# Pilot Feasibility Study: Nurses' Preparedness to Care for Racialized Gender-diverse People

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## Abstract

The nursing profession perpetuates an outdated model that fails to address the health concerns of racialized gender-diverse people. Evidence supports that this population experiences poorer health outcomes, care-avoiding habits, and incompetent healthcare providers. A literature review illuminated gaps in the nursing lens when considering gender-diverse identities outside of Whiteness. An intersectionality framework and cultural humility were used to explore the contexts in which nurses provide care. To fill this knowledge gap, the proposed research question was: How prepared are nurses to provide care to racialized gender-diverse people? A questionnaire was developed by modifying three pre-existing instruments. The online questionnaire served as a pilot feasibility study to collect preliminary baseline descriptive cross-sectional data about Ontario nurses' training, education, knowledge, attitudes, and beliefs about racialized gender-diverse people. Findings indicated potential gaps in training and education that may affect racialized gender-diverse peoples' healthcare. Recommendations are provided for future research and interventions.

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# Chapter 1

## Introduction: A Community Made Invisible by Healthcare

The nursing profession participates in a lack of understanding of the healthcare experiences of racialized gender-diverse (GD) people. Racialized gender-diverse people exist at the intersection of being *racialized;* people and communities that experience racism in ways that impact economic, political, and social life (Chih et al., 2020), and *Gender-diverse;* an overarching descriptor for people who do not align with the traditional sex binary categories of male or female (Thorne et al., 2019). Nursing research has broadly identified racialized and GD groups' healthcare needs and practices separately (de Vries et al., 2022; White et al., 2020). At the intersection of these identities lives an even greater unknown. In order for research to become more representative of society, it must move away from singular analyses of identities when the reality is that the world is a fusion of cultures and identities (Howard et al., 2019). Nursing's lack of attention fails to prioritize data collection on racialized GD people and their healthcare experiences. Consequently, a lack of immediacy for supporting data may result in nursing education, training, and practice gaps.

It is currently unclear how much GD theoretical content is covered in Canadian nursing schools, let alone among intersecting identities. The United States (US) reports 2.12 hours of Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, and all other sexual and gender minorities (LGBTQ2S+[1]) theoretical content is given to nursing

[1] The acronym LGBTQ2S+ was chosen to represent the population of all sexual and gender minorities for this study. Other acronyms are used within this document specific to the cited reference, for example LGBT, LGBT+.

students in their entry to practice education, which is too broad in content and too limited in time (Lim et al., 2015). Demographic data on nurses' ethnicity/cultural backgrounds is not currently collected in Canada. It is estimated that in the US between 73 percent and 81 percent of nurses identify as White (Carson-Newman, 2020). The domination of White people in more secure, respected, and leadership positions creates an opportunity to avoid acknowledging their oppressive roles in racial and gendered hierarchies in healthcare (Bell, 2021).

Not including GD individuals' experiences sufficiently in the nursing entry-to-practice curriculum and not collecting demographic data about nurses are two examples that illustrate gaps that may blind our holistic understanding of racialized GD experiences in healthcare. These gaps materialize in poor healthcare experiences, care-avoiding habits, and poor health outcomes (Bauer et al., 2014; Roller et al., 2015; White et al., 2020). Nurses who do not direct their focus on racialized GD populations may be unaware of racialized GD people's health and social issues, and in some cases, even their existence. The lack of insight is not entirely the fault of individual nurses but a failure of the nursing profession to engage in conversations about racism and cisnormativity that negatively impact racialized GD people and nurses. This study contributes to these discussions and provides a baseline and preliminary assessment of nurses providing care for racialized GD people in Ontario.

## Background

The nursing profession is the largest professional body in Canada's healthcare system (Canadian Institute for Health Information, 2020). This magnitude increases the potential for nurse-patient interactions in virtually all healthcare settings. The nursing

profession is founded on the ideals of the White, straight, cisgender, middle-class woman, and to this day, that nursing identity persists (Bell, 2021). Racialized and GD people have been victimized through the nursing profession's erasing of identities that do not fit within the White cisgender framework (Bell, 2021; Carrier et al., 2020). Research has documented that the intersection of being racialized and GD contributes to peoples' experiences of care-avoiding habits, encounters with healthcare providers who cannot meet their healthcare needs, and poorer health outcomes when compared to White or cisgender people (Millar & Brooks, 2022; Roller et al., 2015; Taube & Mussuap, 2022). The needs of racialized GD people are critical and must be addressed, but this cannot be accomplished by nurses without an introspective look at the nursing profession.

Currently, racialized GD people are experiencing violence in society at disproportionate rates compared to other Canadians. The year 2021 reported the death of 375 GD people worldwide, which has increased by 7 percent from the previous year (Dayal, 2021). These reports insufficiently address the reality, as hate crimes frequently go unreported. Specific to the racialized GD experience, the current lifespan of a black transgender (trans) person may be as short as 35 years of age, although the real lifespan is unknown (Gorvett, 2020), illustrating the brutality they fear for simply existing in society. Acts of violence towards racialized GD people are not mutually exclusive to specific settings. The intersections of racialized and GD identities correspond with multiple forms of oppression experienced at all levels of society (de Vries, 2015). Racialized trans people are articulate about how they experience racism and transphobia simultaneously, resulting in negative healthcare experiences, which differ

from either form of discrimination experienced in isolation (Howard et al., 2019). The impacts of complex discrimination on well-being and physical health are widely recorded (Coburn et al., 2022; Seelman et al., 2017). Within each subgroup of racialized GD people, there may be differences in challenges with health and well-being. For example, nonbinary and genderqueer people may experience more psychological distress, depression, and anxiety than other trans people (Robertson et al., 2021). Despite these differences, a common thread that remains consistent is that prejudice is a baseline for minority GD populations in healthcare. This somewhat supports the reasoning for clustering all racialized GD identities in this study, as the research on this topic is in the infancy stages.

Advocating for change outside the norm begins with understanding the current status quo (Hughes et al., 2020). Cisnormativity dominates in healthcare settings that deny the presence or visibility of GD people (McKenzie et al., 2009). Consequently, the onus shifts onto GD patients to disclose their identities in sensitive settings, particularly during times of need or distress (Bauer et al., 2009). Racialized people encounter similarly dehumanizing experiences in healthcare settings. Racism exists in healthcare settings, resulting in poor health service use outcomes and low satisfaction and trust in health services and healthcare professionals (Hahn et al., 2018). Failure to observe the experiences of intersectionality of patients who are GD and racialized maintains their invisibility in healthcare and perpetuates the lack of protection in policy (Goldenberg et al., 2020; Rodini et al., 2021). Additional obstacles arise within the nursing profession, which exists within larger institutions' social and political contexts (Bell, 2021). These institutional norms of racism and gendered hierarchy have created challenges for

developing a space where change can be fostered. Although, the nursing profession is a direct result of supporting and reproducing these outdated and harmful practices in Canada's healthcare system.

The education system has failed to prepare nurses with the knowledge and resources to care for racialized GD people (Kellett & Fitton, 2017), perpetuating the erasure of GD people's identities in the academic space. Nursing education that ignores racism and gender discrimination perpetuate dominant societal norms such as Whiteness and cisnormativity. Cultural humility must be exercised in a profession where power imbalances exist. The development of cultural humility begins in nursing school, if not before, where students participate in and interact with content that addresses preconceptions, societal stigma, and personal biases (Bell et al., 2019).

The erasure of non-White identities and gender diversity evidenced in nursing school and current practice settings has been normalized and, until recently, had been uncritiqued in relation to conceptualizations of nursing. Practicing in a profession traditionally dominated by White, middle-class, cisgendered, straight women makes it more difficult for people to recognize these obstacles unless they have shared personal identities with racialized and/or GD people. These practices have oversaturated all aspects of the nursing profession and created a culture of unconsciousness to the concerns of racialized GD people. Nurses' statements that they treat everyone the same regardless of gender or skin color emphasize the embodiment of equal treatment (Bell, 2021). These expressions and practices help erase gender diversity and ethnicity and the real-life challenges of these identities in the healthcare system, rather than tending to their individualized care needs. As a guiding principle, cultural humility can bring an

understanding of embodied anti-oppression to practice (Bell, 2021). Further investigation in and of the nursing profession is required to determine how colorblindness and cisnormativity continue to negatively influence the people nurses serve and limit nurses' understanding that would allow the profession to progress toward a genuine commitment to anti-oppression (Bell, 2021). Examining nurses' preparedness to care for racialized GD people will provide an uncomfortable but necessary understanding of the nursing culture that may be supporting harmful traditions that exclude racialized GD people from conversations in education and practice. Avoiding the discomfort of challenging a nurse's practice prioritizes their comfort over the well-being of racialized GD people. This discomfort has been nurtured throughout the development of this study.

# Chapter 2

## Research Question and Approach

### Research Aims

A review of current literature identified substantial gaps in research about racialized GD people; therefore, the lens on nurses is very narrow when considering GD identities outside of Whiteness. Nurses face multiple obstacles, including insufficient education and ill-equipped environments that perpetuate poor health outcomes for this population (Guerin, 2021; Lim et al., 2015). There is limited research to inform how nurses provide care for GD people with intersecting racialized identities in healthcare settings. To help fill this knowledge gap, the proposed research question is: How prepared are nurses to provide care to racialized GD people? The two objectives for this research question are to:

1. identify nurses' knowledge, formal education, and training about providing care to racialized GD people.
2. explore nurse's attitudes and belief systems about providing care to racialized GD people.

Answering this research question and addressing its two objectives will provide a greater ability to comprehend the cultural humility of nurses currently practicing in Canada's healthcare system. Cultural humility is a continuous process that involves continual critical self-reflection, strives to comprehend individual and structural power inequalities, and is rooted in health equality (Isaacson, 2014). Identifying these challenges is necessary for improving care access and overall patient health outcomes and critically questioning nurses' role in racialized GD patient care.

**Framework**

A broad range of research exists on social determinants of health, such as race, gender, and class, related to a spectrum of health inequalities in Canada (Warner & Brown, 2011). However, many researchers treat these groups as distinct factors with specific health consequences (Bauer, 2014). Viewing these phenomena through an Intersectionality lens illuminates social inequalities and inequities through which ethnicity and gender are central determinants of health. Intersectionality allows for reflection on the societal systems of power and opportunities that determine access to health-promoting services and vulnerability to health-threatening risk, the consequences of which cannot be individually fragmented or understood (Hankivsky & Christoffersen, 2008). Kimberlé Crenshaw, a Black feminist, proposed the Intersectionality theory, which asserts that social positions exist within a hierarchy of social power that impacts the human experience (Crenshaw, 1991). Larger interpersonal and structural systems of oppression, such as racism and cisnormativity, influence those intersecting social positions. Intersectionality theory promotes the exploration of racialized GD people as a unique social category with its analysis of the simultaneous impact of and resistance to oppression and power witnessed in healthcare settings (de Vries, 2015). The resilience and oppression induced by racialized GD identities, highlighted by the theory, are essential for designing gender-transformative strategies in healthcare (Fehrenbacher & Patel, 2020).

The past analyses conducted on vulnerable populations are often completed by individuals in positions of authority, making assumptions about how the work will be performed (Tebbe & Budge, 2016). Intersectionality can be incorporated into all the

steps and phases of the research process, from informing topics, such as which participants to use and what type of methodology will be used (Hankivsky et al., 2014). In addition, taking an intersectional approach requires recognizing the researcher's positionality in the research and advocating for the development of community collaborations in research endeavors (de Vries, 2015). In summary, an approach to intersectionality posits that racialized and GD identity are not independent, additive social stratification dimensions but are mutually identifying and reinforcing each other in various ways in the development and preservation of health over the life course (Mullings & Schulz, 2006). Using an Intersectionality theory framework provides a greater understanding of racialized GD people's barriers in a healthcare system that excludes their holistic identity.

In order to situate nurses within healthcare settings to provide care for patients with intersections of gender diversity and racialization, the concept of cultural humility will be employed within the overarching theme of intersectionality. Cultural humility emerged from a need for greater proficiency in the care of minority groups, which remained unmet under the widely used health practice of cultural competence (Foronda et al., 2020). Cultural humility is characterized as a state of openness, self-awareness, egolessness, self-reflection, and critique after engaging with diverse people (Foronda et al., 2020). Cultural competency is an end-state success, but cultural humility is a continuous process that involves continual critical self-reflection, strives to comprehend individual and structural power inequalities, and is rooted in health equality (Isaacson, 2014). A cultural humility framework provides the opportunity for nurses to engage with their abilities to care for racialized GD people and continue to improve. Cultural humility

produces lifelong learning that includes empowerment, partnerships, respect, and optimal healthcare (Foronda et al., 2020).

**Positionality**

Before identifying as a nurse, I (she/ her) exist as an Indigiqueer woman and approached my work through this queer lens. Being an Indigiqueer woman challenges the traditions of gender in ways that allow me to approach the stories of GD people with an openness to understand. It is important to establish that others perceive my physical appearance as a White passing as I have a mixed heritage and am White presenting. The decision to share this sensitive and very personal information is an act of solidarity. I respect those that will be involved throughout this research process and wholeheartedly appreciate their presence in a space (health science research) that invalidates and all too often erases their existence. I acknowledge this disclosure of identity is trivial compared to the struggles that racialized GD people encounter. Still, I believe beginning conversations about the privilege we hold in society is a starting point for change. Nurses must recognize that the profession was formulated on colonialism and continues as a microcosm of a larger power configuration (Weitzel et al., 2020). Nurses must acknowledge that this racism and cisnormativity drive health inequities (Weitzel et al., 2020).

**Words Matter**

Words provide an opportunity of communicating ideas to others. It must not be overlooked that words cannot be separated from their associated connotations and uses throughout history and across or between cultures. It is common in any setting to observe words being weaponized toward individuals or groups of people. Nursing

research cannot disregard these negative connotations of word choice but instead can provide the opportunity to articulate new ways of thinking about and defining individuals and groups. Unfortunately, words used to define populations in nursing research have not progressed as quickly as in the larger society. In this study, I struggled to select the words best suited to defining the focus population. The words I have chosen are not free from controversy or a troubled past. It would be beneficial to address this topic in the future and reflect on the vocabulary currently being used in the nursing literature. Despite the discomfort with the words chosen, I do not feel it is my place to reinvent terms for this study but to highlight and, whenever possible, address the trouble using them may create for some people.

The term racialized is used to describe people and communities that experience racism in ways that impact economic, political, and social life (Chih et al., 2020). In my study, I use the term racialized to include all diverse cultural backgrounds, but it is strictly exclusionary of the white identity. The term gender-diverse is an overarching descriptor for people who do not align with the traditional sex binary categories of male or female. It gives people the liberty to choose their identifier (Thorne et al., 2019). In this study, I will use GD to represent gender identities that are not cisgender. For example, this may include, but is not limited to, transgender, non-binary, Two-Spirit, etc. Throughout this study, there may be terminology that is less familiar to some people. I have included a glossary (Appendix A) with comprehensive definitions to supplement the reader's understanding.

# Chapter 3

## Literature Review

A literature review was conducted to determine the current state of the research exploring nurses' experiences providing care to racialized GD people. It was identified that nursing research on racialized GD populations is widely unexplored. The literature review quickly adopted a broader approach, organically displaying two veins of relevance. First, literature focused on racialized GD peoples' health and experiences in healthcare. Second, literature focused on healthcare providers' roles and understanding concerning GD people, such as conducting research, education, training, knowledge, and attitudes. The limited research that directly addresses nurses' current care practices for racialized GD people emphasizes the lack of awareness within the profession, impacting the potential for nurses to acquire relevant research to inform care. This literature search resulted in 86 studies. Results and the search strategy can be found in Figure 1.

This literature review was structured from the experiences of both racialized GD people and nurses within the societal contexts that they live. The literature review is organized into two overarching headings with seven subheadings that arose in the literature. *Healthcare Experiences in the Canadian Context* highlights Canadian literature specific to GD peoples' experiences and mindsets moving forward. *Healthcare Experiences of Racialized GD People* addresses the realities presented for racialized GD people navigating the healthcare system. *Intersection, Identity, Social Location* addresses the inclusion of intersectional approaches in research that involves populations such as racialized GD people and strategies recommended to adopt the

strategy. *Education* addresses nursing schools' current climate and curriculum and offers potential strategies for improving educational content. *Knowledge and Attitudes* address healthcare providers' knowledge gaps and prejudices of GD communities. *Health research* with *GD People* addressed past, present, and future strategies for conducting research for LGBTQ2S+ populations. *Cultural Humility* describes a strategy that may improve the attitudes and practices of healthcare providers. Contextual information for the selected literature can be found in Table 2.

