Boston College

William F. Connell School of Nursing

MENTAL HEALTH AND MENTAL HEALTH TREATMENT EXPERIENCES OF TRANSGENDER AND GENDER DIVERSE PERSONS

a dissertation

by

BRADLEY PATRICK WHITE
MSN, RN, CNE

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Abstract

Background: Stigma, discrimination, and victimization are common occurrences in the lives of TGGD persons (e.g. non-binary, genderqueer, agender, and other non-cisgender identities) in the U.S., including occurrences in healthcare settings. Additionally, TGGD people in the U.S. experience numerous disparities related to physical health, mental health, substance use, and health risk behaviors. Suicide prevalence data provide the strongest and most urgent indication that healthcare organizations, and mental health providers specifically, are not optimally meeting the needs of this marginalized, at-risk population. TGGD persons have experiences of stigma and discrimination in healthcare settings, and these experiences are directly associated with provider behaviors, staff cultural competence, and institutional policies/practices. Minority Stress Theory suggests that experiences of stigma are directly linked to health outcomes and health disparities. It also suggests disparities may be mitigated by one's internal coping skills and by level of support available from affirming others.

Purpose: This dissertation's research sought to better understand the relationship between stigma/discrimination and sexual/gender minority (SGM) population health and to better understand the experiences of TGGD persons who receive mental health services in the United States. Therefore, this dissertation begins to address this critical need and fill the gap in science. Three discrete manuscripts are proposed to fully explicate three concepts: 1) How state-level policies may affect SGM mental health (a secondary data analysis); 2) A comprehensive understanding of TGGD persons' mental healthcare experiences (an integrative review); and 3) TGGD persons' inpatient mental healthcare experiences (a qualitative study).

Methods: First, we conducted a secondary data analysis examining state-level inclusivity for SGM populations, and relationships with indicators of mental health and health risk behaviors in those states; we sought to determine whether and to what extent there is a relationship between

states' SGM policies and practices, and the mental health and health risk behaviors of those states' SGM residents. Second, we conducted an integrative review examining the mental health treatment experiences of TGGD adults; we sought to synthesize and characterize the existing health literature regarding the mental health experiences of TGGD adults. Third, we conducted a qualitative descriptive study examining the inpatient mental health and substance disorder treatment experiences of TGGD adults; we sought to better understand the inpatient mental health and/or substance treatment experiences of TGGD persons and to identify and characterize facilitators of/barriers to gender-affirming care in inpatient mental health and/or substance treatment settings.

Results: In Chapter Two of this dissertation, an ecological secondary analysis of the BRFSS data set showed statistically significant relationships between LGBTQ persons' state of residence and self-reported mental health symptoms and risk behaviors of the LGBTQ persons who live there. Restrictive state policy environments were shown to function as a distal stress factor and inclusive state policy environments were shown to function as a resilience factor. In Chapter Three of this dissertation, integrative review results suggest that TGGD persons experience incidents of stigma and discrimination in mental health treatment settings. In Chapter Four of this dissertation, participants reported both stigmatizing aspects and welcoming/affirming aspects of inpatient mental health/substance treatment experiences.

Conclusions: This dissertation explored the mental health of TGGD persons through a Minority Stress Theory conceptual framework, including potential distal stress factors, proximal stress factors, and resiliency factors. This program of research has made substantial and meaningful contributions towards an enhanced understanding of TGGD mental health experiences, sources of TGGD stigma, and sources of coping/resiliency. In each chapter, findings suggested the presence

of MST concepts of distal stress factors, proximal stress factors, and resiliency factors. Nursing remains underrepresented in health literature, and dissertation results highlight ample opportunities to advance TGGD population health through nursing practice, nursing education, nursing scholarship, and nursing policy.

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Acknowledgement

My personal mission as a human and my professional mission as a nurse is to help reduce suffering experienced by my LGBTQ+ brothers and sisters – locally, in the U.S., and globally. I don't believe I could have found a more supportive and nurturing academic environment to pursue this path than the Boston College Connell School of Nursing. The endless support I've found here - from faculty, staff, and fellow students - has been everything.

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Chapter One:

Introduction to the dissertation

Bradley Patrick White MSN, RN

Boston College W.F. Connell School of Nursing

Introduction

A three-manuscript dissertation was chosen to show a range of nursing inquiries that together depict the beginning of a program of research. This dissertation's research sought to better understand the relationship between stigma/discrimination and sexual/gender minority (SGM) population health and to better understand the experiences of SGM persons who receive mental health services in the United States (U.S.). This dissertation examined the characteristics of transgender gender diverse (TGGD) persons' mental healthcare and mental healthcare experiences and will provide useful insight that may inform culturally competent delivery of care and contribute to improved population health outcomes.

Chapter One will describe this dissertation's rationale, vision, and program of research. Chapter One includes the following sections: significance of the research proposal; a brief literature review (including *transgender stigma; disparities in mental health, substance use and risk behaviors; and gender-affirming healthcare*); a description of the theoretical framework; overall purpose of the proposed program of research/associated aims; and the implications of the proposed research for nursing science, practice, and education.

Significance of the research proposal

Stigma, discrimination, and victimization are common occurrences in the lives of TGGD persons (e.g. non-binary, genderqueer, agender, and other non-cisgender identities) in the U.S., including occurrences in healthcare settings (Austin & Goodman, 2018). Additionally, TGGD people in the U.S. experience numerous disparities related to physical health, mental health, substance use, and health risk behaviors (Daniel & Butkus, 2015; Safer et al., 2015; Sevelius, Keatley, Calma, & Arnold, 2016). Minority Stress Theory suggests that experiences of stigma are directly linked to health outcomes and health disparities. It also suggests disparities may be

mitigated by one's internal coping skills and by level of support available from affirming others (Meyer, 1995; Meyer, 2003).

Estimates of TGGD population size in the U.S. have varied widely; it is a hidden population. Sexual orientation and gender identity (SOGI) data are inconsistently collected at the population level in the U.S. and by healthcare organizations. Even when assessed, societal stigma and discrimination affect many TGGD persons' decision to disclose their gender identity to healthcare providers; many people choose not to disclose (Flores et al., 2016; Meerwijk & Sevelius, 2017). Despite this, estimates show that approximately 1.4 million Americans (roughly 0.58% of the population) identify as TGGD (Flores et al., 2016; Meerwijk & Sevelius, 2017). A Centers for Disease Control and Prevention study found that two percent of current high school students identify as TGGD (Johns et al., 2017), and it is forecasted that these estimates will continue to increase among younger persons as societal acceptance of gender diversity evolves (Meerwijk & Sevelius, 2017).

Suicide and other health disparities

Disparities related to physical health (e.g. HIV, sexually transmitted infections [STIs]) and mental health (e.g. suicidality, substance use disorder, eating disorders) are present among TGGD persons (Institute of Medicine, 2011; Habarat et al., 2015; Reisner et al., 2019; Safer et al., 2015; Sevelius, Keatley, Calma, & Arnold, 2016; Su et al., 2016) and a more thorough review of these disparities will be provided later in this chapter. These disparities suggest TGGD individuals have a greater need for comprehensive mental health services as compared to cisgender persons (Perry, Chaplo, & Baucom, 2017; Walton & Baker, 2017).

However, the prevalence of suicide and suicidality among TGGD persons provides perhaps the strongest rationale, and urgency, for this area of inquiry. Preventing suicide is a core

function of mental health services, and there is an urgent need to better understand the problem and identify ways to reduce suicide (and other) disparities through all appropriate methods of inquiry. Published research for two decades has consistently demonstrated that TGGD persons are at substantially higher risk for suicide than any other population (McCann & Brown, 2018). TGGD adults have a past-year suicidality prevalence twelve times higher, and a past-year suicide attempt prevalence eighteen times higher, than the U.S. general population (McCann & Brown, 2018). The 2015 U.S. Transgender Survey is the largest-ever survey of TGGD people in the U.S. to-date. Results highlighted that 81.7% of TGGD participants reported *seriously thinking about suicide* in their lifetimes, and 48.3% did so in the last year. Additionally, 40.4% reported a *suicide attempt* in their lifetimes, and 7.3% did so in the last year (Herman, Brown, & Hass, 2019; James et al., 2016). One extensive literature review on TGGD medical and mental health outcomes identified several inquiry areas with an increased need for research and dissemination, including in TGGD mental health (McCann & Brown, 2018).

Significance to nursing

While we know TGGD persons are at increased risk of suicidality and suicide attempts, there is still much we do not know regarding why TGGD people are at such elevated risk and how mental health providers, and nurses specifically, can intervene to reduce the disparity. Mental health providers deliver care in many settings, including outpatient services, partial hospitalization programs, and inpatient mental health/substance treatment programs. As such, there is ample opportunity to reach TGGD clients in need.

