain ideas and information relating to participants interviews for the Individual Research Project on __[title of research project]_____ that is confidential and proprietary to Discloser (hereinafter "Confidential Information"); and

WHEREAS the Recipient has willingly received disclosure beginning on _____ of the Confidential Information pursuant to the terms of this Agreement for the purpose of transcribing digital recordings of participants interviews.

NOW THEREFORE, in consideration for the mutual undertaking of the Disclosure and the Recipient under this Agreement, the parties agree as follows:

1. **Disclosure. Discloser agrees to disclose, and Recipient agrees to receive the Confidential Information.**
2. **Confidentiality**
    - **2.1 No Use. Recipient agrees not to use the Confidential Information in any way, or to manufacture or test any product embodying Confidential Information except for the purposes set forth above.**
    - **2.2 No Disclosure. Recipient agrees to use its best efforts to prevent and protect the confidential Information, or any part thereof, from disclosure to any person.**
    - **2.3 Protection of Secrecy. Recipient agrees to take all steps reasonably necessary to protect the secrecy of the Confidential Information from falling into the public domain or into the possession of unauthorized persons.**
3. **Limits on Confidential Information. Confidential Information shall not be deemed proprietary and the Recipient shall have no obligation with respect to such information.**

Signature of Recipient	**Date**
Signature of Discloser	**Date**