## Racialized GD People's Experiences

### *Healthcare Experiences in the Canadian Context*

It is essential to highlight the overwhelming gap in Canadian literature as this limits the potential for Canadian nurses to acquire relevant research to inform care specific to their Canadian context. The distinction between Canadian and other contexts is essential because pathways of care and health coverage for racialized GD people may differ substantially based on healthcare delivery systems. Although the following studies are vast in the subject, they provide a brief snapshot of various challenges people are facing in Canada.

Logie et al. (2016) found that within African and Caribbean LGBTQ2S+ newcomer and refugee communities in Toronto, social support groups may be a way to create safe spaces that lessen social exclusion and open discussions about specific health needs. The added intersection of being LGBTQ2S+ in Canada and living in poverty creates an "intersectional jeopardy" that exacerbates poor health outcomes and further discriminates people from healthcare (Kinitz et al., 2022). People with dual identities of belonging to a racialized group and being transfeminine are less likely to

have a family doctor (Scheim et al., 2017). Trans people confirm withholding or downplaying their mental distress due to fear of healthcare providers not delivering their full desired treatments and supports (MacKinnon et al., 2020). Trans youth in Quebec identified access to identity-affirming care and services as exceptionally important to their health and well-being (Sansfaçon et al., 2018). Pathways to accessing primary care in Nova Scotia are identified as requiring changes at the individual and healthcare system level of processes (Gahagan & Subirana-Malaret, 2018).

It is identified that all LGBTQ2S+ populations must not be grouped together because it erases any intersectional distinction (Padilha et al., 2022). Trans people require their own dedicated research encompassing their nuanced healthcare experiences (Gahagan & Subirana-Malaret, 2018; Moradi et al., 2016). The social and political recognition of trans people may likely influence care avoidance, which Bauer et al. (2014) explored in emergency department settings. Two-spirit communities experience their own complex individual oppression from other LGBTQ communities. Colonization has victimized Two-Spirit people with racism, degraded their traditional roles, and enforced the gender binary (Dykhuizen et al., 2022).

Dykhuizen et al. (2022) called for a shift in Canadian healthcare from western colonial perspectives to create space for Indigenous ways of knowing to be respected and involve Indigenous people in this integration process. Nurses must establish competencies in providing care to Indigenous people if they actively wish to practice solidarity (Carrier et al., 2020). Lightfoot et al. (2021) also urged nurses to adopt trans-affirming processes to build inclusive spaces that are respectful of gender diversity.

### *Healthcare Experiences of Racialized GD People*

The healthcare experiences of racialized GD people are intensely tied to the relationships between the historical and social contexts (Goldenberg et al., 2020). Goldenberg et al. (2020) emphasized that these differences between state-level policies in the US correlate to healthcare experiences. Despite the awareness of the potential contrast between locations, negative healthcare experiences of racialized GD people pervade the literature. The discussion then shifts to the complexity within these experiences and the victimization of racialized GD people (Kattari et al., 2021). Systemic discrimination linked to racism and cisnormativity altered in severity depending on how dark the person's skin tone was and how agreeably their gender expression "passed" for their gender identity (White et al., 2020). Kattari et al. (2020) reported a similar finding; biracial and multiracial people are more likely to be refused general healthcare. Multiracial transmen/women and Indigenous transmen are reported to avert care altogether due to discrimination (Kattari et al., 2021). The experiences of racism in healthcare are persistent and linked to a long history of discrimination (Agénor et al., 2022). Agénor et al. (2022) employed the example of gynecology and reproductive abuse targeting Black women since slavery. Racialized (BIPOC) GD people report a delayed feeling of discrimination after interacting with healthcare providers due to a need to process the event's complexity to fully realize unfair treatment (Apodaca et al., 2022). This can lead to minority stress which diminishes resources and motivation to engage in healthcare (Apodaca et al., 2022). The minority stress model indicates that the social location of minority groups correlates with stressors that affect poor health outcomes, health-seeking behaviors, and overall well-being (Meyer & Frost, 2013). Racialized trans people also display an awareness of

their intersecting identities, as they report that racism and transphobia are not experienced in isolation (Howard et al., 2019). The example of immigrant Latinx trans people emphasizes the complexities and nuances of Intersectionality. Members of this community appeal for safe places and housing opportunities where their identities will be welcomed and affirmed (Gonzalaz et al., 2022).

These negative experiences for racialized GD people are not isolated to specific healthcare settings or levels. Barriers are experienced at individual, interpersonal, community, and structural levels for racialized GD people, as evidenced by the struggles for Pre-Exposure Prophylaxis (PrEP) uptake in Black and Hispanic/Latinx trans women (Ogunbajo et al., 2021). For example, at a structural-level trans women listed low employment opportunities, unreliable transportation, and unstable housing as barriers to PrEP uptake and adherence (Ogunbajo et al., 2021). Kattari et al. (2020) found greater discrimination of trans African Americans and Indigenous people in emergency health settings than their White counterparts. Sexual healthcare providers are also called upon to increase knowledge and respect for the trans community and their needs (Lindroth, 2016). A lack of knowledge wrongly positions the patient to educate their healthcare provider about their own care (Baldwin et al., 2018; Guerin, 2021; Kattari et al., 2020). An active effort from healthcare providers is necessary for all settings, including virtual telemedicine, for those GD patients unable to attend in-person care (Haminvik et al., 2020).

The healthcare system practices "defensive health information creation" (p. 246) centered around portraying healthcare providers as the leading health authorities for GD health (Wagner et al., 2022). Trans and GD communities also practice defensive health

information creation to oppose cisnormativity encoded in healthcare technology by developing their own information and communication technologies (Wagner et al., 2022). Wagner et al. (2022) employ the example of a participant circulating a google document offline to share a collaborative list of resources for trans and GD people. The racialized GD community is resilient and creative in reacting to negative healthcare experiences. Trans people engage in a dynamic investigation process to find loopholes in care, tailoring it to suit their personal needs (Roller et al., 2015). Howard et al. (2019) described the strategy of racialized people being selective in disclosing their identities, depending on the provider's preferences, for fear of negatively affecting care. GD people engage in defensive and protective practices to connect with others in the community and share their knowledge of positive spaces to access care (Bith-Melander et al., 2010; Wagner et al., 2022). Studies support that community affinity for GD people improves their mental well-being (Cobourn et al., 2022).

Racialized GD people may suffer isolation from both GD communities and communities of color (Levefor et al., 2019). Asian trans people share the adversity of establishing supportive connections with family, trans communities, and Asian communities (Tan et al., 2022). Practicing a positive sense of self for people of minority populations can counteract relationships of internalized stigma one may have (Jefferson et al., 2013). Having a healthcare provider that shares a concordance of ethnicity with their patient can result in greater satisfaction, although GD people may still moderate their identities for fear of transphobia (Howard et al., 2019). These experiences emphasize the erasure of racialized GD identities in healthcare (Roller et al., 2015). Racialized GD people report anticipating these prejudiced experiences and therefore

choose the time they spend advocating for themselves in cis, White spaces (White et al., 2020). For example, Mexican trans asylum seekers exhibited a discomfort and lack of trust in healthcare providers and seldom sought healthcare despite evidence of managing multiple health issues (Gowin et al., 2017). This example may indicate a connection between a racialized GD community and limiting or completely avoiding healthcare spaces which are largely cis, White spaces.

Healthcare providers must become more knowledgeable and prepared to serve racialized GD communities. The responsibility for developing a foundational level of education is solely on the provider, not the patient (Rounds et al., 2013). Members of the house/ball community who have historically been victimized in healthcare reported that positive healthcare experiences with prepared healthcare providers created lasting effects and led to increased healthcare usage (Rowan et al., 2014). Historically, the house/ball community has been made up of LGBTQ2S+ Black people who live in urban areas. They affiliate with social structures called houses and gather at events called balls (Rowan et al., 2014). Members of this community have been marginalized, holding multiple intersecting minority identities.

### *Intersection, Identity, and Social Location*

Intersectional frameworks informed by Black feminist epistemologies, such as Crenshaw's Theory of Intersectionality, are deeply encouraged in health science research (de Vries et al., 2022; Millar & Brooks, 2022; Oswald et al., 2022; Sekoni et al., 2022; Vincent, 2018). An intersectional framework illuminates an interlocking relationship between social locations (e.g., Canadian society, healthcare settings, academic institutions) that are influenced by power and oppression. These social

locations render GD populations invisible in healthcare (de Vries et al., 2022; Sekoni et al., 2022). An intersection of multiple systems of oppression creates a complex rather than additive impact. Systems of oppression are systemic power relationships that exist directionally between social identity groups, resulting in some groups benefiting at the toll of others (Adams et al., 2007). These systems of oppression include racism, colorism, classism, sexism, cissexism, heteronormativity, transprejudice, and ableism (Arreola et al., 2022; de Vries et al., 2022). de Vries et al. (2022) emphasized that in the United States and potentially internationally, trans studies must use Intersectionality to recognize that a person's journey with gender identity impacts not only gender but ethnicity. White normativity has saturated health research, leaving the experiences of racialized GD people underexplored (de Vries et al., 2022; White et al., 2020). Research reports that particular communities within the trans BIPOC (Black, Indigenous, Persons of Color) umbrella report greater psychological distress and discrimination than White trans people (Millar & Brooks, 2022; Taube & Mussuap, 2022).

A study by Kirczenow MacDonald et al. (2021) explored transmasculine people's frustrations with healthcare provider interactions. Participants who experienced negative interactions could not specify the individual factors at play but recognized their healthcare provider's sole focus on their gender identity, despite not being the focus of the visit (Kirczenow MacDonald et al., 2021). Erby and White (2022) described denying identity, misgendering, and pathologizing trans identity as a means of the healthcare provider communicating a disinterest in the person as a whole. Despite the recent push for Intersectional approaches, Sekoni et al. (2022) underscored the reality that non-Western images of LGBTQ2S+ people in health research remain exceptionally rare.

Ignoring the diversity of GD people may lead to an overgeneralization in health services (Taube & Mussuap, 2022). The variance of identities within the racialized GD community emphasizes their heterogeneity in health status (Galupo & Orphanidys, 2022). Intersectionality offers a nuanced approach rather than a stereotyped alternative to White in health research (Sekoni et al., 2022).

Adopting an Intersectional approach cannot be comprehensively achieved without the partnership of local grassroots and community-led movements (Arreola et al., 2022). Intersectionality necessitates a radical, interdisciplinary, and diverse praxis that questions established healthcare, addresses systemic issues, and nurtures resiliency (Arreola et al., 2022). A recent evolution of Intersectionality is Intersectional Expansiveness. Oswald et al. (2022) highlighted neuroqueer youth as an example for explaining intersectional expansiveness. The term captures their continually expanding identities outside conventional categories (Oswald et al., 2022). Additionally, it rejects the oppressive categories that contain them and makes room for the discovery of how gender identities, ethnicity, and neurological capacities interact (Oswald et al., 2022). Barnett et al. (2019) described the gaps in the literature on LGBTQ2S+ people as a self-perpetuating cycle. The more researchers publish these studies, the more likely other researchers and publishers are encouraged to follow suit (Barnett et al., 2019).

## Nurses' Experiences with GD People

### *Education*

The inclusion of LGBTQ2S+ content in nursing curriculum has been and remains minimal and does not adequately address the healthcare needs of groups within the umbrella description (Lim et al., 2015). In the US and the United Kingdom, there are no

requirements for baccalaureate nursing programs to include trans health (Guerin, 2021). It is reported that an average of 2.12 hours are dedicated to broad LGBT content in the US (Lim et al., 2015). In Canada, this has been unexplored. A study by McEwing (2020) found that students require repeated exposure to LGBT content throughout schooling; otherwise, the knowledge acquired diminishes almost back to pre-exposure of LGBT content. Kellett and Fitton (2017) also recommend greater inclusion in a curriculum encompassing terminology, sexuality versus gender, and how to engage in conversations about gender. One of the obstacles to teaching LGBTQ2S+ competency is recognizing the shortcomings of framing LGBTQ2S+ as a western paradigm that centers Whiteness while seeking to reference a plurality of genders (Saini et al., 2022). The authors demonstrate an example of deconstructing this in their own research by using the + in LGBTQI+ as a placeholder for all the GD identities that may not translate into western equivalences and language (Saini et al., 2022).

McDowell and Bower (2016) employed a student-faculty partnership model to create new content additions to their curriculum integrating LGBT topics. Sherman et al. (2021) have conducted similar projects integrating specific trans and GD content into the nursing curriculum. Faculty knowledge, readiness, and comfort level with teaching GD content impact the exclusion of this subject in the curriculum (Abeln, 2019; Klotzbaugh et al., 2020; Lim et al., 2015). Further, faculty staff admits to seldom reading articles about LGBT health in research journals (Lim et al., 2015), thus creating a perpetual loop that leaves out important GD content from entry-to-practice nursing education. Guerin (2021) recommended that faculty development programs should improve inclusivity and cultural competence. Strategies to improve faculty preparedness

may include seminar workshops from content experts and training programs from LGBTQ2S+ community organizations (Lim et al., 2015).

A strategy to promote these conversations in nursing education is "transinclusivity." An environment of transinclusivity promotes space for people traditionally erased in academia (Abeln, 2019). To foster an environment of transinclusivity, Abeln (2019) recommended strategies for people to feel comfortable revealing their trans identity. A zero-tolerance policy should ensure that trans people are respected, forms should be inclusive and ask for preferred pronouns, and staff members should receive training on gender-specific healthcare (Abeln, 2019). Guerin (2021) described a palpable optimism in the new wave of nurses and students pressuring for greater cultural inclusivity in healthcare. Normalizing cultural understanding in nursing programs may improve transvisibility and equip nurses to translate advocacy into practice (Kellett & Fitton, 2018).

Researchers found that nursing health assessment textbooks had minimal content that addressed LGBT health (DeGuzman et al., 2018), perpetuating existing health disparities (Guerin, 2021). The inclusion in textbooks is crucial as they are often a core resource for nurses' cultural knowledge and skill, specifically during formative school years (DeGuzman et al., 2018).

Kellett and Fitton (2017) recommended that structural policy changes, such as competencies, are required to motivate real change. This lack of change is noted by the minor change in nursing education concerning LGBT content in the past decade despite the increased visibility of LGBT health (Marsh et al., 2022). Until large-scale uptake is

accomplished, educators must make explicit efforts to include LGBTQ2S+ content in their courses (Yingling et al., 2017).

### *Knowledge and Attitudes*

Few studies have addressed nurses' level of knowledge of trans people and their health and healthcare needs (Carabez et al., 2016). Carabez et al. (2016) found that some nurses have an understanding of trans people, but a majority have misunderstandings and insecurities about trans people, which impedes the capacity to provide care effectively. Nurses can often identify health inequalities among transgender people, according to Carabez et al. (2016), but they do not recognize that societal stigma and discrimination contribute to adverse health outcomes experienced by trans people. Instead, many respondents believed that these disparities were caused by GD identity (Carabez et al., 2016). Dean et al. (2016) emphasized that the nature of negative attitudes toward GD people is most frequently communicated in nuanced ways. This form of nuanced communication, intentional or not, is a microaggression, signaling to GD people that they are abnormal, unwelcome, or disliked (Dean et al., 2016). Rider et al. (2018) discovered a degree of discomfort and hesitation among nurses and physicians due to a fear of making mistakes during patient interactions. Providers were also worried about being offensive and avoided discussions about GD identities (Rider et al., 2018).

Studies support the positive impacts training has on improving healthcare providers' attitudes toward trans people (Burgwal et al., 2021), although most nurses do not seek training despite reporting working with trans clients (Riggs & Bartholomaeus, 2016). Healthcare providers with trans friends or family reported having more

comprehensive knowledge (Pratt-Chapman & Potter, 2021). Ziegler (2021) suggested methods of mentorship and partnership between healthcare practitioners to promote competence through positive experiences. Examples included the benefit of conferences or team meetings for practitioners to collaborate in the care process for trans people (Ziegler, 2021).