Nurses are among the mental health providers optimally positioned to improve TGGD persons' mental health. As "attention to social justice issues continues to be asserted as an obligation in nursing" (Grace & Willis, 2012, p. 198), the nursing discipline has a duty to

conduct research and implement innovations that optimize quality of life for as many people as possible, particularly the most vulnerable among us. Furthermore, nurses are trained to provide compassionate and non-judgmental care, to provide client and family teaching in all settings, and to assist clients in the development of enhanced coping/resilience (Videbeck, 2019).

Many public health and clinical organizations have not only made broader SGM health a priority but have included guidance and funding opportunities specific to the TGGD subpopulation within the SGM umbrella. To address inequities of societal stigma, discrimination, and denial of human rights, Healthy People 2020 expanded its framework to now improve health and well-being for SGM persons. Additionally, the National Institutes of Health Sexual and Gender Minority Research Office has identified the strategic goals of 1) expanding the knowledge base of SGM health and well-being; and 2) strengthening the community of researchers and scholars conducting SGM research. The National Institute for Nursing Research has also prioritized the funding of SGM-related health inquiries (Institute of Medicine, 2011).

Purpose of dissertation

A robust nursing research agenda is necessary to evaluate potential contributing factors and sequelae of the high suicidality prevalence among TGGD persons (Feldman et al., 2016). Therefore, the purpose of this manuscript-style dissertation is: 1) to better understand the relationship between stigma/discrimination and SGM population health, and 2) to better understand the experiences of TGGD persons who have received mental health and substance abuse services.

While there are many distinctions between clients with mental illness and clients with substance use disorder warranting separate inquires, this study sought to understand the experiences of TGGD people who have been admitted for either a mental health or substance use

concern. Each of these diagnostic areas contribute substantively and uniquely to the biobehavioral wellbeing of clients (Videbeck, 2019) and thus we would be remiss in excluding one. Moreover, dual diagnosis is common and there is often overlap between clients in these two distinct practice settings (Rossi et al., 2016). The American Psychiatric Nurses Association views mental health and substance abuse as commonly co-occurring and endorses substance abuse nursing as a component of mental health nursing (American Psychiatric Nurses Association, 2015). As such, this dissertation will examine the characteristics of TGGD persons' experiences of stigma, mental health characteristics, and mental health/substance abuse treatment experiences and will provide useful insight that may inform culturally competent delivery of care and contribute to improved population health outcomes.

Review of Literature

This section is intended to provide a review of literature in the areas of 1) TGGD stigma; 2) TGGD disparities related to mental health, substance use and risk behaviors; and 3) concepts of gender-affirming healthcare. An additional review of literature specifically related to TGGD persons' firsthand mental healthcare experiences is provided in Chapter Three of this dissertation.

TGGD stigma

In the U.S., stigma and discrimination are daily occurrences for TGGD people, challenging multiple aspects of their lives. Although the sources of these challenges vary from person to person and within varying environments, most TGGD people have experienced discrimination in political, social, religious, familial, and/or healthcare contexts (Institutes of Medicine, 2011; Poteat, German, & Kerrigan, 2013; Stroumsa, 2014). TGGD people self-report

experiences of overt harassment, mistreatment, and discrimination in multiple forms and settings. One study found that 90% of respondents reported employment discrimination, 78% reported harassment or discrimination while in school, 53% reported verbal or physical harassment in public places, and 19% reported they had been denied housing due to their gender minority status (Grant et al., 2011). Among respondents of a 2011 national survey, TGGD persons reported having experienced high rates of lifetime sexual assault (64%) and lifetime physical assault (61%) (Grant et al., 2011). TGGD people have increasingly been victims of violent crime and murder in recent years; the majority of these victims were Black/African-American TGGD women (Human Rights Campaign, 2020).

Although this dissertation will not specifically address TGGD persons under 18, research suggests this pattern persists among younger TGGD persons. TGGD youth experience high rates of stigma, bullying, violence, home displacement, and victimization – up to four times as frequently as cisgender peers (Reisner, Greytak, Parsons, & Ybarra, 2015). These often occur in schools, within families, and in public spheres (Reisner, Greytak, Parsons, & Ybarra, 2015; Watson et al., 2019).

For the purposes of this review, various forms of discrimination, violence, and victimization are collectively considered stigma. For TGGD individuals, everyday stigma is real. There is a "systematic oppression and devaluation as a result of social stigma attached to their gender nonconformity" that may have devastating effects on TGGD persons' developmental congruency with peers, feelings of self-worth, connectedness with others, access to support, access to healthcare, and, ultimately, mental and physical health (Bockting et al. 2013, p. 943).

To effectively consider the concept of TGGD stigma (including in healthcare settings), it is first necessary to understand the basic concept of stigma. According to Goffman (1963),

stigma is a "deeply discrediting" attribute by which "we believe the person with the stigma is not quite human. On this assumption, we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (p. 5). Stigma has profoundly negative consequences on the quality of life of the stigmatized individual or population. Stigma has been defined by health researchers as a "complex and dynamic … social process of labeling, stereotyping, and rejecting human difference as a form of social control" (White Hughto, Reisner, & Pachankis, 2015, p. 222).

Poteat, German, and Kerrigan (2013) conducted a grounded theory analysis of transgender stigma and found that the phenomenon necessarily occurs in the context of four key behaviors: *blaming, shaming, othering*, and *discriminating*. In *transgender blaming*, the perpetrator of stigma feels the transgender person bears responsibility for the stigmatizing actions due to the latter's prioritization of physical appearance and an inconsistency between physical appearance and gender identity. The stigmatizing blamer sees the transgender person as vain, self-absorbed, and too focused on matters related to aesthetic appearance. In *transgender shaming*, the perpetrator of stigma makes conscious and unconscious attempts to assert dominance in an effort to belittle the transgender person. This frequently includes intentionally incorrect pronoun use ('he' instead of 'she', or vice versa) or demeaning language ("That's a pretty name – that's a boy's name. Do you think you're a boy?" [Poteat, German, & Kerrigan, 2013, p. 27]). In *transgender othering,* the perpetrator of stigma assumes the transgender individual has a defect of health or character that somehow renders the latter different than the rest of the population. This frequently takes the form of divisive labeling or erroneous diagnosis without sufficient assessment; transgender individuals are sometimes labeled as "difficult" or are assumed to have a mental health problem or a personality disorder (Poteat, German, & Kerrigan,

2013, p, 27). In *transgender discrimination,* the perpetrator of stigma treats the transgender individual differently than non-transgender people. This occurs both passively, such as when failing to differentiate between sex and gender on intake forms; and actively, such as when asking excessive personal questions related to gender and anatomy that are not indicated for type of health visit being conducted.

Although quantifying stigma is inherently thwarted by challenges, it is nonetheless present and observable in health settings, affecting many populations' healthcare experiences and health outcomes (White Hughto, Reisner, & Pachankis, 2015). Stigma is implicated as a cause of adverse health outcomes, noting that "structural, interpersonal, and individual forms of stigma are highly prevalent among transgender people and have been linked to adverse health outcomes including depression, anxiety, suicidality, substance abuse, and HIV" (p. 223).

In matters related to health and healthcare, TGGD people face inequitable access to care and many health disparities (Institutes of Medicine, 2011). Research acknowledges several factors that directly contribute to disparities. When accessing healthcare, TGGD people report experiencing gender insensitivity, displays of provider discomfort, denial of services, substandard care, verbal abuse, and forced care (Kosenko, Rintamaki, Raney, & Maness, 2013). TGGD persons are also considered to be less likely to be offered routine health maintenance interventions such as cervical cancer screening, mammography, and testicular exam (Institutes of Medicine, 2011; Poteat, German, & Kerrigan, 2013).

Stigma is most often perpetrated in the context of an imbalance of power (Goffman, 1963). Power imbalances are present in many aspects of TGGD persons' lives, including in healthcare contexts. One study suggested that this power imbalance is present in clinical relationships between providers and patients, and thus that healthcare settings are susceptible to

enacting stigma while performing clinical operations (Poteat, German, & Kerrigan, 2013). In the care of TGGD persons, the typical healthcare provider role of expert is challenged. Instead, TGGD patient is often the expert in their care, providing key information and education to their healthcare providers. This often leads to tense interactions, as "the threat to this authority led the provider to dismiss the patient's knowledge as 'myths' even though she admits to not knowing or understanding much of what the patient was telling her. The patient is blamed for the negative encounter because he 'read too much on the internet'" (Poteat, German, & Kerrigan, 2013, p. 27).

Stigma and shame experienced by the transgender person commonly lead to poor physical and/or mental health outcomes. Several research reports (Poteat, German, & Kerrigan, 2013; Tompkins, Shields, Hillman, & White, 2015) have documented that poor health outcomes occur primarily due to feelings of isolation, mistrust in medical providers, and avoidance of healthcare encounters that place emphasis on the discrepancy between physical body and gender identity. Resultingly, transgender individuals are at increased risk for depression, suicidality, non-adherence to prescribed treatments, substance use disorders, self-administration of non-prescribed treatments (primarily unmonitored hormone therapy), and sexually transmitted infections (including HIV) (Poteat, German, & Kerrigan, 2013).