### *Health Research with GD People*

Over the past 20 years, health research focusing on trans populations has increased (Vincent, 2018). It is important to acknowledge the historical past within clinical medicine and sexology that pathologized the trans identity, often depicting trans people as sinful and unwell (Hudson & Romanelli, 2020; Vincent, 2018). It is essential to familiarize ourselves with existing research to ensure research does not continue to repeat problematic practices that risk the traumatic treatment of trans people in health research settings (Vincent, 2018). Avera et al. (2015) recommend wellness and strength-based approaches to depathologize the health of GD people. One strategy proposed exercises reflexivity and participatory action research (PAR) (MacDonnell, 2007; Tebbe & Budge, 2016). PAR is a plan for conducting research that empowers individuals and communities by prioritizing community involvement in the research process and establishing the researcher as a facilitator rather than a leader of the research (Tebbe & Budge, 2016). Smith (2012) draws on Indigenous movements to recommend that researchers reframe their studies to privilege the knowledge and ownership of communities rather than the researcher (Tebbe & Budge, 2016). This extends what the researcher can potentially discover. The "emancipatory researcher" prioritizes listening to communities and supporting how they best share the information

and engage the community (Vincent, 2018). Vincent (2018) also urges that trans research be enhanced through feminist epistemology and methodology. Feminist epistemology and methodology dismantle the power imbalances between the researcher and the participant and recognize the problem of data interpretation and objectivity (Dalton et al., 2022; Vincent, 2018). Morris (2018) calls upon nurses to advocate for and participate in research that ameliorates the traditional, colonial treatment of trans people. Future directions for health science research should prioritize originating from GD patient voices, as this is widely unseen (LeBlanc et al., 2022).

### *Cultural Humility*

A push for a cultural understanding of racialized LGBTQ2S+ populations and their care has motivated the adoption of cultural competency and cultural humility. Cultural competency is one strategy to reduce biases healthcare providers may have about sexual and gender minorities (Nowaskie & Najam, 2022; Sprik & Gentile, 2020); however, cultural humility improves upon the limitations of cultural competency (Sprik & Gentile, 2020). Limitations of cultural competence include the notion that one can achieve or be completely culturally competent (Sprik & Gentile, 2020). Another limitation is that healthcare providers may rely on cultural assumptions learned in training rather than understanding the circumstances of each individual person (Sprik & Gentile, 2020). Cultural humility builds on cultural competency training by shifting the focus onto the patient, provider's self-reflection, and active listening (Sprik & Gentile, 2020). Nurses in all care settings are ideally positioned to improve patient care and experience using cultural humility (Bell et al., 2019). Leadership buy-in is strongly recommended to

increase commitment to cultural competency (Wang et al., 2022) and cultural humility in the workplace (Sprik & Gentile, 2020).

## Conclusion

The literature review further proved health challenges within the racialized GD community and uncovered an absence of content within nursing. One focus of the review highlighted the health concerns and challenges in accessing care for multiple communities within the racialized GD population in Canada and internationally. Although, research on racialized GD people's healthcare experiences is much less developed in the Canadian context. These damaging experiences should motivate a greater need to understand the obstacles impacting racialized GD people's care.

The limitations within the nursing profession proved to demonstrate immense knowledge gaps in the literature. The research, highlighting nurses' experiences in practice, addressed caring for GD people but overwhelmingly neglected the intersection of racialized identities. Nursing has been adopting intersectionality, but this does not seem to be practiced in the literature. These gaps in nursing research may be related to the social position of nurses in Western culture, which uplifts ideals of Whiteness and cisnormativity that tend to limit the inclusion of diverse perspectives and ways of knowing. This exclusion recognized in the literature requires further exploration within the nursing discipline, which influences the nursing profession. This exploration is beyond the scope of this study but is encouraged for future research.

# Chapter 4

## Design

A descriptive cross-sectional online survey design was used to gather baseline data of Registered Nurses (RN), Registered Practical Nurses (RPN), and Nurse Practitioners (NP) in Ontario about their attitudes and knowledge to care for racialized GD people. The study is divided into two parts, the instrument development (described in article format, see Chapter 5) and a cross-sectional descriptive analysis of the findings from feasibility testing of the instrument (Chapter 6). Throughout all stages of the research process, a self-identified non-binary individual who has experience as a community advocate and an academic took on the role of an advisor. This ensured that no decisions were made without the interest of the community as a foundation.

### Advisor OG Thorne’s Biography

O.G. Thorne (they/he) is a non-binary White queer settler currently living on unceeded unsurrendered Algonquin territory. Thorne is a transgender advocate, community organizer, and researcher. They completed their Masters research project that focused on the impact of Ontario's healthcare system, specifically the medicalization of trans youths’ identities at the Children's hospital of Eastern Ontario's (CHEO) Gender Diversity clinic in 2022. Thorne is a recent graduate of Carleton University for Indigenous and Canadian Studies.

## Sample

The target population is RNs, RPNs, and NPs currently registered with the College of Nurses of Ontario (CNO). RNs who are members of the Non-Practicing Class were excluded as they were not currently working in Ontario as nurses. The classes

included in the sample are as follows; General Class RN/ RPN, Extended Class RN (this class encompasses NPs), Temporary Class RN/ RPN, Special Assignment RN/ RPN, and Emergency Assignment RN/ RPN. Demographic questions were collected to contrast the differences in additional training that certain classes of nurses may have received relevant to the care of this population. No restrictions were employed for nurses that are not or have not provided care for racialized GD people. The reasoning for this decision is because nurses may be unaware of the gender identity of their patients.

## Sampling

As of July 2021, the CNO reported the registration of 178 384 General Class RN/ RPN, Extended Class RN, Temporary Class RN/ RPN, Special Assignment RN, RPN, and Emergency Assignment RN, RPN (College of Nurses of Ontario, 2021). High response rates increase parameter estimates' precision, reduce the risk of selection bias, and enhance validity. Response rates of at least 70% are identified as being most desirable for external validity (Burns et al., 2008). A response rate of 70% would suggest a sampling size of approximately 124 868 RNs. Although 70% is ideal, it is identified that response rates for online questionnaires may be between 60-70%, while the addition of controversial topics can often be acceptable with less than 60% response rate (Burns et al., 2008). Being unable to advertise through larger, widespread pathways of communication, a snowball sampling strategy was employed. Snowball sampling is a form of convenience sampling. Adopting sampling through snowballing decreases the reality of reaching a large number of nurses and having them respond to the questionnaire. Although these response rates are recommended in the literature,

they are not realistic to the reality of a pilot feasibility study with smaller resources for sampling.

Chapter 5

# Pilot Feasibility Study: Instrument Development to Assess Nurses' Preparedness to Care for Racialized Gender-diverse People

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## Abstract

Background: There are currently no apparent instruments that assess nurses' preparedness to care for racialized gender-diverse people. Purpose: This feasibility pilot study aimed to develop a tool that explored nurses' knowledge, training, attitudes, and beliefs toward racialized gender-diverse people. Methods: A questionnaire was developed by modifying three pre-existing instruments. The Transgender Knowledge, Attitudes, and Beliefs Scale, the Cross-Cultural Care Survey, and the Nurse Practitioners' Training in Cross-Cultural Care Tool, were strategically combined and evaluated to best capture nurses' awareness of racialized GD people and their preparedness to provide care. The online questionnaire served as a pilot feasibility study to collect preliminary baseline descriptive cross-sectional data about Ontario nurses' training, education, knowledge, attitudes, and beliefs about racialized gender-diverse people. The population targeted for this research were Registered Nurses, Registered Practical Nurses, and Nurse Practitioners in Ontario. Results: A total of 149 nurses responded to the questionnaire. A reliability analysis and correlation analysis were conducted. Conclusions: Recommendations are proposed for the further development of this instrument to attain greater data collection from nurses Canada-wide.


*Keywords:* racialized, gender-diverse, nursing knowledge, nursing training, attitudes, beliefs, instrument development

## Pilot Feasibility Study: Instrument Development to Assess Nurses' Preparedness to Care for Racialized Gender-diverse People

There are currently no apparent instruments that assess nurses' knowledge, training, attitudes, and beliefs toward racialized GD people. GD is an overarching descriptor for people that do not align with the traditional binary (male or female). It provides the liberty to choose their own identifier (Thorne et al., 2019). Racialized may be defined as people and communities that experience racism in ways that impact economic, political, and social life (Chih et al., 2020). For supplemental definitions, please see the glossary in Table 1.

Minimal research currently exists on the health needs of racialized GD people at a population level in Canada. In 2020, Trans PULSE (Chih et al., 2020) presented the first quantitative research contrasting the health and well-being of White vs. racialized trans and GD people in Canada. The findings revealed that racialized respondents were more likely than their White counterparts to report their health as poor and reported being less likely to have a plan to or pursue gender-affirming care. Racialized respondents revealed avoidance behaviors from public settings due to concerns of assault or being outed (Chih et al., 2020). The lack of Canadian research emphasizing the needs of racialized GD communities requires seeking international research to supplement the limited Canadian literature. Research has documented that racialized GD people practice care-avoiding habits, encounter healthcare practitioners who cannot meet their healthcare needs, and have poorer health outcomes than White or cisgender people (Farvid et al., 2021; James et al., 2016; Millar & Brooks, 2022; Roller et al., 2015; Smart et al., 2022).

The profound research gaps serve as an indicator that healthcare practitioners cannot optimally provide care to racialized GD people if these discussions are not evidently occurring in research or the nursing profession as a whole. Nurses do not enact their professional role without the impact of their socialization, political views, socioeconomic status, and identity as White or racialized (Hassouneh, 2006). Nursing and nursing institutions, such as education, operate within these same social and political contexts that, without questioning, perpetuate organizing principles of colonial practices (Bell, 2021), which become harmful in erasing the existence of racialized GD people in all aspects of healthcare. Contrasting international research with the findings of the Trans PULSE report, it may be fair to consider racialized GD people rarely experience healthcare from a place of safety and acceptance. Healthcare practitioners should ask themselves: Why have we not alleviated these concerns, and how can we strive to provide safer healthcare spaces for racialized GD people?

The preliminary step to addressing these issues is having a means of collecting this information. There currently is no existing instrument to address nurses' knowledge about racialized GD healthcare, further perpetuating the knowledge gaps surrounding the issue. This niche must be filled because the health and well-being of racialized GD people are critical, and nurses are well-situated to deconstruct racist and cisnormative patterns in healthcare that may contribute to negative healthcare experiences. Multiple tools have broadly assessed the points of "education and training" (Chun et al., 2010; Tidwell, 2017; Weissman et al., 2005) and "attitudes and beliefs" (Clark & Hughto, 2020; Cooper et al., 2012; Kanamori et al., 2017) for racialized populations or GD populations but never encompassed both identities intersecting in one tool.

The purpose of this study was to develop a tool that explored nurses training, education, attitudes and beliefs of racialized GD people. The following three instruments were chosen to be modified to develop this tool. The Transgender Knowledge, Attitudes, and Beliefs Scale (T-KAB) was chosen to set a foundation for establishing questions that offer insight into nurses' personal understanding of transgender people. The scale consists of 22 items on a 4-point Likert scale encompassing the concepts of knowledge, attitudes, and beliefs toward transgender people (Clark & Hughto, 2020). The Cross-Cultural Care Survey (CCCS) is a 45-item multidimensional instrument that assesses knowledge, skills, attitudes, and the quantity of cultural content included in medical residents' training programs using 4-point and 5-point Likert scales (Chun et al., 2010). The tool's role in this study is to assess healthcare practitioners' preparedness to care for patients with more than one intersecting cultural indicator. The Nurse Practitioners' (NP) Training in Cross-Cultural Care Tool (NP-CCCS) is a 48-item instrument created to determine NP's attitudes, knowledge, and skills to care for transgender people using 4-point and 5-point Likert scales (Tidewell, 2017). The instrument was explicitly chosen for this study to introduce the topic of training and how prepared nurses report being to care for transgender people. Permission was granted for the modification of all validated instruments except the NP-CCCS. All efforts were exhausted attempting to contact the author; therefore, minor changes were made to honor best and respect the instrument's purpose during instrument development.

The three instruments mentioned were strategically combined and evaluated to best capture nurses' awareness of racialized GD people and their preparedness to provide care. Developing an instrument encompassing multiple identities (racialized and

GD) aligns with an intersectional research approach. Employing intersectionality requires understanding historically oppressed communities, how those identities intersect, and the socio-political context of their healthcare (Bauer et al., 2021). Kimberlé Crenshaw, a black feminist, proposed the intersectionality theory, which asserts that social positions exist within a hierarchy of social power that impacts the human experience (Crenshaw, 1991). Those intersecting social positions are influenced by larger interpersonal and structural systems of oppression, such as racism and cisnormativity. Practicing this theory in quantitative research promotes exploring racialized GD people as a unique social category by analyzing the simultaneous impact of power, resilience, and oppression witnessed in healthcare settings (Bauer et al., 2021; de Vries, 2015).

Ignoring this approach, the multiple forms of resilience and oppression that correspond with the intersection of racialized GD identities cannot be understood. Research supports the effect of intersectionality as racialized transgender people describe how both causative factors, racism, and transphobia, present simultaneously and result in negative healthcare experiences, which differ from either form of discrimination experienced in isolation (Howard et al., 2019). This study used Crenshaw's Intersectionality theory as a foundation to develop and psychometrically evaluate an instrument that could measure nurses' knowledge, training, attitudes, and beliefs toward racialized GD people in Ontario. An instrument for collecting information on the strengths and weaknesses of nurses' current practice status while caring for racialized GD people may begin to address the current health and well-being of racialized GD people. The revised instrument from this study is available upon request.

## Methods

A review of pre-existing instruments was conducted to explore nurses' knowledge, training, attitudes, and beliefs toward racialized GD people. The four domains of knowledge, training, attitudes, and beliefs were identified through a literature review and established as the focus for the instrument searches. The search strategy organically took on an informal approach as preliminary searches resulted in very few studies. A literature search was conducted in CINAHL, Medline, Google Scholar, and the University of Ottawa Omni libraries. These databases were selected to encourage a focus on nursing research and allied healthcare professions. The searches could not be limited only to the nursing profession due to narrow results, which required additional hand searching for relevant instruments. The key criteria being identified were any combination of the following concepts; attitudes, beliefs, education, curriculum, training, perceptions, beliefs, preparedness, skill, cross-cultural care, nurse, healthcare practitioner, racialized GD or racialized identities, and GD identities separately. Any additional terms that appeared in the results but are not included in this list were evaluated individually for applicability to the studies' four domains. The initial search yielded 16 instruments that could address at least one of the four required concepts. The instruments were screened, and records were excluded if they did not fit the criteria (see Figure 1). Exclusion criteria included tools not in English, not easily accessible, not applicable for healthcare providers/ practitioners, and did not include a focus on the concepts of education, training, attitudes, or beliefs. The exclusion criteria were minimal to allow for greater case-by-case analysis, as there were few relevant results. Eleven instruments were excluded for these reasons. Five instruments were deemed relevant

to the study for the desired purpose of modification. It is important to identify that of the five instruments (Chun et al., 2010; Clark & Hughto, 2020; Hobson-Powell, 2019; Kanamori et al., 2017; Tidwell, 2017), the three chosen for the following reasons; the instrument addressed more than one concept, the instrument introduced ideas of Intersectionality or cross-cultural care, or the instrument acknowledged the inclusion of GD people in the creation process. Considering this criterion, the three selected instruments, with slight modifications to the focus population, could combine and address the concepts of attitudes, beliefs, education, and training. See Table 2 for a description of the three instruments vs. the newly modified instrument.

## Instrument Development

### *The T-KAB Scale*

T- KAB Scale is an updated version of previous transgender attitude scales. The main improvements of this version impacted content validity (Kanamori et al., 2017). Cronbach's alpha for the T-KAB Scale demonstrated strong internal consistency (α =.97) (Kanamori et al., 2017). The tool presents questions that encompass the three concepts; knowledge, attitudes, and beliefs. The scale consists of 22 items (*n* = 22) on a 4-point Likert-type scale, one being "strongly disagree," and four being "strongly agree." To maintain the fidelity of the original instrument, the 4-point Likert-type scale was kept to obtain a negative or affirmative response. The T-KAB Scale was selected to provide foundational insight into nurses' unique understanding of transgender people. All 22 items were maintained and required minimal changes. For this study, the following minor language changes to the scale were made; transgender was replaced with GD to

represent the population of interest. These changes better encompass all GD identities as opposed to transgender, which makes up a single identity within the GD umbrella.

### *The CCCS*

The CCCS was developed to assess the preparedness of medical residents to care for diverse cross-cultural patient populations. The tool's original purpose was to evaluate skills related to more than one cultural indicator (Chun et al., 2010). The CCCS is a 45- item multidimensional instrument that assesses (*n* = 45) knowledge, skill, attitudes, and the quantity of cultural content included in a medical resident's training program, unlike other assessments that focus solely on attitudes (Chun et al., 2010). One section of the CCCS was chosen to be modified for use in this study. It evaluates the skillfulness of delivering cross-cultural care on a 5-point Likert-type scale (*n = 9*). One being "not at all skillful" and five being "very skillful." Despite the tool's differences in population focus, it was judged to be appropriate for addressing the concept of providing cross-cultural care. Changes were made to the vocabulary, enhancing the relevance to the proposed study's context with nurses, not medical residents. The population of focus, transgender, was modified to be GD. This allowed the items to assess the intersecting identities of ethnicities among the GD population.

### *The NP-CCCS* Instrument

This 48-item (*n* = 48) instrument was created for a dissertation determining whether NP's attitudes, knowledge, and skills are prepared for transgender healthcare (Tidwell, 2017). The survey utilized the pre-existing CCCS instrument and modified it to their needs. Three sections from the CCCS were determined to be most relevant for this study. The first section assesses problems nurses encounter while providing cross-

cultural care (*n* = 9) with four selections; no problem, small problem, moderate problem, or big problem. The second section concerns preparedness to provide cross-cultural care on a 5-point Likert-type scale consisting of nine questions (*n* = 9). One being "very unprepared" and five being "very prepared." The third section assesses the usefulness of training and education (*n* = 6) with five response options; not at all useful, somewhat useful, useful, very useful, or did not have. These questions are essential to this study because they depict post-school training. The instrument's population focus was changed to nurses rather than only NPs. The vocabulary was changed from transgender to racialized GD.

**Population and Sample**

The target population of this research was nurses in Canada. Due to time frame and feasibility, the population was reduced to nurses in Ontario. The inclusion criteria were RNs, Registered Practical Nurses (RPN), and NPs currently registered with the College of Nurses of Ontario (CNO). RNs who are members of the Non-Practising Class were excluded as they are not currently working as nurses in Ontario. The classes included in the sample are General Class RN/ RPN, Extended Class RN (this class encompasses NPs), Temporary Class RN/ RPN, Special Assignment RN/ RPN, and Emergency Assignment RN/ RPN. Exploring the knowledge and attitudes of all nurses in Ontario depicted the landscape of cultural humility and how differences in levels of education and training can impact the care of racialized GD patients. No restrictions were employed for nurses that are not or have not provided care for racialized GD people. The reasoning for this decision is that nurses may be unaware of the gender identity of their patients.

**Data Security, Management, and Collection**

The validated instruments, demographic and professional questions were combined into a single questionnaire and reviewed by the thesis committee. The questionnaire was put through two preliminary testing techniques. The first phase was content validation to see whether response categories needed to be changed, edit wording, and provide feedback on the length of the tool (Yusoff, 2019). The questionnaire was reviewed by content experts who are professionals and public members with expertise in racialized GD care and instrument creation. The second phase was pre-testing to test the questionnaire on members of the target population to evaluate reliability, validity, and usability before final distribution (Grimm, 2010). Pretesting consisted of recruiting graduate students in the school of nursing at the University of Ottawa as they encompass the sample inclusion criteria. The first 30 respondents were included in the pre-testing phase.

The questionnaire was loaded into SurveyMonkey, a secure online survey delivery tool. The respondents' data is securely kept in a data center that is accredited by System and Organization Controls for Service Organizations and follows security and technological best practices (SurveyMonkey, 2021). Transport Layer Security protects user logins, and collected data is transferred via a secure HTTPS connection (SurveyMonkey, 2021). Data is encrypted at rest using industry-standard encryption techniques and robust encryption algorithms (SurveyMonkey, 2021).

**Recruitment**

Revisions were made after the review of the thesis committee, content validation, and pre-testing. An email was sent to nurses through social networking/ social media

platforms, e.g., Rainbow Nursing Interest Group, with a flyer advertising participation in the study. Nursing social media groups were encouraged to share the study with their networks. The flyer contained a description of the research purpose and a secure link to the questionnaire on SurveyMonkey. An informed consent document was required of the participants prior to completing the questionnaire. The informed consent document consisted of the study's purpose, risks and benefits of completing, confidentiality, and data security. Participants were under no obligation to participate and if they chose to participate, withdrawal from the study could occur any time and/or refusal to answer any questions, without suffering any negative consequences. Any time before submission of the questionnaire, if participants chose to withdraw, all data gathered until the time of withdrawal would be removed from the dataset and not used in the study. By completing and submitting the questionnaire, participants were consenting to participating in the study. Ethics approval was received from the University of Ottawa's Research Ethics Board, which operates in accordance with the Tri-Council Policy Statement.

## Results

### Demographics

A total of 149 nurses responded to the questionnaire. Ninety percent of respondents were female, 95% identified as cisgendered, 78% as straight, 77% identified with White ethnoracial groups, and 81% were born in Canada. The largest age group was 25-34 (39%), followed by 18-24 (26%). Sixty-two percent practice in acute care settings and 73% of respondents provide care to gender-diverse patients in their current practice. The majority groups are highlighted to demonstrate the potential homogeneity of the population motivated to complete the questionnaire. The minority

groups within each demographic question, although smaller numbers, exhibited the existence of diverse and expansive identities within the respondents. Please see Table 3 for in-depth demographics.

**Reliability Analysis**

Cronbach's alpha analysis was applied to check each question's internal consistency and reliability in the data set. Cronbach's alpha is used for multiple scale items to determine whether the items converge or not. A value above 0.7 is considered acceptable and reliable (Namdeo & Rout, 2016). Results demonstrate that the values for all variables are reliable except for the T-KAB scale, which resulted in slightly low reliability ($\alpha$=0.615). A low reliability score indicates poor internal consistency, which may originate from the vocabulary changes made during the modification of the tools. Table 1 shows the reliability of all the scales. Factor analysis was not completed due to the low sample size of the study. Polit (2010) recommends for effective factor analysis, the sample size must be large, with a minimum of at least 300.

**Correlation Analysis**

Pearson's correlation analysis was applied to determine if there is a relationship among the variables; "knowledge, attitudes, and beliefs," skillfulness, preparedness, and issues providing care to racialized GD people. Pearson's correlation is a bivariate analysis to measure the direction and magnitude of a relationship between 2 variables. Correlation analysis is used to explain the level of strength between two variables when they are associated with one another (Bewick et al., 2004). Table 2 shows the correlation analysis of the variables. Skillfulness negatively and significantly correlated with knowledge, attitudes, and beliefs. The nature of the relationship is weak ($r = -.189$, $p<0.05$). This

indicates that the skill level required to provide care for racialized GD people decreases with increased knowledge, attitudes, and beliefs. Preparedness to provide care is positively and significantly related to skillfulness ($r = 0.653$, $p<0.01$). Nurses who are more skilled would be considered more prepared to provide care. Knowledge, attitudes, and beliefs are negatively and significantly related to issues faced while providing care to gender-diverse people ($r = -.213$, $p<0.01$). This indicates that nurses with high-level knowledge of racialized GD people will face fewer issues providing care. Additionally, preparedness is negatively and significantly correlated to issues providing care ($r = -.169$, $p<0.05$). Highly prepared nurses will face fewer issues in providing care to racialized GD people.

## Discussion

This study is a first of its kind in Canada and relatively uncharted territory within the nursing profession. The critical nature of this study was revealed by the significant gaps identified while developing an instrument to assess nurses' knowledge, education, attitudes, and beliefs of racialized GD people. Previous studies have questioned the preparedness of nurses to care for historically oppressed, underserved populations (Browne, 2007; Markey et al., 2018). Studies have also been conducted on the health and well-being of racialized LGBTQ2S+ populations (Arlee et al., 2019; Levefor et al., 2019). Research focusing on racialized GD populations in Canada is beginning to grow but remains relatively unexplored (Chih et al., 2020).

A strength of this study was to position itself amongst the previous research mentioned while advancing ideas of intersectionality in research and placing an opportune focus on nurses' position in the cycle of care. Critiquing the current status

quo of the nursing profession welcomes discussions of change and how nurses can be active allies and means of change for racialized GD people in healthcare. Nurses can be a positive intermediary between healthcare experiences and racialized GD people. After all, nurses make up the largest professional body in Canada's healthcare system, increasing the likelihood of patient interaction in virtually all healthcare settings (CIHI, 2020). Being a changemaker means stepping into spaces that may feel uncomfortable and critical of the current practice standard. Bell (2021) supports that nursing requires further investigation in and of the profession to determine how colorblindness and cisnormativity continue to negatively influence the people nurses serve and limit nurses' understanding and knowledge that would allow the profession to progress toward a genuine commitment to anti-oppression. The development of this study's instrument is a pragmatic way to begin addressing these essential questions posed to the nursing profession, which has historically been left to the unknown for far too long.

The development of this instrument was not without challenges and limitations. The lack of research on nurses caring for racialized GD people meant that this study required greater creativity, having few studies to resemble. Unfortunately, real-world limitations prevented the study from achieving a high response rate, which is vital for testing new instruments. Chronbach's alpha was acceptable for all variables except the T-KAB scale. The poor internal consistency within the instrument requires further investigation to determine how the vocabulary modifications may have resulted in a lower score than the original T-KAB scale. For further development of the tool, this section should be further examined to remove any items that may not be scoring well. The correlation analysis overall demonstrated the affirmative relationship between

nurses being more highly trained and increasing knowledge of racialized GD people to correlate with more preparedness and skill to provide care for racialized GD people. Although this study is new in its development, these results reassure the positive impacts better training and education may have for the care of racialized GD people. The study has also validated the pertinence of research on intersecting identities and is strongly encouraged for future studies. No person exists in the world with a singular identity, and our instruments should encompass this. Targeting the experiences of racialized GD people more closely allows for a more comprehensive understanding of their healthcare experiences and needs. Expanding nurses' ways of understanding others only improves our practice and participates in the exercise of cultural humility. Moving forward, although this tool requires further development and testing, there is a need for understanding racialized GD people and learning how to best prepare nurses to provide compassionate, informed care. Further developing the instrument and sampling a much larger group is a step towards addressing this problem and creating change from inside the healthcare system, beginning with nurses. Developing a robust understanding of the current status of nurses' knowledge invites additional avenues for critical observation, such as nursing school curriculum or perhaps nursing culture, and finding strategies to better educate and prepare nurses.

## Conclusion

Nurses hold a key to improving the healthcare of racialized GD people. This study is the first of many steps toward learning how nurses can better serve the racialized GD population. The further development of this instrument can create a means of accessing greater data collection from nurses in Canada. This may provide

insights into Canada's healthcare system and how nurses inform their practice for racialized GD people. This pilot feasibility study aimed to fill a gap in nursing research and overall nursing knowledge for the care of racialized GD people. Although the author recognizes limitations to the instrument, the study serves as a reminder that all people deserve to receive equitable healthcare that empowers and uplifts their human experiences. The Authors declare that there is no conflict of interest. No funding was received for the carrying out of this research project.

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**Table 1**

*Glossary*

| | |
|---|---|
| Gender-Diverse | An overarching descriptor for people that do not align with the traditional binary (male or female). It provides liberty to choose their own identifier (Thorne et al., 2019). |
| Racialized | People and communities that experience racism in ways that impact economic, political, and social life (Chih et al., 2020). |
| Intersectionality | Highlights the interrelationships between gender, class, race, sexual orientation, and dis/ability and situates these intersections within complex power structures that vary across contexts (Etengoff, 2020) |
| Cisgender | A person whose gender identity matches their assigned or biological sex (Aisner et al., 2020). |
| Transgender | Persons whose gender identity or expression varies from their sex assigned at birth (Scheim et al., 2017). |
| Cisnormativity | Describes the expectation that all people are cissexual" and denies the existence of trans people in cultural knowledge and institutional infrastructure (Bauer et al., 2009). |
| Dehumanization | A failure to acknowledge another human life as a subject for moral treatment due to disgust for that person (Harris & Fiske, 2015). |
| Cultural Humility | Cultural humility is characterized as a state of openness, self-awareness, egolessness, self-reflection, and critique after engaging with diverse people (Foronda et al., 2020). |
| LGBTQ2S+ | An umbrella term to encompass all gender and sexuality minorities. |
| Colorblindness | Argument that someone cannot perceive a person's skin color and that it is unimportant (Etengoff, 2020). |
| Heteronormativity | An exclusionary belief structure in which heterosexual orientation are the norm (Burton et al., 2021). |

*Note: please use this tool to enhance your understanding of the research and also to improve your own personal knowledge.*

**Table 2**

*Methods Table*

| | T-KAB | CCCS | NP- CCCS | New Instrument |
|---|---|---|---|---|
| Type | Questionnaire | Questionnaire | Questionnaire | Questionnaire |
| Items | 22 | 45 | 48 | 55 |
| Themes | 1. Acceptance of the gender spectrum (n= 8)<br><br>2. Social tolerance (n= 7)<br><br>3. Comfort and contact with transgender people (n= 7) | 1. Training (n= 10)<br><br>2. Formal evaluation (n=1)<br><br>3. Residency training (n=6)<br><br>4. Preparedness (n= 8)<br><br>5. Delivering cross-cultural care (n= 8)<br><br>6. Helplessness (n= 1)<br><br>7. Skillfulness (n=10)<br><br>8. Importance of CCC (n=1) | 1. Teaching (n=10)<br><br>2. Formal evaluation (n=1)<br><br>3. Training Usefulness (n=6)<br><br>4. Preparedness (n=9)<br><br>5. Helplessness (n=1)<br><br>6. Problem delivering care (n=9)<br><br>7. Self-learning (n=1)<br><br>8. Skillfulness (n=9)<br><br>9. NP specific question (n=1)<br><br>10. Importance of CCC (n=1) | **Demographic and Professional Questions** n=13 (not included in item count)<br><br>**T-KAB** All questions-maintained n= 22<br><br>**CCCS** Skillfulness of providing CCC n=9<br><br>**NP-CCCS** Problems encountered delivering care N=9<br><br>Preparedness N=9<br><br>Usefulness of training/ education N=6 |
| Population and Sample | 216 people from US general public, recruited from Amazon's Mechanical Turk | 84 residents in 4 specialities from a community-based hospital with university affiliation | Pop: 1,134 nurse practitioners<br><br>Sample: 30 NPs | |
| Item Generation | Literature review, insight from TG health and scale development experts, input from qualitative research with TG people | Modification of previous 2005 CCCS. | Modification of 2017 Chun CCCS. | |

| | | | | |
|---|---|---|---|---|
| Format | 4-point Likert scale | 4-point Likert scale and 5-point Likert scale | 4-point Likert scale and 5-point Likert scale | |
| Validity | Cronbach's alpha for overall scale was .97<br><br>Factor 1 (gender binary) a= 0.95, Factor 2 (social tolerance) a= 0.93, Factor 3 (comfort and contact) a= 0.91 | The standardized Cronbach α indicated high internal consistency for the 9 items (α = .93). The second factor, general cross-cultural preparedness (knowledge), accounted for an additional 11% of the variance. The 8 items' standardized Cronbach α indicated extremely high internal consistency (α = .94). The third factor, attitude toward culture (attitude), consisted of only 2 items but accounted for 8% of the variance. The standardized Cronbach α was adequate (α = .62). The revised CCCS thus can be used as 1 score or as 3 subscale scores. | internal consistency reliability of Knowledge, Skills, and Negative Attitude was very high (Cronbach's alpha = .900 to .912). The internal consistency reliability of Positive Attitude, with only two items, was adequate (Cronbach's alpha = .656). | |