Lastly, stigma often results in increased resistance, resiliency, and connectedness with peers. Goffman (1963) asserts as a "pivotal fact" that stigmatized individuals and populations wish for the same quality of life as non-stigmatized people; when faced with stigma, transgender people frequently engage in practices to strengthen their resolve, collaborate and bond with peers, and work to improve their status in the world through individual and collective action.

Disparities in mental health, substance use and risk behaviors

TGGD persons in the U.S. experience numerous disparities related physical health, mental health, substance use, and certain health risk behaviors. Regarding *physical health*, prevalence rates for HIV and STI are persistently high among TGGD persons. As compared to both the general population and the lesbian, gay, and bisexual population in the U.S., TGGD people in the U.S. are at the highest risk for HIV (22-29% prevalence among transgender women) and sexually transmitted infections (STI) (Habarat et al., 2015; Reisner et al., 2019). One TGGD sample reported high lifetime occurrences of chlamydia (55%), syphilis (48%), and gonorrhea (47%); 33% reported a history of more than one STI (Reisner et al., 2019). Additionally, healthcare providers are less likely to offer preventative health interventions (e.g. HPV vaccine, HIV pre-exposure prophylaxis [PrEP]) and health screenings (e.g. mammography, pap smear, prostate cancer screening) (Institutes of Medicine, 2011; Poteat, German, & Kerrigan, 2013).

Mental Health. TGGD persons disproportionately experience suicidality, self-harm, post-traumatic stress disorder (PTSD), and eating disorders. Lifetime prevalence for suicidal thoughts is estimated to be 45-52% (approximately 3% for general population), and lifetime prevalence for suicide attempt is 31-32% (approximately 0.5% for general population) (Adams, Hitomi, & Moody, 2017). One large study (n=744) of TGGD persons found that 41.9% of TGGD adults had engaged in non-suicidal self-injurious behaviors (e.g. cutting, hitting, burning self) in their lifetime (dickey, Reisner, & Juntunen, 2015). A secondary analysis of TGGD adults (n=4,115) showed that gender identity was significantly and positively associated with attempted suicide (Miller & Grollman, 2015).

Although data pertaining to suicide rates among TGGD youth are difficult to collect, some estimates indicate a suicidality rate of roughly 50% and a suicide attempt rate of roughly

30% among TGGD youth (Connelly et al., 2016; Olson et al., 2015; Reisner et al., 2015). TGGD youth in the U.S. experience disproportionately high rates of depression (up to 58%), self-injurious behaviors (up to 20.6%), and eating disorders (up to 15.8%) (Connelly et al., 2016).

Prevalence of PTSD among TGGD persons was 18% to 61% across studies, and reports of everyday discrimination experiences were high and resulted in increased associated PTSD symptoms (Reisner et al., 2016). Eating disorder symptoms and diagnoses appears to be substantially higher among TGGD young adult college students than their cisgender peers. The prevalence of self-reported eating disorder in one sample was 7.4%. Prior studies of cisgender Americans have found a lifetime anorexia nervosa prevalence of 0.3% in males and 0.9% in females and lifetime bulimia nervosa prevalence of 0.5% in males and 1.5% in females (Diemer et al., 2015).

Substance use and other health risk behaviors. TGGD persons are more likely than cisgender persons to engage in several health risk behaviors, including alcohol use, substance use, and smoking. Scientific literature in these areas is immature, and there is a clear need for ongoing healthcare attention to better understand the risk behaviors of TGGD persons. Ten percent of TGGD adults in one study had been treated for substance use disorder in their lifetime (Keuroghlian, Reisner, White, & Weiss, 2015). Non-medical use of prescription drugs is high among TGGD persons (26%), with primary misuse related to non-prescribed hormones (30.3%), analgesics (23.9%), anxiolytics (17.4%), stimulants (13.5%), and sedatives (8.4%) (Benotsch et al., 2013). A systematic review of alcohol research with TGGD populations noted significantly high prevalence of hazardous alcohol use across studies but also cited frequent methodological weaknesses, indicating a need for more research in this area (Gilbert et al., 2018). A secondary analysis of a large (n=4,115) sample of TGGD adults showed that gender identity was

significantly and positively associated with drug/alcohol abuse and smoking (Miller & Grollman, 2015).

Compared to cisgender peers, TGGD youth were at increased odds of ever using alcohol, cigarettes, marijuana, and nonmarijuana illicit drug use in the past 12 months (ORs range from 1.42 to 1.80; $p < 0.01$) and of regular marijuana and illicit drug use (ORs range from 1.66 to 1.75; $p < 0.01$) (Reisner et al., 2015).

Gender-affirming healthcare

Gender-affirming healthcare (GAHC) is defined broadly as multimodal care that seeks to allow a person, regardless of sex assigned at birth, to live a life congruent with their self-identified gender. It also refers to specific medical and/or surgical interventions intended to align the patient's appearance or physical body with the patient's gender identity; lifestyle changes, exogenous hormone therapy, and/or surgical masculinization/feminization procedures all may be included in this (Puckett et al., 2018).

Importance of access. Research suggests that inadequate access to GAHC, including gender-affirming hormone therapy and gender-affirming surgery, are contributing factors to negative mental health outcomes (American Medical Association, 2019). Limited or delayed access to puberty-blocking agents and cross-sex hormones is a significant source of distress that inhibits developmental congruency with peers when in adolescence, thus exacerbating feelings of disconnectedness and isolation that permeate throughout adulthood. Increased access to gender-affirming hormone therapy and gender-affirming surgery is linked to reduced symptoms of gender dysphoria, improved mental health, and enhanced sense of well-being (Hembree et al., 2017; Olson-Kennedy et al., 2018). Additionally, TGGD people with access to GAHC have

significantly lower rates of suicidality than TGGD people without such access (Allen, Watson, Egan, & Moser, 2019).

Barriers to gender affirming care. TGGD persons face multiple institutional barriers to GAHC, including lack of access to welcoming healthcare providers, health insurance coverage exclusions and denials for gender-affirming health care, and a dearth of FDA-approved gender-affirming medical and surgical care (Stevens, Gomez-Lobo, & Pine-Twaddell, 2015). Sixteen states have some language prohibiting Medicaid coverage for gender-affirming medical and surgical interventions (Human Rights Campaign, 2019). Although gender identity data for TGGD adolescents is inconsistently collected and reported, coverage for such people seeking GAHC appears to be even lower. One early proponent of adolescent GAHC in the U.S., a pediatric endocrinologist, estimates that of the 200 TGGD adolescents he treated in his clinic between 2007-2015, less than 20% were able to obtain insurance coverage for GAHC (Hartocollis, 2015). Insurance denials for hormone therapy occur despite the medical consensus that hormone therapy is generally considered safe for adults and adolescents (Society for Adolescent Health and Medicine, 2013; Olson-Kennedy et al., 2018) and that similar hormone therapies for other conditions, such as precocious puberty, are widely used and are covered by public and private insurances (Stevens, Gomez-Lobo, & Pine-Twaddell, 2015).

Costs of gender affirming care. Gender-affirming medical and surgical care has been shown in existing literature to impose minimal or no new costs (Baker, 2017). A cost analysis following Massachusetts' expansion of TGGD-inclusive coverage determined that covering transition-related services is cost-effective, especially when considering the financial and human costs associated with untreated gender dysphoria (Padula, Heru, & Campbell, 2016). An analysis of California's expansion of TGGD-inclusive coverage found that removing transgender

exclusions had "immaterial" effect on costs. The California Department of Insurance found that benefits of TGGD-inclusive coverage far exceed the "insignificant" costs; benefits included improved health outcomes among TGGD people, such as reduced suicide risk, lower rates of substance use, and increased adherence to HIV treatment (Baker, 2017, p. 1803).

Training for healthcare providers. In addition to increasing health insurance coverage for gender-affirming hormone therapy and surgery, there must also be an emphasis placed on increasing the number of healthcare providers trained in providing gender affirming health care (Stroumsa, 2014). Access to a welcoming healthcare system is considered a protective or mediating factor among TGGD persons, potentially reducing mental health and other disparities (Watson et al., 2019). Many health organizations and health professionals in the U.S. have called for a much wider availability of gender affirming health care for TGGD persons of all ages (American Medical Association, 2019; Kirouac, 2016; National Association of Pediatric Nurse Practitioners, 2019). However, current evidence suggests there is much room to grow in U.S. healthcare provider competence in providing gender-affirming care. A lack of training and preparedness has been observed from the perspectives of providers and patients; healthcare providers report feeling un- or under-prepared to competently treat transgender patients (Carabez, Eliason, & Martinson, 2016), and transgender patients report a lack of confidence in the knowledge level of their healthcare providers (von Vogelsang, Milton, Ericsson, & Stromberg, 2016).