**Table 3**

*Demographics In-depth Overview*

| | |
|---|---|
| Question 1: Which of the following most closely matched your identity? | 136 females (89.5%) 8 (4.6%) male nurses, 6 (3.9%) non-binary. |
| Q2: What is your gender identity? | 142 (95.3%) were Cisgender, 3 (2.0%) were transgender and 4 (2.7%) did not reveal their gender identity |
| Q3: Which of the following most closely matches your sexuality? | (119, 77.8%) were straight, 11 (7.2%) were bisexual, 8 (5.2%) were Queer, 5 (3.3%) were lesbians, 5 (3.3%) were pansexual, 3 (2.0%) were Gay and 2 (1.3%) did not mention their sexuality |
| Q4: Which of the following ethnoracial groups most closely matches your self-identity? | 107 (65.2%) were White Canadian or White American, 19 (11.6%) were White European, 8 (4.9%) were South East Asian, 7 (4.3%) were South Asian, 5 (3.0%) were Black Canadian or Black American, 3 (1.8%) were East Asian, 3 (1.8%) were Middle Eastern, 3 (1.8%) were Black African, 2 (1.2%) were Indigenous and only 1 (0.6%) was Latin American |
| Q5: What is your immigration history? | 120 (80.5%) were born in Canada, 19 (12.8%) immigrants, 4 (2.7%) were multigenerational settlers and 2 (1.3%) were Indigenous |
| Q6: Do you have a disability (mental, physical, cognitive, etc.)? | 21 (14.1%) yes, 126 (84.6%) no, and 2 (1.3%) preferred not answering |
| Q7: Where are you located? | 107 (71.8%) were from urban or city centers, 42 (28.2%) were from rural or small towns |

| | |
|---|---|
| Q8: How old are you? | 14 (9.4%) were 18-24 years, 38 (25.5%) were 25-34, 57 (38.3%) were 35-44, 21 (14.1%) were 45-54, 17 (11.4%) were 55- 64 years, and 2 were over 65 years old |
| Q9: How many years have you practiced? | 33 (22.1%) less than 5 years, 37 (24.8%) were 5-10 years, 46 (30.9%) were 11-20 years, 10 (6.7%) were 21-25 years and 23 (15.4%) were more than 25 years |
| Q10: What is your level of education? | 103 (53.4%) completed BScN, 28 (14.5%) had completed MScN, 7 (3.6%) completed PhD in nursing, 20 (10.4%) had RPN diploma, and 35 (18.1%) had a non-nursing degree or diploma or certificate |
| Q11: What is your current practice setting? | 62 (41.6%) acute care setting, 17 (11.4%) critical care setting, 28 (18.8%) community health setting, 13 (8.7%) public health setting, 6 (4.0%) long term care setting, and 23 (15.4%) did not specify their practice setting |
| Question 12: I currently provide care to gender-diverse patients. | 110 (73.8%) yes, 27 (18.1%) no, 12 (8.1%) were unsure |
| Question 13: I know of someone who is gender-diverse. | 126 (84.6%) knew of someone who is gender diverse,16 (10.7%) answered no, 7 (4.7%) were not sure |
| Question 14: Do you have someone in your family (chosen, biological, legal family) who is gender-diverse? | 49 (32.9%) yes, 89 (59.7%) no, and 11 (7.4%) were no sure about this |

**Table 4**

*Reliability Analysis*

| Variable | Cronbach's Alpha Value | N of Items |
|---|---|---|
| Knowledge, attitudes, beliefs | .615 | 24 |
| Skillfulness | .890 | 8 |
| Preparedness | .866 | 7 |
| Issues to provide care | .858 | 7 |

**Table 5**

*Correlation Analysis*

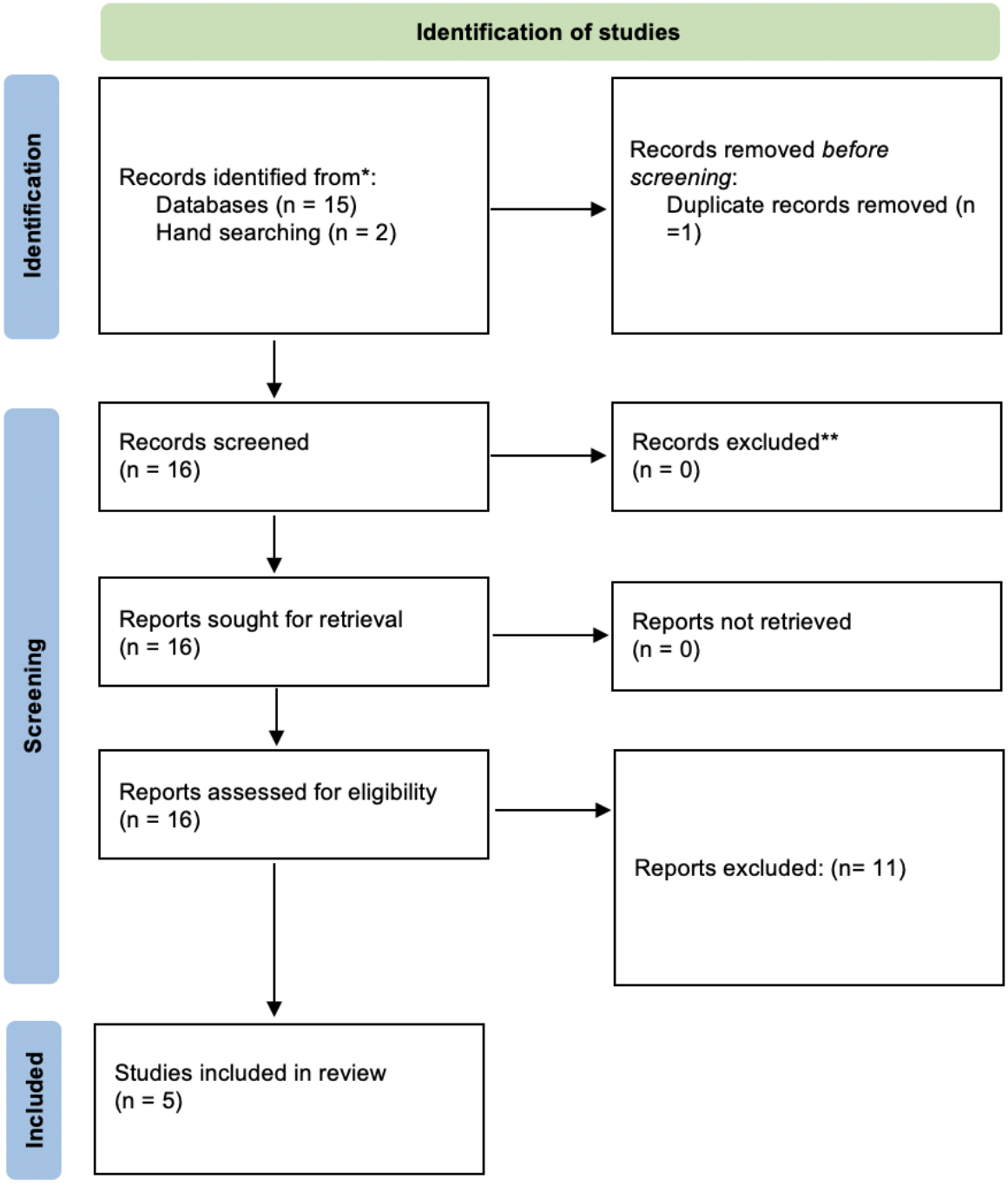
| Variables | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Knowledge, attitudes, beliefs | 1 | | | |
| Skillfulness | -.189* | 1 | | |
| Preparedness | -.064 | .653** | 1 | |
| Issues providing care | -.213** | -.029 | -.169* | 1 |

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

**Figure 1**

*PRISMA Instrument Development*



# Chapter 6

## Results from Feasibility Testing

### Demographics

The majority of nurses were females (*n* = 136, 89.5%), followed by eight (4.6%) male nurses and six (3.9%) non-binary people. The gender identity of the nurses who took part in this research displays that 95.3% (*n* = 142) were cisgender. The majority were straight (*n* = 119, 77.8%). 76.8% of participants (*n* = 126, 76.8%) identified as White Canadian, American, or European. 80.5% were born in Canada. Most participants (*n* = 107, 71.8%) were from urban areas or city centers, while 42 (28.2%) were from rural or small towns. The majority of the participants were between 35 and 44 years of age, with a majority having between 11 and 20 years of nursing experience. More than half of the respondents (*n* = 103, 53.4%) had completed a BScN, 28 (14.5%) had completed a MScN, seven (3.6%) were Ph.D. prepared, and 20 (10.4%) had an RPN diploma. The most popular practice setting was acute care at 41.6%, followed by critical care (11.4%) and community health settings (18.8%).

The majority of respondents (73.8%) reported currently providing care to racialized GD people. The majority of nurses (84.6%) of nurses knew someone who was GD and 32.9% reported having a person in their family identifying as GD. Both these questions resulted in a small percentage of people being unaware if they knew of GD patients or family members (4.7%, 7.4%). Please see the Appendix E for a detailed breakdown of the respondents' demographics.

### Transgender Knowledge, Attitudes, and Beliefs Scale

The majority of respondents either strongly disagree (66, 44.3%) or disagree (60, 40.3%) that a person with a vagina cannot be a man. Similarly, they also strongly disagree (66, 44.3%) or disagree (61, 40.9%) that a person with a penis cannot be a woman. Fifty-five percent (35.9%) of respondents strongly agree that there is more than one way to medically transition. Seventy-seven (51.7%) people believed female to male transgender people are not real men, while 76 (51.0%) believed that male to female transgender are not real women. Seventy-nine respondents (53.0%) reported that a person with a vagina who identifies as male should not be able to use a men's bathroom. Ninety-two respondents (61.7%) said that there are only 2 genders which are male and female. Eighty-two (55.0%) respondents believe that a person with a penis and identifies as female should not be able to use a women's bathroom. Seventy-nine respondents (97.3%) said that GD people should have the opportunity to undergo operations to change their anatomy. One hundred one respondents (67.8%) agreed that GD people should be accepted completely into our society, and (45, 30.2%) they should have equitable access to medical care. Eighty (53.7%) respondents accepted that GD people should be given an equal opportunity to legally change their name without any cost, 99 (66.4%) agreed that there is a need for the organizations to promote GD rights, 100 (67.1%) disagreed that people with GD should not be able to have their genitalia removed. One hundred five respondents (70.5%) disagreed that being gender-diverse goes against their beliefs. Seventy-eight respondents (52.3%) strongly agreed that gender diverse people are not useless, and they are a benefit for the society. One hundred nine respondents (73.2%) said that they avoid interacting with people whose gender is not clear. Ninty-four respondents (63.1%) strongly disagreed that people with both breast and penis make

them uncomfortable. Seventy-seven respondents (51.7%) strongly disagreed that they want to know the gender of the person who they meet. Sixty-five respondents (43.6%) do not feel uncomfortable if they cannot tell that someone is a man or woman. Another 76 (51.0%) disagreed about feeling uncomfortable knowing that a close family member is dating a GD person. Seventy-five respondents (50.3%) agreed that they would feel comfortable if they learned that their friend is GD and 86 (57.7%) felt comfortable with their neighbor being GD.

**How Skilled are Nurses to Deliver Cross-cultural Care to Racialized GD People?**

Sixty-five respondents (43.6%) felt very skillful in listening to how a patient wants to be addressed or interacted with, 68 (45.6%) felt moderately skilled in taking a social history. Fifty-nine respondents (39.6%) felt they had a moderate level skill for contextualizing the patient's reasoning for their behavior or perceived illness. Sixty-five respondents (43.6%) also felt they had a moderate skill level for recognizing the mistrust patients have of the healthcare system or the nurse, 60 (40.3%) felt they had an expert level skill to actively advocate for the care needs and treatment options identified by the patient. Sixty-two respondents (41.6%) felt they had moderate skills to identify cultural beliefs that might affect the process of clinical care and 59 (39.6%) felt moderately skilled in respecting the dynamics of diverse family/ support networks when the patient was making decisions.

**How Prepared Are Nurses to Care for Racialized GD People?**

Nurses were somewhat prepared for cultural practices (*n* = 62, 41.6%), health benefits or practices that differ from Western medicine (*n* = 73, 49.0%), a distrust of the Canadian healthcare system (*n* = 61, 40.9%), and limited English proficiency (*n* = 58,

38.9%). Fifty-eight respondents (38.9%) feel somewhat prepared for the new immigrants, for spiritual and religious beliefs (*n* = 57, 38.3%) and 72 (48.3%) were well prepared for the belief system which is different from their own belief systems.

**Issues When Delivering Cross-Cultural Care**

The data shows that a lack of practical experience in caring for this population is a moderate level issue (*n* = 58, 38.9%). Lack of time to adequately address cultural issues that impact racialized GD people (*n* = 63, 42.3%), inadequate cross-cultural training during nursing education and training was identified as problematic (*n* = 67, 45.0%). Absence of good role models or mentors for cross-cultural care for racialized GD populations was identified as problematic (38.9%). Dismissive attitudes about cross-cultural care for racialized GD populations among nurses as peers was identified as problematic (*n* = 56, 37.6%). Dismissive attitudes about cross-cultural care for racialized GD populations (*n* = 47, 31.5%).

**Training**

The perception of the majority of nurses (*n* = 37, 24.8%) was that lectures and seminars were useful for informing their delivery of care to racialized GD people. Forty-one respondents (27.5%) thought that case-based discussions were useful. Fifty respondents (33.6%) were in favor of on the job training in community-based settings, 42 (28.2%) considered on the job training in hospital settings, 55 (36.9%) supported training led by GD people, 55 (36.9%) were in favor of the diversity of colleagues and 38 (25.5%) considered having a faculty as a role model to be very useful.

# Chapter 7

## Integrated Discussion

### Introduction

The insights produced from this pilot feasibility study have revealed that the nursing profession requires considerable transformation before a commitment to cultural humility of racialized GD people can be fulfilled. The literature review, combined with the questionnaire findings, documented the erasure of racialized GD identities in many facets of the nursing profession. These deficits contrasted with the optimistic willingness of nurses to understand the care needs of racialized GD people. The main findings from this project should motivate all nurses to better engage in caring for all people with a myriad of intersecting identities and backgrounds.

### Summary

This study makes strides toward understanding the realities of nurses in Ontario who provide nursing care for racialized GD people. The overall purpose was to provide a preliminary look at nurses' knowledge, education, training, attitudes, and beliefs because the care of racialized GD people is widely unaddressed in Canadian health research. To achieve this overall objective, a literature review was conducted to address the review question: what is the current state of the literature exploring nurses' experiences providing care to racialized GD people? Additionally, quantitative data was gathered from Registered Practical Nurses, Registered Nurses, and Nurse Practitioners practicing nursing in Ontario to answer the research question: how prepared are nurses to care for racialized GD people? This study served as an example of successfully performing research with (O.G. Thorne), for and about racialized GD people and

established the importance of continuing this stream of inquiry within the nursing profession. The main findings document nurses' acknowledgment of their lack of preparation from all healthcare institutions, from schools of nursing to clinical practice spaces, to inform their care of racialized GD people. Abeln (2019) advocates that increasing GD awareness in all contexts of nursing knowledge development will improve health outcomes for all GD people, especially those who experience microaggressions or outright racism or structural racism in healthcare settings. The research findings were unfavorable as nurses are largely unprepared, and some continue to perpetuate outdated care models that expose people to the harms of microaggression, racism, and systemic racism. However, recognizing the issues is a beginning step toward nurses becoming mindful of these issues in practice, which further motivates the need for future progress to address the challenges racialized and GD people face in seeking equitable and safe high-quality healthcare.

**Main Findings**

The negative attitudes of healthcare providers are widely recorded, which creates negative healthcare experiences and poor health outcomes for LGBTQ2S+ people (Guerin, 2021; Pratt-Chappman & Potter, 2021). To my knowledge, no studies have addressed the attitudes and beliefs of nurses regarding intersecting racialized and GD identities. To assess this, the Transgender Knowledge, Attitudes, and Beliefs (T-KAB) Scale measured the concepts of knowledge, attitudes, and beliefs toward GD people was used. Scoring higher on the T-KAB scale demonstrated a lesser need for skill when caring for racialized GD people. This does not indicate that no skill is required; it affirms the positive effects of trans-affirming attitudes and clinical skills in combination. Riggs

and Bartholomaeus (2016) found similar correlations between positive attitudes and training to improve the care of trans people in healthcare.

Current literature spotlights nurses' knowledge gaps across all GD healthcare topics (Carabez et al., 2016; Kellett & Fitton, 2017). Guerin (2021) described nurses as lacking a critical understanding of gender diversity and how to best care for trans and nonbinary people in healthcare. This pilot feasibility study confirmed that fewer issues would occur in their practice if nurses had greater knowledge about racialized GD people. Improving nurses' understanding and awareness is essential to promoting health and service use in the trans community (Guerin, 2021).

Skill development in nursing students is often the emphasis for nurses training (Sherman et al., 2021) but is less often explored with current practicing nurses in Canada. This pilot feasibility study illuminated that having a skillfulness to provide care to racialized GD people was perceived by nurses as having the potential to increase their preparedness to care while also decreasing the likelihood of problems in their practices. Strategies for increasing nurses' pre-service and in-service skills to care for LGBTQ2S+ people can be found for specific healthcare settings, which would address the perceived needs for enhanced knowledge and skills of this study's participants. Kaiafas and Kennedy (2021) provide a practical example of how healthcare providers' knowledge and skills in providing care to trans people in an emergency department were improved through practical interventions. These studies help inform future projects but do not fully grasp the actualities of the racialized GD population. An intersectional distinction of trans people is necessary to design future care mobilizations (Padhila et al., 2022). Overlooking this distinction contributes to the domination of a healthcare

system that reproduces stereotypes, biases, and inequalities (Padhila et al., 2022). Advancing strategies from the literature would require an expansion of the trans population to involve the distinctions between intersecting identities and their corresponding healthcare experiences so as not further to ignore people often overlooked in the GD community. This understanding is required to improve training systems for healthcare providers effectively.