Most research on healthcare provider education of TGGD care has focused on physicians. Although some medical schools require curricular content related to TGGD care, there is no similar requirement in most nursing academic organizations. Approximately 65% of medical schools offer some level of TGGD-related education, and 80% of schools that offer this

education do so in required courses (Krisberg, 2018). TGGD content in nursing education is variable (Abeln & Love, 2019). This has resulted in inconsistent TGGD content in registered nursing and advanced practice nursing curricula. Additionally, advanced practice nurses (NPs) report a significant knowledge gap in caring for TGGD individuals and therefore feel unprepared to effectively provide GAHC (Paradiso & Lally, 2018). It is therefore critical to concurrently consider enhanced education and training for RNs and NPs.

In summary, there is an overall gap is in nursing science regarding how mental healthcare for TGGD persons is delivered, how TGGD persons experience their mental healthcare, and how nurses may become optimally prepared to provide gender-affirming mental healthcare; this dissertation work is an attempt to address this gap.

Theoretical framework

Minority Stress Theory (MST) guided this dissertation as the primary theoretical framework. Meyer (1995, 2003) proposed a minority stress model that depicts the relationship between external (distal) stressors, internal (proximal) stressors, resiliency (coping) responses, and mental health . Among other concepts, MST posits that chronic and acute stress experienced by members of marginalized groups have negative effects on individuals' internal coping and thus mental health (Meyer, 1995; Meyer, 2003; Meyer, 2014; Meyer et al., 2017). SGM persons may experience internal (proximal) and external (distal) stress factors that are specific to their sexual and/or gender identity, often surpassing stress levels experienced by people who identify as heterosexual and/or have a gender identity consistent with their birth sex (Meyer, 1995; Meyer, 2003).

A defining component of minority stress is stigma and discrimination; it is well-documented that TGGD persons adults experience frequent stigma and discrimination in the U.S (Bialer & McIntosh, 2017; Poteat et al., 2013; Stroumsa, 2014). Chronic, prolonged stigma and discrimination have consistently been shown to adversely affect the mental health of those experiencing them (McLaughlin, Hatzenbuehler & Keyes, 2010). This cumulatively suggests that TGGD persons' mental health is related to the level of experienced stigma.

Previous minority stress research supports this concept, finding that mental health of SGM persons is adversely impacted by events such as violence and victimization and workplace insensitivity and discrimination (Holman, 2018; Velez et al., 2013). Moreover, minority stress has been identified as a predictive factor in the occurrence of mood and anxiety disorders among gay and bisexual men, hazardous drinking among lesbian women, and has been implicated in high rates of depression, suicidality, and smoking among transgender persons (Eldahan et al, 2016; Lewis et al., 2016; Velez et al., 2013). Furthermore, minority stress concepts have been successfully integrated into the mental health treatment of sexual minority persons (Alessi, 2014).

Previous research has found that restrictive statewide immigration policies have an impact on mental health of immigrants (Hatzenbuehler at al., 2017). However, little research exists on the relationship that states' SGM-affecting policies may have on mental health and risk behaviors of its SGM citizens. This paucity of research on the effect of public policy, particularly state policy, was the impetus behind the ecological secondary analysis study design in Chapter Two of this dissertation. The model used for that analysis is an adaptation of Meyer's minority stress model. In it, state-based policies and practices are identified as potential distal stressors that may impact the proximal stressors, coping responses, and, ultimately, the mental health of LGBTQ persons.

Purpose of the proposed program of research/associated aims

TGGD persons in the U.S. experience numerous mental health disparities. When experienced acutely, mental health symptoms (particularly suicide/self-harm and substance-related behaviors) warrant inpatient psychiatric hospitalization. When experienced sub-acutely, mental health symptoms warrant treatment by a mental health provider. Accordingly, TGGD individuals have a greater need for mental health services (including inpatient care) as compared to the general population (Walton & Baker, 2017).

Additionally, TGGD persons have experiences of stigma and discrimination in healthcare settings, and these experiences are directly associated with provider behaviors, staff cultural competence, and institutional policies/practices (Carabez, Eliason, & Martinson, 2016; Daniel, Butkus, & Moyer, 2015; Faught, 2016; Roller, Sedlak, & Draucker, 2015; Stroumsa, 2014). It is also known in healthcare that patients' perceptions (of all genders) regarding the quality of their healthcare is associated with hospital readmission rates, clinical improvement, treatment adherence, and patient prognosis (Akerele et al., 2017; Moss et al., 2014; Rylander et al., 2016).

It stands to reason, therefore, that TGGD persons who experience gender-insensitive healthcare may be at risk for increased hospital readmission, reduced clinical improvement, treatment non-adherence, and poorer prognosis. Suicide prevalence data provide the strongest and most urgent indication that healthcare organizations, and mental health providers specifically, are not optimally meeting the needs of this marginalized, at-risk population. This indicates a clear need for healthcare organizations and mental health providers to adopt clear, consistent, evidence-based policies and practices that affirm gender and may ultimately lead to reduced health disparities. Literature suggests providers of varied disciplines have reported

feeling underprepared and inadequately trained to optimally serve TGGD persons (Carabez, Eliason, & Martinson, 2016).

Therefore, this dissertation proposes to begin to address this critical need and fill the gap in science. Three discrete manuscripts are proposed to fully explicate three concepts (Table 1.1): 1) How state-level policies may affect SGM mental health (a secondary data analysis); 2) A comprehensive understanding of TGGD persons' mental healthcare experiences (an integrative review); and 3) TGGD persons' inpatient mental healthcare experiences (a qualitative study).

This dissertation will be among the first to specifically evaluate the relationship between state policy (enacted stigma) and mental health, substance use, and health risk behaviors among SGM persons. Additionally, this dissertation will be among the first to explore the inpatient mental health care experiences of TGGD adults. The results of this study will potentially identify recommendations for culturally competent evidence-based TGGD inpatient mental health services, lead to better-informed TGGD-specific clinical practices, and help illuminate the next pathways of research inquiry in this area.

Table 1.1. Manuscript Table with Associated Aims

Manuscript	**Aims**
Chapter 2. Secondary data analysis: state-level inclusivity for SGM populations, and relationships with indicators of mental health and health risk behaviors in those states.	**Aim:** To determine whether and to what extent there is a relationship between states' SGM policies and practices, and the mental health and health risk behaviors of those states' SGM residents.
Chapter 3. Integrative review: The mental health treatment experiences of transgender and gender-expansive adults.	**Aim:** To synthesize and characterize the existing health literature regarding the mental health experiences of TGGD adults.
Chapter 4. Qualitative descriptive study: Inpatient mental health and substance disorder treatment experiences of TGGD adults. • **Question 1:** What are the first-hand experiences of TGGD adults who have been admitted to an inpatient mental	**Aim 1.** To better understand the inpatient mental health and/or substance treatment experiences of TGGD persons. **Aim 2:** To identify and characterize facilitators of/barriers to gender-affirming

health and/or substance treatment setting? • **Question 2a:** What aspects of care in inpatient mental health and/or substance treatment settings were viewed by TGGD adults as welcoming and affirmative? • **Question 2b:** What aspects of care in inpatient mental health and/or substance treatment settings were viewed by TGGD adults as unwelcoming and non-affirmative?	care in inpatient mental health and/or substance treatment settings.

Implications of the proposed research for nursing science

These manuscripts may provide valuable information to those seeking to optimize gender-affirming mental healthcare, improve patient outcomes, and ultimately reduce health disparities. Four clear areas of potential nursing science could emerge from this proposed program of research: 1) nursing science related to practice (inpatient mental health/substance use treatment); 2) nursing science related to education; and 3) nursing science related research and scholarship, and 4) nursing science related to policy.

First, inquiry related to inpatient mental health and substance treatment (practice) is particularly important due to the unique nature of the care provided; inpatient treatment includes frequent contact between patients and providers, requires community management of interpersonal situations between patients, and is more intimate than outpatient settings (Walton & Baker, 2017). Inpatient hospital units, including mental health and substance treatment units, are managed by nurses. Additionally, most care in such settings is delivered by nurses and nursing staff. There is therefore a robust area of inquiry for nursing science related to providing gender-affirming care to clients in inpatient settings. The results of Chapter Four may begin this area of inquiry by providing key information about TGGD patients' perspectives of their care.

Nursing practice has the potential to expand because of this program of research. Results from this dissertation's research may help providers understand how state public policy relates to their SGM clients' mental health and how to accordingly provide care that addresses and/or mitigates this (Chapter Two). Results may also identify best practices and areas for improvement in all aspects of healthcare organizations' care delivery structure (Chapters Two and Three). While nursing care qualities will specifically be elicited in participant interviews, there is also opportunity for participants to describe non-nursing related aspects of their care. This may yield new information for nurse leaders who seek to enhance the gender-affirming care of their respective care areas.

Nursing education may also potentially be expanded because of this dissertation. While nursing education is not specifically addressed in this dissertation, all areas of nursing practice development have implications for nursing academia. It has been shown that nursing students, nurses, and advanced practice nurses all have knowledge deficits in providing gender-affirming nursing care. Nurse educators and nursing academic organizations are optimally positioned to enhance registered nurses' and advanced practice nurses' preparedness by providing TGGD-specific course content in curricula, creating an environment of gender inclusivity that becomes the norm for nurses entering the workforce, and expanding nursing science to include what is known about best practices for TGGD content inclusion in nursing education curricula.

Summary

This proposed dissertation includes research that seeks to demonstrate whether policy, stigma, and mental health are related among SGM persons (Chapter Two), to synthesize and summarize what is known in health literature regarding TGGD persons' mental healthcare experiences (Chapter Three), and to explicate TGGD persons' inpatient mental health and

substance treatment experiences (Chapter Four). Findings will be summarized and contextualized within the MST theoretical framework. Results of this proposed dissertation have the potential to enhance nursing science related nursing practice, nursing education, nursing scholarship, and nursing policy.

References

Refer to Cumulative Reference List

Chapter Two:

Exploring relationships between state-level LGBTQ equality and BRFSS indicators of mental health and risk behaviors: a secondary analysis

Bradley Patrick White MSN, RN
Nadia Abuelezam, ScD
Holly B. Fontenot, PhD, RN/NP, FAAN
Corrine Jurgens, PhD, RN, ANP, FAHA, FHFSA, FAAN

This manuscript replaces aspects of the methods and results sections of the traditional dissertation. Bradley P. White will be the primary author on this manuscript; contributions include conceptualization of study, statistical analysis, and drafting of manuscript. Dr. Abuelezam will be the second author; contributions include oversight of statistical analysis and critical appraisal/substantial contributions towards manuscript drafts. Dr. Fontenot will be the third author; contributions include critical appraisal/substantial contributions towards manuscript drafts. Dr. Jurgens will be the fourth author; contributions include oversight of statistical analysis and critical appraisal/contributions towards manuscript drafts. This manuscript was accepted on March 9, 2021 to the Journal of the American Psychiatric Nurses Association, a peer-reviewed journal with an impact factor of 1.665 (2019). The target audience for this journal is all nurses and researchers with an interest in mental health. This manuscript represents a significant contribution to the dissertation work.

Abstract

Purpose: Minority Stress Theory suggests that repeated exposure to enacted stigma adversely affects mental health. States have authority to enact policies impacting level of equality experienced by LGBTQ residents. The purpose of this study was to explore relationships between states' level of LGBTQ equality and indicators of mental health/risk behaviors among an LGBTQ sample.

Methods: The 2018 Human Rights Campaign State Equality Index (SEI) and the 2018 Behavioral Risk Factor Surveillance Survey (BRFSS) were used to examine relationships between states' levels of LGBTQ equality (predictor variable) and indicators of mental health/risk behaviors (outcome variables). Relationships were explored using descriptive statistics and survey-weighted logistic regression.

Results: Lower state inclusivity increased odds of: fair/poor general health (adjusted odds ratio AOR: 1.22, 95% CI: 1.01-1.48), poor mental health days (AOR: 1.34, 95% CI: 1.11-1.62), smoking (AOR: 1.62, 95% CI: 1.27-2.07), heavy drinking (AOR: 1.54, 95% CI: 1.26-1.86) and binge drinking (AOR: 1.23, 95% CI: 1.01-1.49). State inclusivity did not influence odds of a depressive disorder diagnosis or driving under the influence of alcohol.

Conclusion: State policies affect the mental health and risk behaviors of LGBTQ persons. More research is needed to determine whether state policies affect other domains of LGBTQ persons' health. Healthcare providers working with LGBTQ persons should be mindful of the relationship between state policies and LGBTQ mental health/risk behaviors and should seek to implement mitigating healthcare strategies such as the use of validated screening measures.

Introduction

Ample research has demonstrated that lesbian, gay, bisexual, and transgender (LGBTQ) persons in the United States (U.S.) face significant health disparities, including reduced access to care, reduced access to health insurance, and disproportionately high rates of depression, anxiety, substance use behaviors, and suicidality (Blosnich et al., 2014; Institute of Medicine, 2011; Su et al., 2016). Some researchers have attributed these disparities in part to effects of minority stress, defined here as the burden of additional daily stress experienced by members of marginalized communities (Meyer, 195; Meyer, 2003). Minority stress has been frequently identified as a contributing factor to population mental health disparities among multiple marginalized communities, including LGBTQ persons (Meyer, 2014). A defining component of minority stress is stigma and discrimination; it is well-documented that LGBTQ adults experience frequent stigma and discrimination in the U.S. (Bialer & McIntosh, 2017; Poteat, German, & Kerrigan, 2013; Stroumsa, 2014). Chronic, prolonged stigma and discrimination have consistently been shown to adversely affect the mental health of those experiencing them (Hatzenbuehler et al., 2010).

When considered cumulatively, LGBTQ persons' mental health may be related to the level of stigma they face in their lives. This is consistent with Minority Stress Theory (MST), which posits that chronic and acute stress experienced by members of marginalized groups has negative effects on individuals' mental health (Meyer, 1995). MST acknowledges that LGBTQ persons experience internal and external sources of stigma that are related to their sexual and/or gender identity. Importantly, stigma-related stress levels for LGBTQ persons surpass levels experienced by people who identify as heterosexual and/or have a gender identity consistent with their birth sex (Meyer, 1995; Meyer 2003).

External stigma comes in many forms and can be perpetrated via public policy. Individual states have broad authority to enact an array of policies that directly affect the overall level of equality experienced by the state's LGBTQ population (Gonzales & Henning-Smith, 2017; Human Rights Campaign, 2019). States' discretion in LGBTQ-related public policy includes the ability to decide whether to offer gender affirmation care as part of the state's Medicaid program, whether LGBTQ people can adopt children, whether LGBTQ curriculum can be taught in public schools, and whether HIV criminalization laws are in place (Human Rights Campaign, 2019). The Human Rights Campaign has identified 54 state public policy areas such as those described above (e.g. whether LGBTQ people can adopt children) that directly affect level of LGBTQ inclusivity. Inclusive states had effective LGBTQ advocacy efforts as well as statewide laws and policies that enhanced LGBTQ equality and access to legal protections. Restrictive states had a dearth of effective LGBTQ advocacy efforts as well as state laws and policies that restricted LGBTQ equality and access to legal protections (Human Rights Campaign, 2019). Thus, state-specific policies may either enhance or hinder progress toward equality for LGBTQ persons.

LGBTQ population health largely has been measured through the lens of state-specific policies. Research indicates state specific policies have significant impact on the health of the most marginalized and vulnerable residents, including LBGT persons (Gonzales & Henning-Smith, 2017; Hatzenbuehler et al., 2010). One study compared how LGBTQ and non-LGBTQ residents rated their own general health in each state, and whether states had inclusive or restrictive policies. In restrictive states, LGBTQ persons were significantly more likely than non-LGBTQ persons to rate their general health as fair or poor (Gonzales & Henning-Smith, 2017). Additionally, prior to nationwide marriage equality, researchers found that LGBTQ persons in

states prohibiting marriage equality were affected by depression, anxiety, and alcohol use disorder at significantly higher rates than their counterparts residing in states recognizing marriage equality (Hatzenbuehler et al., 2010).

However, little is known about how mental health and risk behaviors may vary for LGBTQ persons across state public policy environments. We, therefore, analyzed data to examine the relationship between states' level of LGBTQ inclusivity and the mental health and risk behaviors of LGBTQ residents.

Theoretical Framework

MST served as a theoretical framework for the selection of variables in the model analyzed. Meyer (1995, 2003) proposed a model of minority stress depicting the relationship between external (distal) stressors, internal (proximal) stressors, resiliency (coping) responses, and mental health. The model used for this analysis is an adaptation of Meyer's minority stress model. In it, state-based policies and practices are identified as potential distal stressors that may impact the proximal stressors, coping responses, and, ultimately, the mental health of LGBTQ persons (Figure 1).

Methods

Data Sources and Variables Used

To quantify the relationship between the level of state inclusivity and indicators of mental health and risk behaviors among LGBTQ persons, two data sources were used. First, the 2018 Human Rights Campaign State Equality Index (SEI) provided the independent variable used in the analysis. The SEI analyzed 54 indicators of equality to rate states, including whether states have LGBTQ-inclusive hate crimes laws, gender-affirming transgender health coverage in Medicaid programs, and laws prohibiting LGBTQ adoptions. Each state was assigned one of

four levels, based on the level of LGBTQ equality in the state: 1) High priority to achieve basic equality (lowest rating possible); 2) Building equality; 3) Solidifying equality; and 4) Working toward innovative equality (highest rating possible). While there were many states in the Level 1 and Level 4 categories, there were relatively few states in the Level 2 and Level 3 categories. As a result, a dichotomous predictor variable was created wherein Levels 1 and 2 were combined into one SEI category (restrictive states; lower levels of LGBTQ equality); Levels 3 and 4 were combined into one SEI category (inclusive states; higher levels of LGBTQ equality) (Figure 2).