A large question that seems to loom over the nursing profession is the discourse around representation and diversity in professional spaces. In Canada, to the author's knowledge, there are no reports on the demographics of nurses' cultural/ethnic identities. However, this data is accessible in other countries, such as the US (Carson-Newman, 2020). Summarizing the demographic data from this study, participants were 89.5% (*n* = 136) female, 95.3% (*n* = 142) cisgender, 77.8% (*n* = 119) straight, and 76.8% (*n* = 134) White. Although the sample size was small and likely not representative of the entire Ontario nursing workforce population, this finding ignites a compelling conversation because the sample is predominantly White cisgender straight women. The unbearable Whiteness historically represented in Canada's nursing population is not representative of Canadians' rich, diverse backgrounds (Etowa et al., 2011). Normalizing the White majority enables a lack of awareness of society's racial climate (Bell, 2020).

The centering of the nursing profession around Whiteness and how this limits the potential to care for those outside the norm, especially racialized GD people. Saini et al. (2022) suggested there is an inability to fully comprehend LGBTQ2S+ competency through a lens of Whiteness and heteronormative lived experiences. Many studies

describe “the games” queer racialized people must play, advocating for their health in White heteronormative spaces (Howard et al., 2019; White et al.,2020). For example, racialized trans people discuss an internal risk-benefit analysis they perform, weighing their relationship with their healthcare provider (Howard et al. 2019). They fear which parts of their identity to disclose as not to yield a negative reaction, potentially limiting the quality of their care (Howard et al. 2019). Howard et al. (2019) proposed a polar perspective that patients report greater comfort with healthcare providers that share similar identities. Considering the impact that diversity may have on racialized GD people's health, there needs to be a more significant push for uplifting diverse perspectives and representation within the nursing profession.

The issue about discourse then becomes centered around the importance of taking an approach to decolonizing the nursing profession to allow for the inclusivity and safety of diverse peoples. This example illuminates current realities affecting GD nurses in their practice settings. Dykhuizen et al. (2022) suggested strategies for decolonizing the Canadian nursing profession to foster cultural humility for Two-Spirit people. Decolonization of nursing education can include curriculum on oppression and structural violence that will foster the cultural humility of patients but also retain people with diverse backgrounds in the nursing profession (Dykhuizen et al., 2022). Nurses can specifically begin to work alongside Indigenous communities to identify barriers affecting the holistic care of Two-Spirit people and develop resources for safe spaces to access care (Dykhuizen et al., 2022). I believe these strategies and diverse ways of knowing could positively impact the nursing care of racialized GD people and within the profession at large. Further dialog within the profession and research are needed to

improve nurses' knowledge and skills to provide safe, effective, and respectful care to racialized GD people.

**Strengths and Limitations**

Taking on new territory within nursing research is not without its limitations. Due to obstacles with professional nursing bodies, the questionnaire could not be distributed to Ontario nurses at large, resulting in a much smaller sample size. This restricted the ability to study a representative sample of the Ontario nursing population; therefore, the study was pivoted to become a pilot feasibility study. Moving forward, it would be of value to conduct the study on a larger scale. Another limitation was the low scoring for the reliability of the T-KAB scale ($\alpha = 0.615$). For future investigations, factor analysis on the scale items should be done to determine which category of items had an adverse effect on instrument performance. Although the study developed a deeper understanding of nurses' current state of practice and knowledge about providing nursing care to racialized GD people, I acknowledge this may perpetuate research gaps that occur when researchers cluster all identities based on gender or race/ethnicity and how it may erase the diverse challenges specific identities face in healthcare spaces.

The study shows its most considerable strength in that it stands alone as the first study to explore nurses' preparedness to care for racialized GD people in Ontario and may be the only study in Canada as well. This study has established the applicability and feasibility of conducting research with nurses to understand their knowledge, attitude, and skills in providing healthcare to racialized GD people in the Canadian context and the need for further exploration. The foundational methodology of the study is built on the ideas of Intersectionality, which provided an appropriate lens to

understand the study. It would be remiss not to acknowledge the insights and guidance of OG Thorne, advisor, throughout the research process, which helped to align the study with a gender non-binary perspective.

## Nursing Implications

This study has addressed the immense need for greater training of practicing nurses and the education of nursing students about the healthcare needs of racialized GD people. To reiterate what previous researchers have asserted, nurses must use their power to pressure decision-makers for policy changes (Abeln, 2019; Lightfoot et al., 2021; Sprik & Gentile, 2020). Only with policy change demanding the inclusion of competencies will there be an urgency to include healthcare for racialized GD people in educational nursing spaces, both pre-service and in-service. A greater critique is required of how nursing programs and healthcare institutions are being operated to perpetuate Whiteness and heteronormativity and silence diverse ways of guiding these spaces. At the personal level, nurses must continue questioning their beliefs and how they impact their practices. Fostering an approach around listening to those oppressed in healthcare spaces and amplifying their voices allows us to hear what is needed from us as nurses (Dykhuizen, 2022). Active listening is an impactful way to practice cultural humility (Bell et al., 2019) and is essential for establishing an effective and mutually respectful relationship between nurses and the people to whom they provide care. Use your influence as a nurse and knowledge-keeper to educate those around you that may require additional support to engage in the cultural humility of racialized GD people.

## Future Research

Throughout the process of conducting this study, the obstacles that arose allowed for future avenues of research to strengthen and progress the study further. Impacted by time restrictions, a scoping review was not achieved; a literature review was conducted instead. Expanding on the literature findings, a scoping review would serve as the first scoping review to explore a comprehensive analysis of the current state of nurses' experiences providing care for racialized GD people. The study's questionnaire would benefit from further testing to improve the items' scoring. The questionnaire could then be distributed across Canada to develop a more representative sample of the nursing landscape. The study was limited to a quantitative methodology, it would be beneficial to explore nurses' experiences and opinions with a qualitative methodology. Exploring more abstract ideas for future studies, research would benefit from further critiquing the Whiteness in nursing spaces and how this impacts efforts to decolonize the profession, and the care nurses provide.

## Conclusion

This pilot feasibility study has opened up a long overdue conversation about how prepared nurses are to care for racialized GD people. The literature established large gaps in nursing knowledge due to minimal content in nursing school and little to no training in workplaces (Burgwal et al., 2021; Carabez et al., 2016). The literature also demonstrated countless experiences of groups in the racialized GD community reporting negative healthcare experiences and health outcomes (Gonzalaz et al., 2022; Howard et al., 2019; Kattari et al., 2021). The combination of the concepts of nurses and racialized GD people is largely unexplored in the Canadian context. The questionnaire findings highlighted nurses' acknowledgment of their lack of preparedness

and their newfound desire to learn more. Nurses demonstrated that positive attitudes and beliefs would positively impact their care. This pilot feasibility study has established critiques within the nursing profession that have long left resounding negative effects on racialized GD people in Ontario. It is time for nurses to engage in caring for racialized GD people that is consistent with the emancipatory objectives of social justice.

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**Table 1**

*Glossary*

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| Gender-Diverse | An overarching descriptor for people that do not align with the traditional binary (male or female). It provides liberty to choose their own identifier (Thorne et al., 2019). |
| Racialized | People and communities that experience racism in ways that impact economic, political, and social life (Chih et al., 2020). |
| Intersectionality | Highlights the interrelationships between gender, class, race, sexual orientation, and dis/ability and situates these intersections within complex power structures that vary across contexts (Etengoff, 2020) |
| Cisgender | A person whose gender identity matches their assigned or biological sex (Aisner et al., 2020). |
| Transgender | Persons whose gender identity or expression varies from their sex assigned at birth (Scheim et al., 2017). |
| Cisnormativity | Describes the expectation that all people are cissexual" and denies the existence of trans people in cultural knowledge and institutional infrastructure (Bauer et al., 2009). |
| Dehumanization | A failure to acknowledge another human life as a subject for moral treatment due to disgust for that person (Harris & Fiske, 2015). |
| Cultural Humility | Cultural humility is characterized as a state of openness, self-awareness, egolessness, self-reflection, and critique after engaging with diverse people (Foronda et al., 2020). |
| LGBTQ2S+ | An umbrella term to encompass all gender and sexuality minorities. |
| Colorblindness | Argument that someone cannot perceive a person's skin color and that it is unimportant (Etengoff, 2020). |
| Heteronormativity | An exclusionary belief structure in which heterosexual orientation are the norm (Burton et al., 2021). |

*Note: please use this tool to enhance your understanding of the research and also to improve your own personal knowledge.*

**Table 2**

*Contextual information: selected literature from literature review*

| Article reference | Purpose | Sample | Design/ Methodology | Findings |
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| Abeln, 2019 | Outline the mental health inequalities faced by trans populations and the need for improvements in nursing education to bridge these gaps. | N/A | Commentary | It is crucial that nursing educators incorporate information on the transgender experience into their courses to better prepare future nurses to care for this population in the mental health care setting. |
| Adams et al., 2007 | To provide teachers and facilitators with an accessible pedagogical approach to issues of oppression in classrooms. | N/A | Book | N/A |
| Agénor et al., 2022 | Exploring Black, Latinx, Native, Asian, and other transmasculine young adults of color's experiences ac- cessing and utilizing sexual and reproductive health services, including HIV and STI testing, cervical cancer screening, and contraceptive care, using focus group discussions. | Self-identified as a person of color, including but not limited to Black, Latinx, Native, and/or Asian; were assigned female at birth (AFAB); self-identified as transmasculine, including but not limited to a transgender man or a masculine gender diverse (e.g., non-binary and gender fluid) person; were between 18 and 25 years of age; and resided in | Qualitative research | Found that transmasculine young adults of color experienced cissexism, heterosexism, and racism in accessing and utilizing sexual and reproductive health services. |

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| | | the greater Boston area | | |
| Apodaca et al., 2022 | Examines the lived experience of unfair treatment among patients from BIPOC and/or LGBTQ+ people. | 25 BIPOC and/or LGBTQ people | Interviews | Describing how patients react to experiences of unfair treatment and discrimination, our findings enhance the understanding of health disparities. |
| Arreola et al., 2022 | Few studies have examined Latina/x/os' health in the context of multiple systems of oppression targeting their identities, including anti-immigrant prejudice. | N/A | Commentary | Present a focus on heterosexism, ageism, and transprejudice to exemplify ways in which intersectional S&D affect Latina/ x/o immigrants. |
| Avera et al., 2015 | Utilizing the evidence-based indivisible self wellness (IS-Wel) model to conceptualize the experiences of transgender individuals. | Case study | Case Studies | Wellness and strength-based approaches are needed to depathologize transgender and gender-nonconforming persons. |
| Baldwin et al., 2018 | Examines interactions between transgender and gender non-binary (TGGNB) individuals and their health care providers. | 119 participants | Mixed-method | Prioritizing the provision of care for TGGNB in formal medical education and training programs to ensure that health care providers and their staff have the knowledge and experience they need to provide higher-quality care to gender diverse patients. |
| Barnett et al., 2019 | Identified U.S.-based psychological research on lesbian, gay, bisexual, and transgender (LGBT) | Literature between 1988-2018 | Content analysis | Literature has a significant focus on pathology. Underrepresented groups included |

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| | people of color by extending the period covered to 2018. | | | cisgender and transgender women; transgender men; older individuals; Asian Americans, Native Hawaiians, and Pacific Islanders; American Indians and Alaska Natives; and multiracial individuals. |
| Bauer et al., 2014 | Document the extent of trans-specific negative emergency department (ED) experiences, and of ED avoidance. | 433 trans people | Exploratory analysis | First exploratory analysis of ED avoidance, utilization, and experiences by trans persons documented ED avoidance and possible unmet need for emergency care among trans Ontarians. |
| Bell et al., 2019 | Describe teaching strategies that can be used by other nurse educators learning about culturally humble care of sexual and gender minority patients. | N/A | Commentary | Cultural humility has emerged as an effective strategy to improve the understanding of our own culture and others. |
| Bith-Melander et al., 2010 | Explored the needs of transgender people of color, including bio- logical transitioning issues, gender and group membership identity formation, HIV, and other health issues. | 43 transgender youth and adults of color in San Francisco | Ethnographic qualitative study | The major themes that emerged were gender identity, group membership, transitioning and related issues, sex work, alcohol and drug use, mental health and health care, sense of community, HIV, resources, and other support. |

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| Burgwal et al., 2021 | The need of healthcare providers (HCP) to acquire knowledge, as well as on the effect of training on their level of competence and confidence in working with transgender people. | 810 HCP across four different European countries | Online survey | Provided strong support for the use of training in improving healthcare conditions for transgender people, not only to raise confidence levels of HCP in working with transgender people, but to improve transgender-specific healthcare conditions in general. |
| Carabez et al., 2016 | Explored practicing nurses' knowledge of the needs of transgender patients. | 268 nurses in the San Francisco Bay Area | Structured interviews | Findings revealed nurses' discomfort and lack of knowledge about transgender people and their health care needs. |
| Carrier et al., 2020 | To introduce readers to the term Two-Spirit and to provide a broad overview of Indigenous conceptualizations of gender, sexuality, and spirit, to address implications for the nursing profession, and to outline potential applications of this knowledge in practice. | N/A | Commentary | Nurses who wish to operate in solidarity with Indigenous populations need to demonstrate competencies in providing culturally safe care. |
| Cobourn et al., 2022 | Addresses a gap in literature regarding differences in factors contributing to psychological well-being between binary trans and NB people as well as understanding these factors in a | Secondary data from the Social Justice Sexuality Project | Multiple group-path analysis | Perceived family support, religiosity and being connected to an LGBT community were significantly associated with psychological well-being for binary trans people, while |

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| | predominately POC sample. | | | only LGBT community connectedness was significantly associated with psychological well-being for NB people. |
| Dalton et al., 2022 | Demonstrate how a feminist approach to supervision can empower supervisors to help marriage and family therapy trainees develop competency in transgender care. | N/A | Vignette | Feminist-informed supervision methods provide a way to bridge the gap between training programs and clinical practice in fostering transgender competency. |
| Dean et al., 2016 | Argues that negative experiences for LGBTQIA are produced by a variety of subtle, ostensibly insignificant features of healthcare spaces and interpersonal interactions called microaggressions. | N/A | Commentary | Training healthcare professionals about LGBTQIA issues is unlikely to adequately address the harms of heteronormative schemas and microaggressions, and it does not ensure that all patients are given the appropriate standard of care. |
| DeGuzman et al., 2018 | Content analysis of two commonly used health assessment textbooks was completed to identify material that prepared nurses for LGBT patient interactions. | 2 textbooks | Content analysis | Nursing textbooks often lack sufficient content on caring for LGBT patients. |
| de Vries et al., 2022 | Explores shifts in racial identity by multiracial/multiethnic trans people as they transition gender and the ways Whiteness and nationalist ideology shape their | 6 self-identified multiracial, multiethnic, and multi-heritage | Semi-structured interviews | As participants transitioned gender and were acknowledged by others in their gen-der identity, shifts in their embodiment were |

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| | racialized gender experiences. | | | used by others to ascribe a new racialized gender. |
| Dykhuizen et al., 2022 | Aim to answer the question: What information is currently available pertaining to the health of Canadian Two Spirit people? | 13 articles related to the health and wellness of the Canadian Two Spirit community | Literature review | Assessing the impact that colonization has had on the intersections of gender, race, sexuality, class, culture, and spirituality, Two Spirit people face unique health concerns. |
| Erby & White, 2022 | Explore issues of power and privilege in the counseling relationship with Queer- identified clinicians and apply the multidimensional model of broaching behavior with TGNB clients of Color. | Literature focusing on the interaction and impact of client and clinician race, gender, and sexual/affectional identities in the counseling relationship is presented | Literature review | The model provides a practical tool to facilitate critical conversations of power, privilege and identity in the counseling relationship. |
| Gahagan & Subirana-Malaret, 2018 | Explores the perceived barriers to primary health care as identified among a sample of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) identified individuals and health care providers in Nova Scotia, Canada. | 283 LGBTQ respondents | Online survey | The primary health care needs of LGBTQ populations in Nova Scotia are not being met and this may in turn contribute to their poor health outcomes across the life course. |
| Galupo & Orphanidys, 2022 | A special issue to showcase a diverse representation across authors and across a range of topics affecting our international transgender BIPOC communities. | N/A | Commentary | Introduces the articles below as they have been organized into four different sections: (1) Immigration and Migration; (2) Intersecting Dimensions of Oppression; (3) |