Second, the 2018 Behavioral Risk Factor Surveillance Survey (BRFSS) provided the outcome variables (primarily indicators of mental health status and risk behaviors) for analysis. The BRFSS is a collaborative project administered by the Centers for Disease Control and Prevention's (CDC's) Population Health Surveillance Branch in partnership with state departments of public health. All 50 states participate in the annual BRFSS, a telephone survey designed to collect data on health-related risk behaviors, chronic health conditions, and use of preventative services among a non-institutionalized adult sample. The survey used a dual-frame technique in which land lines and cellular lines were included in the sampling. Use of the dual-frame technique improved the BRFSS' validity, data quality, and representativeness, as 50.8% of U.S. households have only wireless telephones (Centers for Disease Control and Prevention, 2017). The BRFSS surveys approximately 450,000 people annually.

The BRFSS contains a required core module along with several optional modules. The core module administered by all states provided indicators of overall health, mental health, and risk behaviors for this analysis (Figure 1). An optional module administered by 29 states included indicators of sexual orientation and gender identity; thus, 21 states could not be included in the analysis (Figure 2).

Statistical Analyses

Descriptive statistics and chi square tests were used to characterize the study sample. Survey-weighted logistic regression was used to analyze relationships between the dichotomous independent variable (state level of inclusivity) and the following dependent variables: 1) self-reported overall health; 2) number of days in the last month that mental health was not good; 3) depressive disorder diagnosis; 4) smoking status; 5) drinking status; 6) binge drinking status; and 7) driving under the influence of alcohol. Relationships between these variables were analyzed to determine whether the data were consistent with the MST theoretical model. Regression models controlled for all demographic variables evaluated: sex, age, race, ethnicity, education level, income, and metropolitan status (Table 1). Significance for all statistical tests was set at $p \leq 0.05$. Listwise deletion was used to address missing data, thus rendering equal sample sizes for all analyses. SAS was used to conduct all analyses. To reduce bias due to unequal probability of selection, design weighting was conducted by the CDC. Those weighting procedures were preserved in this secondary analysis. This secondary analysis of a publicly available dataset was exempt from Institutional Review Board approval.

Results

The sample consisted of 9183 self-reported LGBTQ respondents in 29 states (Table 1). The sample was slightly more female than male and was comprised of an even distribution across age ranges. White respondents represented most of the sample in all states. In restrictive states, there were more Black/non-Hispanic respondents than in inclusive states (11.1% and 6.8%, respectively; $p < .05$). More respondents in inclusive states had an income of more than $50,000 (46.7%, compared to 36.4% of respondents in restrictive states; $p < .05$). The proportion

of those who identified as unemployed was higher in inclusive states (5.5%, compared to 4.8% of respondents in restrictive states; $p < .05$).

Pearson chi-square tests for association were conducted between the states' level of equality and all outcome variables. Significant associations were found with self-rated general health status [$\chi2$ (1, N = 9183) = 32.70, $p < .05$]; a history of a depressive disorder diagnosis [$\chi2$ (1, N = 9183) = 21.43, $p < .05$]; number of poor mental health days in the last month [$\chi2$ (1, N = 9183) = 37.66, $p < .05$]; cigarette smoking status [$\chi2$ (1, N = 9183) = 92.99, $p < .05$]; and heavy drinking [$\chi2$ (1, N = 9183) = 21.01, $p < .05$]. No significant associations were found with binge drinking [$\chi2$ (1, N = 9183) = 9.92, $p = 0.08$] or driving while under the influence of alcohol [$\chi2$ (1, N = 9183) = 8.43, $p = 0.10$].

Adjusted logistic regression revealed several significant relationships (Table 2). After controlling for all demographic variables, state inclusivity was significantly associated with general health status, poor mental health days, smoking, heavy drinking, and binge drinking (Table 2). As compared to inclusive states, LGBTQ respondents in restrictive states were significantly more likely to rate their general health as fair or poor (AOR 1.22; 95% CI 1.01-1.48); to have 15 or more poor mental health days in the past month (AOR 1.34; 95% CI 1.11-1.62); to be a current cigarette smoker (AOR 1.54; 95% CI 1.26-1.86); to be a current heavy drinker (AOR 1.46; 95% CI 1.10-1.94); to have engaged in binge drinking the past month (AOR 1.23; 95% CI 1.01-1.49).

Discussion

This ecological secondary analysis used a well-validated and robust sample to highlight relationships between level of state LGBTQ inclusivity and self-reported mental health and risk behaviors of LGBTQ adults in the U.S. More than 50 relevant policy indicators determined state

level of inclusivity. Regression model results indicated there are significant relationships between state level of inclusivity and general health, number of depressed days in the last month, smoking, and drinking. No significant relationships were detected between state level of inclusivity and the diagnosis of a depressive disorder and or driving under the influence of alcohol.

Our analysis supports previously published findings demonstrating that state policies affect the mental health of LGBTQ persons (Bialer & McIntosh, 2017). As 54 indicators of inclusivity were included in the SEI calculation, future research could clarify which specific state policies are primarily implicated in the effect on LGBTQ persons' general health.

Our results indicate that state level of inclusivity may be associated with the number of poor mental health days reported by respondents (more poor mental health days among people in restrictive states). Although the BRFSS has previously been used to demonstrate significant relationships between racial minority stress and number of poor health days in the past month (Anderson, 2013), to our knowledge no existing research has demonstrated this finding among LGBTQ persons. Since the number of days during which a psychiatric symptom was experienced in the last month has been shown to be an effective measure of mental health status, further research administering this measure to an LGBTQ sample may reveal new information regarding daily prevalence of this population's mental health symptoms (Iyer, Spaeth-Rublee, & Pincus, 2016).

LGBTQ persons have consistently been shown to smoke cigarettes at higher rates than the general population. Additionally, experiences of stigma and number of self-reported poor mental health days have been shown to be significant predictors of cigarette smoking among LGBTQ persons (Grady et al., 2014; Pachankis, Hatzenbuehler, & Starks, 2014). Our findings

complement past work and suggest that level of state inclusivity is also a potential contributor to increased rates of smoking of LGBTQ adults. While more research in this area is needed, there is ample evidence to suggest that smoking cessation interventions targeting LGBTQ persons, particularly in states with lower levels of inclusivity, are indicated.

Significant relationships were observed between state level of inclusivity and drinking behaviors. Our findings suggest that people in restrictive states are both more likely to be heavy drinkers and to have engaged in binge drinking in the past month. Specific efforts to decrease heavy and binge drinking among LGBTQ persons should be implemented. Partially because of the effect of social desirability, many measures of alcohol use have had inconsistent psychometric properties. However, previous research suggests that respondent recall of the number of episodes of binge drinking (such as in BRFSS) is an accurate measure of problematic alcohol use (Esser et al., Paljärvi et al., 2012). Additionally, level of stigma has been shown to significantly affect rates of alcohol use among LGBTQ persons (Pachankis, Hatzenbuehler, & Starks, 2014). The use of well-validated alcohol use screening intervention is therefore indicated. One such intervention, the Screening, Brief Intervention, and Referral to Treatment (SBIRT), has been implemented in sexual health clinics in the past and is encouraged for at-risk LGBTQ youth (Appel et al., 2017).

No significant relationship was found between level of state inclusivity and diagnosis of a depressive disorder. However, since data from thus study suggests a disproportionate presence of mental health symptoms in less inclusive states, the absence of disproportionate rates of a depressive disorder diagnosis may signal barriers to appropriate diagnostic care among this population. Past research has shown that LGBTQ persons face significant barriers to accessing care and this may be an example of that phenomenon (IOM, 2011; IOM, 2011b). Research is

needed to clarify whether LGBTQ persons are experiencing depressive symptoms without the ability to access appropriate diagnostic mental healthcare.

Limitations

There are some acknowledged limitations to this secondary analysis. First, the optional BRFSS module on sexual and gender identity was not administered in all 50 states. The results of this analysis therefore cannot be generalized to all states. Second, mental health and risk behavior items on BRFSS are limited in scope and language. It is possible that different items with strong psychometric properties would yield different results. Third, the refusal rate on several items was high. While we could speculate that refusal may be related to mental health stigma and/or social desirability influences, we do not know from this analysis why respondents chose not to answer some items. The reasons for refusal may have potentially influenced the results we reported here. Fourth, the sample was more highly educated and had higher income than the general population and thus results may not be generalizable to all groups of LGBTQ individuals. While mental illness and risk behaviors affect all socioeconomic strata, a more socioeconomically diverse sample may yield different results. Lastly, this analysis did not include proximal stressors and resilience factors in the MST model due to absence of appropriate variables in the data set. Future research could provide new information regarding the roles of proximal stress and resiliency in the mental health effects of distal stress (stigma).

Conclusion

States have wide discretion in the implementation of inclusive or restrictive LGBTQ-affecting policies. Many states have led the way with innovative LGBTQ policies, while some states actively restrict LGBTQ inclusivity. This analysis reveals that state policies in this domain may have a significant effect on the mental health and risk behaviors of LGBTQ persons. Further

research using more focused survey instruments among a more diverse sample may provide additional insight into the relationships between state policy and LGBTQ mental health.

Figure 1. Minority Stress Theory adaptation

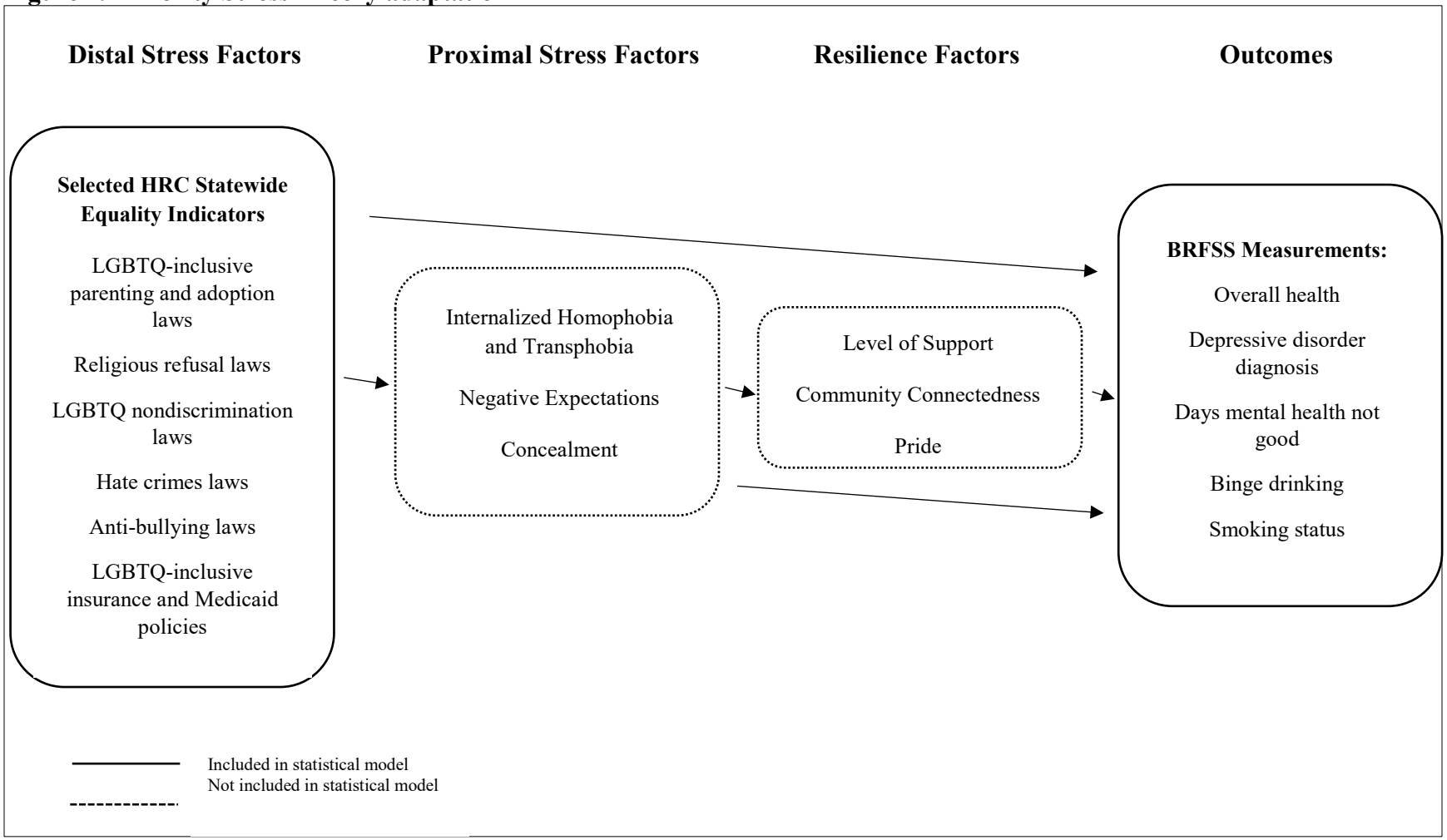

Figure 2. BRFSS variables used

Core variables:

- General health: "Would you say that in general your health is …"
- Depressive disorder: "Has a provider ever told you, you have a depressive disorder?"
- Poor mental health days: "Now thinking about your health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
- Smoking: "Do you now smoke cigarettes every day, some days, or not at all?"
- Heavy drinking: "During the past 30 days, on the days when you drank, about how many drinks did you drink on average?"
- Binge drinking: "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks (for men) or 4 or more drinks (for women)?"
- Driving under the influence: "During the past 30 days, how many times have you driven when you've had perhaps too much to drink?"

Optional variables:

- "Do you consider yourself to be … (sexual orientation)?"
- "Do you consider yourself to be transgender?"

Figure 3. Human Rights Campaign's 2018 State Equality Index rating

Original SEI rating:	Dichotomous predictor variable for this analysis:
Level 1 (High priority to achieve basic equality) (n=17) • Arizona, Florida, Idaho, Kansas, Louisiana, Mississippi, Missouri, Montana, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, West Virginia Level 2 (Building equality) (n=1) • Wisconsin	Level 1 states (restrictive states) (n=18): • Arizona, Florida, Idaho, Kansas, Louisiana, Mississippi, Missouri, Montana, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Wisconsin, West Virginia,
Level 3 (Solidifying equality) (n=1) • Maryland Level 4 (Working toward innovative equality) (n=10) • Connecticut, Delaware, Hawaii, Illinois, Minnesota, Nevada, New York, Rhode Island, Vermont, Washington	Level 2 states (inclusive states) (n=11): • Connecticut, Delaware, Hawaii, Illinois, Maryland, Minnesota, Nevada, New York, Rhode Island, Vermont, Washington

Not included in analysis (n=21):

- Alabama, Alaska, Arkansas, California, Colorado, Georgia, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oregon, South Dakota, Utah, Wyoming

Table 1. Demographic and descriptive results (n = 9183)

	Level 1 Restrictive states	Level 2 Inclusive states
Total sample	41% (3854)	59% (5329)
Sex		
Male	43.6% (1681)	46.1% (2457)
Female	56.4% (2173)	53.9% (2872)
Age		
18 to 24	13% (501)	12.3% (655)
25 to 34	19% (733)	17.8% (947)
35 to 44	14% (537)	14.5% (776)
45 to 54	13.8% (532)	15.1% (809)
55 to 64	17% (654)	17.5% (931)
65 or older	23.2% (897)	22.7% (1211)
Race/ethnicity		
White, non-Hispanic	72.9% (2808)	71.5% (3809)
Black, non-Hispanic	11.1% (429)	6.8% (360)
Other race, non-Hispanic	4.1% (161)	7.3% (391)
Multiracial, non-Hispanic	3.1% (122)	4.1% (221)
Hispanic	8.7% (334)	10.3% (548)
Education level		
Did not graduate high school	8.4% (324)	7.7% (412)
Graduated high school	27.1% (1046)	22.8% (1213)
Attended college/technical school	28.9% (1112)	26.5% (1413)
Graduated college/technical school	35.6% (1372)	43% (2291)
Employment status		
Employed, work in the home, retired, student disabled, or not looking for work	95.2% (3670)	94.5% (5034)
Unemployed	4.8% (184)	5.5% (295)
Income		
Less than $15,000	13.9% (537)	11% (586)
$15,000 to $24,999	22.6% (871)	19.6% (1045)
$25,000 to $34,999	12.5% (481)	10.6% (567)
$35,000 to $49,999	14.6% (564)	12% (640)
$50,000 or more	36.4% (1401)	46.7% (2491)
Metropolitan status		
Metropolitan county (at least one metro area of >50,000 people)	71.8% (2767)	78.5% (4181)
Non-metropolitan county (no metro area of >50,000 people)	28.2% (1087)	21.5% (1148)
Self-reported overall health status		
Excellent or good	75% (2890)	79.6% (4242)
Fair or poor	25% (964)	20.4% (1087)
Number of poor mental health days (in last month)		
0-14	76.4% (2943)	80.4% (4282)
15-30	23.6% (911)	19.6% (1047)

Diagnosed with a depressive disorder		
Yes	36.2% (1397)	33.6% (1789)
No	63.8% (2457)	66.4% (3540)
Current cigarette smoker		
Yes	24.6% (949)	18.5% (984)
No	75.4% (2905)	81.5% (4345)
Current chewing tobacco user		
Yes	3.5% (134)	2.3% (124)
No	96.5% (3720)	97.7% (5205)
Binge drinking in last month		
Yes	19% (731)	19.3% (1028)
No	81% (3123)	80.7% (4301)
Heavy drinker (>14 drinks/week for men, >7 drinks/week for women)		
Yes	8.9% (342)	8.5% (455)
No	91.1% (3512)	91.5% (4874)
Drove while having too much to alcohol to drink (last month)		
Yes	48.7% (1877)	44.3% (2360)
No	51.3% (1977)	55.7% (2969)