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| | | | | Health Disparities and Minority Stress; and (4) Perspectives on Healing. |
| Guerin, 2021 | Examines the potential benefit of educating nurses in providing culturally competent care in the interest of improving experiences of health care for transgender people. | N/A | Commentary | Recommends that nurses are provided with transgender inclusive education both as preregistered student nurses, and as registered nurses. |
| Goldenberg et al., 2020 | Little is known about the relationships between these policies and use of medical gender affirmation services (eg, hormone treatment, ther-apy/counseling), or about how these associations may vary among different racial and ethnic groups. | 2015 U.S. Trans Survey of nearly 28,000 TGGD people | Multilevel modeling | State-level transgender-specific policies influence medical gender affirmation service use and seem to affect use by non-Hispanic white TGGD people and TGGD people of color differently. |
| Gonzalaz et al., 2022 | Investigates the resource needs of immigrant Latinx transgender community members living in the United States. | 18 immigrant Latinx transgender people living in a large metropolitan city in Florida | Semi-structured interviews | Immigrant Latinx transgender community members in this study provided guidance about broad resources needed to enhance their wellness and safety and promote liberation of community members. |
| Gowin et al., 2017 | Explored stressors resulting health issues, and the needs of this particularly vulnerable population. | 45 asylum seekers | Systematic document review | Stressors contribute to mental/physical health issues that affect their social and economic stability and security. |

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| Haminvik et al., 2020 | The benefit of telemedicine for transgender and gender nonbinary (TGNB) individuals, who have less access to both gender-affirming and general medical care due to the consequences of stigma, discrimination, and marginalization. | N/A | Commentary | Engagement of TGNB patients will facilitate identification of any unique barrier to telemedicine-delivered gender-affirming care and inform changes that may be needed in virtual clinical practice to optimize patient-centered care. |
| Howard et al., 2019 | Investigate how TPOC healthcare experiences are shaped by both race/ethnicity and gender identity. | 22 trans and racial/ethnic minorities | Semi-structured interviews and focus groups | TPOC have different experiences compared with white transgender or cisgender racial/ethnic minorities. |
| Hudson & Romanelli, 2020 | Examines participants' perspectives on the role of community in enhancing health and well-being. | 38 LGBTQ-identified people of color in New York City | Interviews | Community strengths identified by participants included (a) safety, acceptance, and support; (b) interconnectedness and resource sharing; and (c) advocacy, collective action, and community potential. Recommendations for policy, practice, and future research are suggested, including efforts toward community power building. |
| Jefferson et al., 2013 | Examined transgender identity among trans women of color, coping self-efficacy, discrimination, and the likelihood of depression symptoms. | Data from a subset of trans women of color participants | Pilot intervention | Exposure to discriminatory events and combined discrimination positively associated with depression symptom odds. |

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| Kattari et al., 2020 | (1) Does the likelihood of being denied health care vary by gender within the TNB population, and if so, how? (2) How do socioeconomic and identity characteristics, including gender identity, race, income, disability status, age, and education level, affect the likelihood of TNB individuals being denied health care? | Data from the 2015 U.S. Trans Survey (n=27,715) | Survey | A need for better training of healthcare providers to be inclusive and reduce denial rates of their transgender and nonbinary patients. |
| Kellett & Fitton, 2017 | To raise readers' awareness about the problems inherent to transinvisibility and to propose several curricular and structural-level interventions that may serve to gradually increase the recognition of gender diversity in the planning and delivery of nursing education and practice. | N/A | Commentary | Modeling gender inclusiveness and acceptance in nursing education settings should be combined with upstream structural interventions to influence practice related to gender diversity within the profession as a whole. |
| Kinitz et al., 2022 | To determine what is known about the health of 2SLGBTQþ people in Canada experiencing poverty. | N=33 | Literature review | Research that directly interrogated the experiences of 2SLGBTQþ populations experiencing poverty was sparse. |
| Kirczenow MacDonald et al., 2021 | Explore the experiences of transmasculine individuals with pregnancy and birth. | 22 trans-masculine individuals who had experienced one or more pregnancies | Qualitative interviews | Experiences of gender dysphoria among transmasculine individuals during pregnancy and birth vary widely. |

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| Klotzbaugh et al., 2020 | Investigates pre- and post-knowledge of medical guidelines, disparities, policies, and attitudes specific to gender minorities among advanced practice nursing students attending a gender minority health module. | Practice nursing students | Questionnaire: pilot study | Twenty-seven percent of the students reported experience with gender minority patients. |
| LeBlanc et al., 2022 | Aimed to collect qualitative data from a sample of TGD com- munity health center patients on health research priorities to inform future TGD-centered research in the field of TGD health. | 28 patients from two community health centers | Focus groups | Cross-cutting themes about TGD research priorities pertaining to social factors and health included: (1) Embodiment: understanding and investigating the complex and intersectional lived experiences of TGD individuals; (2) Social determinants of health: the impact of structural and interpersonal stigma on TGD health; and (3) Resiliency and health promoting factors: the need to expand public health research beyond disparities to assess resiliency and health promotion in TGD communities. |
| Levefor et al., 2019 | To understand disparities that may exist in distress and therapeutic response between TGNC and cisgender clients. | 41,691 clients from the Center for Collegiate Mental Health 2012–2016 dataset | Secondary quantitative data | TGNC Clients of Color experienced more distress than either White TGNC clients or cisgender Clients of Color. |

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| Lightfoot et al., 2021 | Explore the conceptual understanding of trans-affirming care as it pertains to nursing, and to provide recommendations for trans-affirming nursing care at the systemic, organizational, and individual level. | 136 articles | Integrative review and concept analysis | The antecedents identified were depathologization of gender variance and cultural humility. The defining attributes were patient-led care, trans-affirming culture, and trans-competent providers. The consequences were improved psychological and physical health outcomes. |
| Lim et al., 2015 | Assesses the knowledge of faculty in baccalaureate nursing programs and their readiness to teach about LGBT health | 739 nursing school administrative leaders | Survey | The knowledge, experience, and readiness for teaching LGBT health among baccalaureate faculty are limited. |
| Lindroth, 2016 | Describes how transgender people experience meetings with health care professionals. | 20 persons aged 18-74 and identifying as transgender and non-binary | Interviews | Disrespect among health care professionals is the core category connected to the experiences in the result; transgender people experience estrangement, expectations and eviction in different sexual health-promoting settings. |
| Logie et al., 2016 | Explore experiences of social support group participation among LGBT African and Caribbean newcomers and refugees in an urban Canadian city. | 29 LGBT African and Caribbean newcomers and refugees | Focus groups | Participant narratives highlighted immigration stressors, social isolation, mental health issues, and challenges meeting the SDOH. |
| MacDonnell, 2007 | Explores the relevance of power | Community nurses in the Canadian | Case study | The findings suggest that dynamics of power, |

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| | relations to nursing ethical inquiry. | province of Ontario | | including gender, influence nurses' ability to advocate for sexual minorities through research, prompting the development of a public statement on knowledge production. |
| MacKinnon et al., 2020 | Explicate how standardized readiness assessments coordinate access to hormones and surgeries in Canada. | 22 trans people, clinicians, clinician-educators, and administrators | Institutional ethnography | Trans patients downplay or withhold mental health concerns from clinicians, or otherwise do additional work (e.g., take up unwanted psychiatric interventions) to convince providers they are "mentally ready" to transition. |
| Marsh et al., 2022 | Identify factors influencing the decision to teach lesbian, gay, bisexual, transgender, and queer (LGBTQ) content in baccalaureate nursing programs and determine priority areas for future intervention. | 111 nurse educators from across the United States | Survey | Average scores on items related to barriers, outcomes, control, norms, and attitudes were found to significantly correlate with the intention to teach LGBTQ content. |
| McDowell & Bower, 2016 | Developed transgender health content for students in a baccalaureate nursing program and used a student–faculty partnership model to integrate new content into the curriculum. | Johns Hopkins University School of Nursing | Curriculum integration project | Mitigated common barriers to developing and integrating new, diversity-related topics into a baccalaureate nursing curriculum. |

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| McEwing, 2020 | Developed an educational program for BSN students to improve competency in providing care for LGBT individuals. | 124 students | Educational program implementation | Overall LGB competence scores improved from pre- (M = 4.42) to post-test (M = 5.20) and did not significantly decrease at one-month (M = 5.03, $p < .001$). Similar findings were observed in the transgender cultural competence scores (pre- (M = 4.02); post- (M = 5.08); one-month (M = 4.92, $p < .001$)). |
| Meyer & Frost, 2013 | Examined the effects of minority stress on the physical health of lesbians, gay men, and bisexuals (LGBs). | 396 participants | Interviews | Self-appraised minority stress exposures were not associated with poorer physical health at 1-year follow-up. Prejudice-related stressful life events have a unique deleterious impact on health that persists above and beyond the effect of stressful life events unrelated to prejudice. |
| Millar & Brooks, 2022 | Examine racial/ethnic differences in gender-related discrimination and psychological distress within a sample of transgender individuals. | 99 self-identified transgender adults recruited through North American LGBTQ organizations | Questionnaire (secondary data) | This research highlights that BIPOC are a heterogeneous group; by solely examining race/ethnicity as a binary variable, studies mask potential important |

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| | | | | differences among different groups. |
| Moradi et al., 2016 | Provides a content analysis of more than a decade (2002–2012) of academic scholarship about trans people and issues. | 960 trans-focused publications | Content analysis | The analyses revealed that the literature on trans people and issues is growing, although many publications include trans people and issues nominally without substantive attention. |
| Morris, 2018 | Improving nursing care for transgender people. | | Commentary | To provide culturally, sensitive care to TGs, nurses and other healthcare professionals should start by learning about issues affecting TG health and improve knowledge on the terminology, for better patient-nurse communication. |
| Nowaskie & Najam, 2022 | Aimed to characterize healthcare professionals' LGBT cultural competency by comparing twelve different demographically diverse healthcare professional groups based on gender identity, sexual orientation, and race. | Deidentified data (N = 2254) was aggregated from three independent studies | multivariate analyses of covariance | Compared to men, women reported significantly higher LGBT-DOCSS scores, except significantly lower Clinical Preparedness. |
| Ogunbajo et al., 2021 | Assessed general attitudes, experiences, and beliefs about PrEP as well as individual-, interpersonal-, community-, and structural-level barriers to PrEP | 30 Black and Hispanic/ Latinx transgender women | Interviews | Findings indicated the presence of individual-level barriers including cost concerns, mental health issues, substance use, and concerns about PrEP side |

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| | uptake and adherence. | | | effects including hormone interaction. |
| Oswald et al., 2022 | Unpack the methodological, epistemological, and ethical modes of inquiry embedded in a participatory, multi-method, intergenerational survey of/by/for LGBTQIA2S+ youth from across the Unites States. | 1800 youth | Intergenerational participatory survey | Illustrate how neuroqueer youth operate in ways that are multi-scalar with struggles that are deeply personal, embodied, and political. |
| Padilha et al., 2022 | To integrate and analyse the literature produced by nurses in terms of care, education and understanding of the reality of transgender (trans) people. | 33 articles | Integrative review | Nurses must work to provide a space for convergence and enhancement of the rights of trans people and cease to be a verticalized care model. |
| Pratt-Chapman & Potter, 2021 | Explored the degree to which sociodemographic factors and student affiliation with SGM people explained self-reported competence in caring for SGM patients. | Health care professional students and faculty | Online survey (secondary data) | Sociodemographic factors, lived experiences, and amount of training in SGM-specific health matter when it comes to health care professional students' sense of preparedness in caring for SGM patients. |
| Rider et al., 2018 | Examined health care providers' experiences and attitudes about working with TGD youth to identify specific training needs. | 14 nurses and physicians who work with adolescents | Semi-structured interviews | Specific training is needed to help providers manage discomfort with gender-related topics and simultaneously develop their knowledge of and skills for discussing gender issues. |
| Riggs & Bartholomaeus, 2016 | Explore the experience, knowledge and | 96 mental health nurses | Survey | Commenting on the dearth of competency and |

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| | attitudes of a sample of Australian mental health nurses with regards to working with transgender people. | | | practice documents specific to mental health nurses working with transgender people, and it outlines the Australian standards that would mandate their development. |
| Roller et al., 2015 | Construct a theoretical framework that depicts the process by which transgender individuals engage in health care. | 25 individuals who self-identified as transgender | Grounded theory study | Central phenomenon of how TIs engage in health care was the core process of navigating the system. The core process involves four sub-processes: needing to move forward, doing due diligence, finding loopholes, and making it work. |
| Rounds et al., 2013 | Obtain this information via focus groups with LGBTQ people regarding behaviors of health care providers that improve or impede quality of care and then to summarize those behaviors. | 11 people | Focus groups | Concludes with a list of behaviors that enhance or impede quality care that can serve as a guide for healthcare professionals. |
| Rowan et al., 2014 | North Carolina, 12 house/ball members were interviewed about their experiences with health care providers and their assessment of any barriers to care due to their affiliation with the rather clandestine house/ball sub-culture. | 12 house/ball members | Interviews | House/ball members reported both positive and negative perceptions of treatment by their health care providers with respect to their house/ball involvement. |

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| Saini et al., 2022 | To share the development, embedding, and formative evaluation of an interdisciplinary project to improve LGBTQI+ health content across an undergraduate nursing curriculum. | 87 student nurses enrolled in the final semester of their undergraduate degree | Cross-sectional online survey | Opportunities to better embed LGBTQI+ competency included clear acknowledgement of wider systems of power and oppression, integration and consistent modeling by nursing faculty, and linkage of content to other equity issues to address the intersectional nature of inequities. |
| Sansfaçon et al., 2018 | Presents the results of Stage One of interviews (n D 24) conducted for a Community-Based Participatory Action Research (CBPAR) qualitative research project based in Quebec. | 24 interviews | Interviews | Supports existing evidence on trans youth's experiences, they also provide a more nuanced portrayal of the complex ways in which recognition, as well as non-, mis-, or mal-recognition, influence trans youth's well-being at different sites. |
| Scheim et al., 2017 | Examined the prevalence of and factors associated with not having a family physician among transgender (trans) people in Ontario, Canada. | RDS survey of trans Ontarians age 16 and above (n=433) | Survey (secondary data) | First quantitative evidence of health disparities by race and gender within a Canadian transgender population and suggest a social gradient in access to care within Ontario's "universal health insurance" system. |
| Sekoni et al., 2022 | To collect, analyse and interpret accounts of the everyday health | 35 interviews | Empirical study | The article has significant implications for policy and |

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| | experiences and practices of LGBT+ people in Nigeria. | | | healthcare education and responds to a call from the World Health Organisation to generate context-specific data to guide interventions targeted at minority population groups. |
| Sherman et al., 2021 | To assess the preliminary efficacy and feasibility (i.e., attrition, engagement, acceptability) of the TCIP in improving the TGD-related health knowledge and attitudes among a sample of pre-licensure nursing students. | Bachelor's in Nursing Science (BSN) program at Johns Hopkins School of Nursing | Online survey | Findings indicate TGD-specific content improved student's gender sensitivity overtime, with improvements in self-reported skills in providing care for TGD people and knowledge of additional TGD-specific re-sources. However, gender sensitivity remains low among student's and students requested more TGD content suggesting room for further improvement. |
| Smith, 2012 | Explores intersections of imperialism and research - specifically, the ways in which imperialism is embedded in disciplines of knowledge and tradition as 'regimes of truth'. | N/A | Book | Concepts such as 'discovery' and 'claiming' are discussed and an argument presented that the decolonization of research methods will help to reclaim control over indigenous ways of knowing and being. |
| Sprik & Gentile, 2020 | To describe the limitations of cultural competency training and argue for | N/A | Commentary | Practical components of successful cultural humility trainings |

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| | healthcare systems to implement cultural humility trainings as a way to reduce LGBTQ health disparities at the end-of-life. | | | including leadership buy-in, appropriate outcome measurements, multiple training sessions, and fostering a safe reflection space. |
| Tan et al., 2022 | To examine how social positions (gender, ethnicity, and migrant status) and social determinants of mental health were inter-related for Asian transgender people in Aotearoa/New Zealand. | 49 Asian participants | Qualitative and quantitative | Study provides evidence for health care providers, researchers, and policy makers to employ a culturally appropriate lens to improve knowledge about the intersectional experiences of being Asian and transgender. |
| Taube & Mussuap, 2022 | To survey 125 TGD people of color and 625 white TGD adults (18 to 68 years old, M 1⁄4 26.0, SD 1⁄4 9.2) about their experiences of growth from adversity. | 125 TGD people of color and 625 white TGD adults | Survey | Results support the use of the PTGI-X with TGD populations and across racial TGD subgroups and indicate that growth from adversity is not only prevalent in TGD people but also relevant to positive outcomes, particularly in TGD people of color. |
| Tebbe & Budge, 2016 | To provide readers with tools to critically consider decisions related to conducting research with trans populations. | N/A | Commentary | This article seeks to not only raise a number of important considerations for research with trans populations but also to provide readers with critical tools for adapting decision making when planning and conducting research with trans populations. |

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| Vincent, 2018 | Draws on practical experiences of doing research with transgender communities, and insider group status, to construct six categories to consider when working on trans-focused research. | N/A | Commentary | Reflecting on the overlapping and non-exhaustive nature of these categories, and wider structural concerns that may trouble knowledge pro- duction more generally. |
| Wagner, et al., 2022 | Examines how transgender and gender nonbinary (T/GNB) persons from South Carolina navigate informational barriers within healthcare systems. | 26 T/GNB individuals | Semi-structured interviews and focus groups | Findings note healthcare systems producing cisnormativity by design resulting in T/GNB individuals viewing healthcare spaces as exclusionary. |
| Wang et al., 2022 | Determined factors associated with healthcare providers' behaviour and intention to offer culturally competent care to Taiwanese sexual and gender minority older adults and identified related training requirements. | 25 providers | Qualitative descriptive design (semi-structured interviews) | Identified multilevel factors associated with the providers' cultural competence in caring for sexual and gender minority older adults in Taiwan. |
| White et al., 2020 | To gather data from the narrative of Black transgender men to facilitate deeper under- standing of racism and cissexism through the unique perspectives of those experiencing it. | 10 Black transgender men | Interviews | Six major themes were identified: developing an empowered view of self, navigating double consciousness, having a target on your back, strategies of resilience, culture of silence, and finding quality care. |
| Yingling et al., 2017 | Describe our experience in incorporating lesbian, gay, bisexual and transgender (LGBT) | N/A | Discursive paper | Despite the lack of formal direction from the nursing sector, nursing faculty should |

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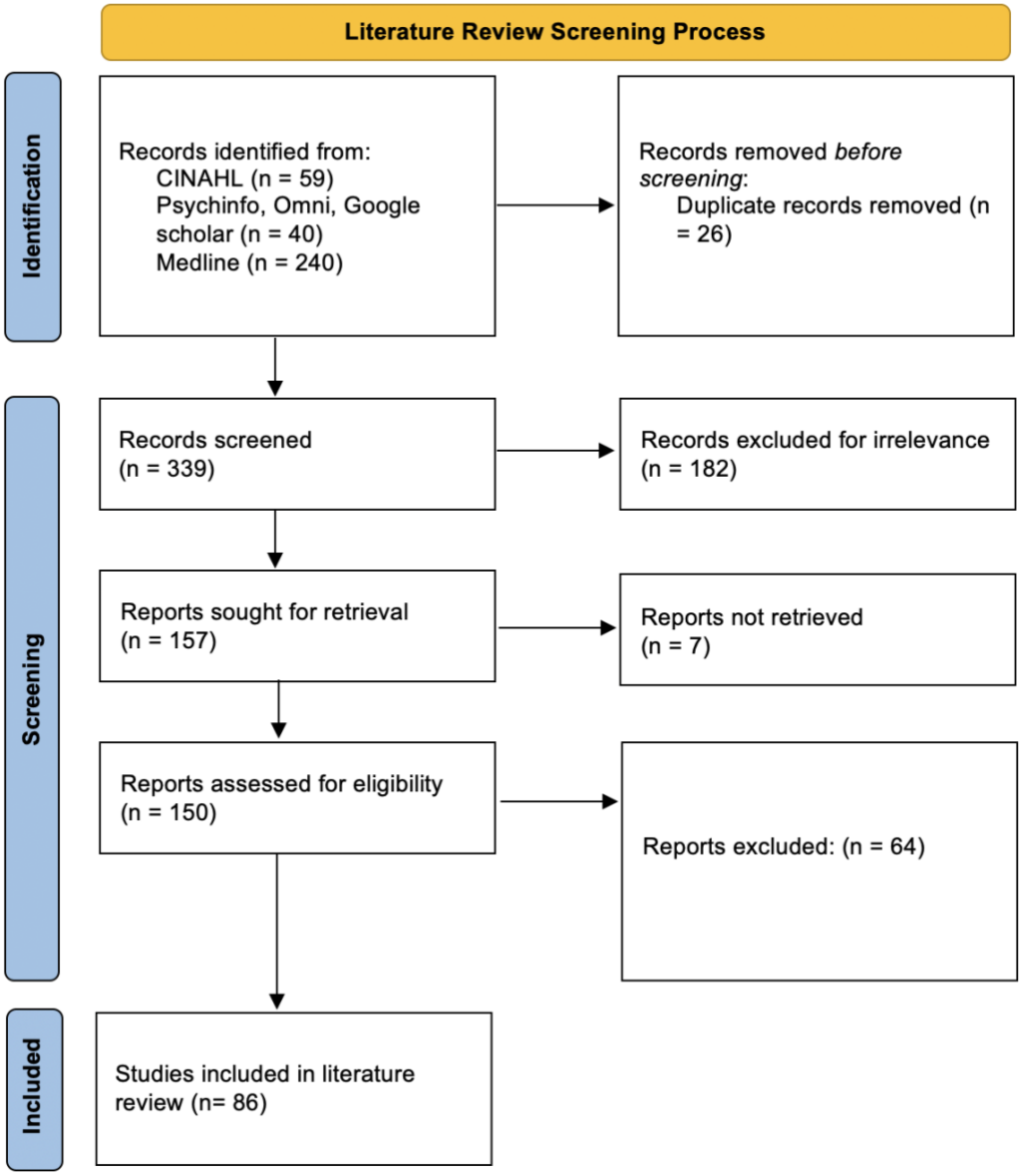
| | health content into the family nurse practitioner curriculum at a Midwestern college of nursing in the United States. | | | prepare nursing students to provide culturally sensitive and competent care to LGBT people. Our experience incorporating LGBT-specific content into the family nurse practitioner program has proven to be positive for both students and faculty. |
| Ziegler, 2021 | To understand nursing activities, training and key supports needed to provide primary care to transgender individuals | 6 nurse practitioners, registered nurses and registered practical nurses total | Qualitative description methodology and interviews | Supporting nurses to develop capacity and work to full scope of practice can improve access to care. |

**Figure 1**

*PRISMA Literature Review*




## Search Terms

### CONCEPT 1: Gender-diverse

1 exp Transsexualism/ or exp Transgender Persons/

2 lgbt*.tw,kf.
3 (gay* or queer* or transgender* or bisexual* or homosexual* or ?glbt* or lesbian*).tw,kf.
4 (gender adj2 (minorit* or identit*)).tw,kf.
5 exp Gender Identity/
6 (non-binary or nonbinary).tw,kf.
7 ((non-binary or nonbinary) adj3 (gender* or identit*)).tw,kf.
8 (pangender* or bigender* or agender* or trigender* or mixed gender* or third gender* or two-spirit* or nonheterosexual* or nonheterosexual* or lesbigay*).tw,kf.
9 (genderqueer* or gender crossing).tw,kf.
10 (transsex* or transex* or trans-spectrum or transspectrum).tw,kf.
11 (gender adj2 nonconform*).tw,kf.
12 exp "Disorders of Sex Development"/ or exp Gender Dysphoria/
13 (intersex* or DSD or genderless or shemale).tw,kf.
14 (gender neutral or non-gender* or gender incongruence).tw,kf.
15 queer-spectrum.tw,kf.
16 (other gender or androgynous or neuter or neutrois or gender fluid).tw,kf.
17 (male-to-female and (MtF or transgender woman or trans wom#n or transwom#n or transgirl*)).tw,kf.
18 (female-to-male and (FtM or transgender man or trans m#n or transm#n or transboy*)). tw,kf.
19 (gender adj1 div*).tw,kf.
20 Trans*exual*.tw,kf.
21 (2-spirit* or twospirit* or bi spirit* or bispirit*).tw,kf. Note: 2S isn't properly accepted as a current term in medline
22 (Transgend* adj1 Perso*).tw,kf.
23 or/ 1-22 (104148 results)

**Concept 2: Racialized**

24 ((ethnic* or racial* or cultur*) adj3 (group* or minorit* or population* or diverse* or origin*)).tw,kf.
25 (visible adj1 minorit*).tw,kf.
26 (migrant* or immigrant* or emigrant* or refugee* or expatriate*).tw,kf.
27 "people of colo*r".tw,kf.
28 exp cross-cultural comparison/ or cultural characteristics/ or cultural diversity/
29 (African americans or racial groups or American native continential ancestry group or Indians, central America or American Indian, Central or American Indians, Central or Central American Indian or Central American Indians or Indian, Central American or Amerinds, Central American or American Amerind, Central or American Amerinds, Central or Amerind, Central American or Central American Amerind or Central American Amerinds Indians, North American + or American Indian, North or American Indians, North or Indian, North American or North American Indian or North American Indians or Amerinds, North American or Amerind, North American or North American Amerind or North American Amerinds or American Indians or Alaska Natives or

American Indians or Indians, American or American Indian or American Natives or American Native or Native, American or Natives, American or Native Americans or American, Native or Native American or Native Americans, Federally-recognized or American, Federally-recognized Native or Federally-recognized Native American or Federally-recognized Native Americans or Native American, Federally-recognized or Native Americans, Federally recognized or Indigenous Canadians or Canadians, Indigenous or Indigenous Canadian or Canadian Natives or Canadian Native or Native, Canadian or Natives, Canadian or Native Canadians or Canadian, Native or Canadians, Native or Native Canadian or Metis Canadians or Canadian, Metis or Canadians, Metis or Metis Canadian or First Nation Canadians or Canadian, First Nation or Canadians, First Nation or First Nation Canadian or Nation Canadian, First or Nation Canadians, First or Indians, South American or American Indian, South or Indian, South American or South American Indian or South American Indians or Amerinds, South American or American Amerind, South or Amerind, South American or South American Amerind or South American Amerinds or Inuits or Inuit or Kalaallits or Kalaallit or Inupiats or Inupiat or Aleuts or Aleut or Eskimos or Eskimo Asians or Asian or Cambodians or Cambodian or Asian Continental Ancestry Group or Vietnamese or Vietnameses or Japanese or Koreans or Mongoloid Race or Mongoloid Races or Race, Mongoloid or Races, Mongoloid or Asiatic Race or Asiatic Races or Race, Asiatic or Races, Asiatic or Thai or Thaus or Burmese or Burmeses or Chinese or Asian Americans or Americans, Asian or Asian American or Japanese Americans or Americans, Japanese or Japanese American or Chinese Americans or Americans, Chinese or Chinese American or Vietnamese Americans or American, Vietnamese or Americans, Vietnamese or Vietnamese American or Asian Indian Americans or Asian Indian American or Indian American, Asian or Cambodian Americans or American, Cambodian or Americans, Cambodian or Cambodian American or Hmong Americans or Americans, Hmong or Hmong American or Korean Americans or American, Korean or Americans, Korean or Korean American or Filipino Americans or Americans, Filipino or Filipino American or Blacks or African Americans or African American or American, African or Black Americans or American, Black or Americans, Black or Black American or Afro-American or Afro American or Afro-Americans or Afro Americans or African-Americans or African-American or Native Hawaiian or Other Pacific Islander or Native Hawaiians or Hawaiian, Native or Hawaiians, Native or Native Hawaiian or Oceanic Ancestry Group or Ancestry Group, Oceanic or Ancestry Groups, Oceanic or Group, Oceanic Ancestry or Groups, Oceanic Ancestry or Oceanic Ancestry Groups or Australoid Race or Australoid Races or Races, Australoid or Australian Race or Race, Australian or Races, Australian or Pacific Islander Americans or Pacific Islander American or Pacific Island Americans or Pacific Island American or Maori or Aboriginal Australians or Aboriginal Australian or Australian, Aboriginal or Australians, Aboriginal or Aborigines, Australian or Aborigine, Australian or Australian Aborigine or Australian Aborigines).tw,kf.
30 or/ 24-29 (810099 results)

**CONCEPT 3: Preparedness (Sub-concepts: cultural competency, education/ training, attitudes/ beliefs)**

31 exp Cultural Competency/ or exp Clinical Competence/ or exp Culturally Competent Care/ or exp transcultural Nursing/ or exp education, nursing/ or exp education, nursing, continuing/ or exp education, nursing, baccalaureate/ or exp education, nursing, graduate/ or exp attitude/ or exp culture/ or prejudice/ or exp bias, implicit/
32 and/ 23, 30, 31 (339 results)

**General Guidelines Screening Literature (Common themes in searches):**

Exclusion:

- Studies about reproduction
- No obvious focus on any GD group
- HIV care with no focus of nurses or racialized GD populations
- Gender studies on cis women
- Population focus groups lgbt
- Cancer research
- Sexual health
- Sexual minority focus
- Children of lgbt parents
- General HIV treatment research
- Not English

Inclusion

- Research done in nursing field
- GD experiences with healthcare professionals/ healthcare system
- Health and well-being of racialized GD populations
- Nursing curriculum/ research focus on lgbt inclusion
- Healthcare provider training for lgbt+
- Intersectionality
- Cultural humility/ competency

# Appendix

*Canadian Journal of Nursing Research (CJNR) Author Guidelines*

*Canadian Journal of Nursing Research (CJNR),* Canada's leading journal in nursing research and scholarship, invites manuscripts of interest to nursing and healthcare clinicians, educators, leaders, policy makers, and researchers. *CJNR* serves both the Canadian and the international nursing communities as a forum for the dissemination and communication of nursing research and scholarship. We, therefore, welcome submissions of high-quality original research and research-related manuscripts from Canadian as well as international authors.

A quarterly peer-review publication, *CJNR* accepts quantitative, qualitative, and mixed-method manuscripts on a broad spectrum of topics that include, but are not limited to, nursing and health interventions across the life span, health services and health systems, social and material determinants of health, nursing education, nursing leadership, nursing measurement, family health, community and population health, palliative care, and healthy aging, systematic reviews, and research methodology. We also welcome opinions, editorials, and commentaries that are of special interest to nurse researchers.

Manuscripts will be acknowledged upon online submission. Each submission will be subject to initial vetting by the Editor-in-Chief and the assigned handling editor to determine its suitability for *CJNR* prior to subjecting it to blind peer-review by at least two reviewers.

The following guidelines are designed to assist authors with the manuscript preparation and submission process. *Manuscripts that do not conform to these guidelines will be returned to the authors without further review*.

Manuscript Preparation Guidelines General Requirements:

- The submitted manuscript, including the abstract, tables, and reference list must be *double-spaced, left-justified with one-inch (2.54 cm) margins, and typed using size 12 Arial font*.
- Authors should avoid the inclusion of appendices in all submissions, except in rare situations where authors deem the appendix indispensable.
- All pages, including the title page and reference list, must be numbered using Arabic numerals (i. e., 1, 2, 3, etc.).

- To facilitate the review process, insert line numbers on all pages of the manuscript. Include a short title (no more than 50 characters) as a header on all pages, including the title page, for the purposes of double-blind peer-review.
- The entire manuscript (including tables, figures, and references) must be prepared according to the *Publication Manual of the American Psychological Association* (APA Style Manual 7th edition).
- All listed references must match the citations in the text and vice versa.
- Authors are required to provide the names and contact information of three peer reviewers who have expertise in the topic area but are at arm's length from the submitting authors. Our editors will verify the suitability and qualifications of the suggested reviewers; and they *may* select up to one of the recommended reviewers.
- All manuscripts will be considered for publication on the understanding that they a) have not been published or b) are submitted solely to *CJNR*.
- Authors of manuscripts that are accepted for publication will be asked to review proof copies after copy editing and before publication.

For more in-depth guidelines please visit https://journals.sagepub.com/pb-assets/cmscontent/CJN/AG-CJNR%20July%202020-1595374153613.pdf