Table 2. Logistic Regression[a]

	AOR	95% CI
General health[b]		
Fair or poor	1.22	1.01-1.48*
Days when mental health was not good[c]		
15+ days when mental health was not good	1.34	1.11-1.62*
Diagnosed with a depressive disorder[d]		
Yes	0.85	0.72-1.01
Current cigarette smoker[e]		
Yes	1.54	1.26-1.86*
Current heavy drinker[f]		
Yes	1.46	1.10-1.94*
Binge drinking in past month[g]		
Yes	1.23	1.01-1.49*
Driving under the influence of alcohol in past month[h]		
Yes	1.07	0.91-1.26

* Significant at 95% C.I.

a. Model reference category = Inclusive states
b. Reference category = Excellent or good health
c. Reference category = Less than 15 days when mental health was not good
d. Reference category = No depressive disorder diagnosis
e. Reference category = Not a current cigarette smoker
f. Reference category = Not a current heavy drinker
g. Reference category = No binge drinking in past month
h. Reference category = No driving under the influence of alcohol in past month

References

Refer to Cumulative Reference List

Chapter Three:

Transgender and non-conforming persons' mental healthcare experiences: an integrative review

Bradley Patrick White MSN, RN
Holly B. Fontenot, PhD, RN/NP, FAAN

This manuscript replaces the literature review section of the traditional dissertation. Bradley P. White was the primary author on this manuscript; contributions include conceptualization of study, design of review methods, data analysis, and drafting of manuscript. Dr. Fontenot was the second author; contributions included critical appraisal/substantial contributions towards manuscript drafts. Additional non-authored support was provided by Dr. Judith Vessey (mentorship on integrative review process) and Wanda Anderson (nursing librarian; provided guidance on search criteria and strategy). This manuscript was published in 2019 in Archives of Psychiatric Nursing, a peer-reviewed journal with an impact factor of 1.299 (2018). Archives of Psychiatric Nursing *publishes peer-reviewed research of interest to psychiatric/mental health care nurses. The journal considers the field of psychiatric/mental health care in its broadest perspective, including theory, practice and research applications related to all ages, special populations, settings, and interdisciplinary collaborations in both the public and private sectors. This manuscript represents a significant contribution to the dissertation work.*

Abstract

Introduction: Transgender and gender non-conforming (TGNC) people in the United States face disproportionate rates of mental health disorders, including suicidality, depression, anxiety, and substance use disorders than the general population. Patients' experiences utilizing mental healthcare is a determinant in their care-seeking behaviors and treatment success.

Aim/question: The purpose of this integrative review is to better understand the firsthand mental healthcare experiences of TGNC persons.

Method: The authors sought to locate recent English-language articles that described the mental healthcare experiences of TGNC persons. To do so, only articles that conducted data collection with a TGNC sample were considered for review.

Results: Seven articles met criteria for review. Four themes emerged that depicted experiences of health promotion (welcoming environments, staff knowledge and response) and health prevention (enacted stigma, racial disparities and intersectional insensitivity).

Discussion: Themes indicated that TGNC persons have mixed experiences (excellent to harmful/damaging) when receiving mental healthcare. There is room for healthcare provider growth in skills to increase TGNC cultural competency.

Implications for practice: Mental healthcare providers and nurses would benefit from interventions to promote TGNC culturally competent care, including in-service training or continuing education for the current work force as well as incorporating TGNC content into pre-licensure educational curricula.

Keywords: Transgender, gender non-conforming, mental health, stigma, psychiatry, nursing, treatment experiences

Accessible Summary

What is known on the subject:

- Transgender and gender non-conforming (TGNC) people in the United States experience high rates of mental health disorders such as depression, anxiety, suicidality, and substance use disorder.
- TGNC people are more likely than other marginalized groups and the general population to need mental health services such as psychotherapy, counseling, substance use disorder treatment, and inpatient mental health services.
- Little is known about the perspectives or experiences of TGNC persons as they seek and receive mental health services.

What the paper adds to existing knowledge:

- This paper reviews existing literature on the mental health treatment experiences of TGNC persons.
- This paper identifies key themes related to the firsthand experiences of TGNC persons' mental healthcare encounters.

Implications for practice:

- The results of this review offer mental healthcare providers and staff insight into welcoming clinical practices for TGNC people.
- Results shows there is a need for more mental healthcare provider and staff training for culturally competent services for TGNC persons.
- Further research priorities are identified, including in inpatient settings and among TGNC people of color.

Introduction

Transgender and gender non-conforming (TGNC) people in the United States (U.S.) are at disproportional risk for several negative health outcomes as compared to the general population (Carabez, Eliason, & Martinson, 2016; Institute of Medicine, 2011; Poteat, German, & Kerrigan, 2013). Most TGNC people have experienced discrimination in political, social, religious, familial, and/or healthcare contexts (Institute of Medicine, 2011; Poteat et al., 2013; Stroumsa, 2014). TGNC people face unequal healthcare access and health disparities including high rates of depression, substance use disorders, HIV/AIDS, suicide, and sexually transmitted infections (Institute of Medicine, 2011; Su et al., 2016).

Transgender individuals have been described to experience a "systematic oppression and devaluation as a result of social stigma attached to their gender nonconformity" (Bockting et al., 2013, p. 943). Despite the documented presence of such disparities within the healthcare system, research suggests that nurses and other healthcare providers (HCPs) have limited formal or informal training in the specific healthcare needs of gender minorities (Austin, 2015), and HCPs report feeling underprepared to serve TGNC people. TGNC persons' experiences of stigma and discrimination within health systems is associated with HCP behaviors and institutional policies/ practices, including gender insensitivity, displays of provider discomfort, denial of services, substandard care, and verbal abuse from HCPs (Carabez et al., 2016; Daniel & Butkus, 2015; Kosenko, Rintamaki, Raney, & Maness, 2013; Roller, Sedlak, & Draucker, 2015).

Mental health disparities facing the TGNC community are also well documented (Su et al., 2016). Related to the impact of minority stress and discrimination, and secondary to disproportionate rates of hospitalization-warranting conditions (e.g. suicidality and substance use disorder), TGNC individuals have a greater need for mental health services as compared to the

general population (Perry, Chaplo, & Baucom, 2017; Walton & Baker, 2017). Therefore, in order to develop interventions, it is imperative to understand the experiences of TGNC persons' with obtained mental healthcare in the U.S. This integrative review examines recent multidisciplinary research to gain a comprehensive understanding of this experience. Results will identify gaps in knowledge and opportunities for advancing nurses' preparedness for providing comprehensive and gender-affirming mental health care for this marginalized population.

Method

We sought to uncover and review existing research specifically examining TGNC persons' mental healthcare experiences. Databases searched were CINAHL, Scopus, PubMed, and PsychINFO. Original research articles were systematically sought by using set search criteria for each database. Terms included "transgender" AND "mental health care *or* psychiatric care *or* psychiatry *or* mental health counseling" AND "experiences *or* perceptions *or* attitudes *or* views *or* feelings." Only articles published between 2010 and 2018 were included due to the rapidly evolving public awareness of transgender persons and experiences. Additionally, in 2011, *Healthy People 2020* added health goals for lesbian, gay, bisexual, and transgender (LGBTQ) populations. This national prioritization of health for sexual and gender minorities is likely to shift or signal a shift in subsequent science and practice initiatives.

Other inclusion criteria were as follows: 1) any report that presented mental health experience data collected from TGNC persons, 2) reports published in English, and 3) data collected in the U.S. or Canada. Exclusion criteria included articles solely presenting mental healthcare providers' (MHCP) experiences, and articles broadly describing LGBTQ persons' experiences without a clear explication of the experiences of TGNC persons.

Article titles and abstracts produced in searches were reviewed for relevance based on goals of the review and inclusion criteria. A total of 571 articles were screened for inclusion and 96 were fully assessed for inclusion. The article selection process is presented in the Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA) flow diagram (Figure 1). Using a pre-determined process, data and key information were extracted for relevance evaluation. Aims, objectives, methods, and key findings sections were screened according to inclusion and exclusion criteria. The overall analysis was enhanced by the supervision of two experienced researchers, one with sexual and gender minority (SGM) health clinical and research expertise. An academic reference librarian was consulted to ensure the rigor of the literature search.

Findings

The results of this integrated review represent the key insights, findings, and themes from the selected articles, as detailed in Table 1. Seven articles met the inclusion criteria; three quantitative studies, and four qualitative studies. Lastly, the levels of evidence were critiqued and found to have acceptable quality for inclusion (Dearholt & Dang, 2018). The articles selected primarily assessed quality of outpatient mental health counseling or therapy. One article assessed services at a residential substance use disorder treatment facility (Lyons et al., 2015); another article assessed services at drug treatment programs, rape crisis centers, domestic violence shelters, and mental health centers (Kattari, Walls, Whitfield, & Langenderfer Magruder, 2017). Four themes emerged; two were facilitators of health (*welcoming environments* and *HCP knowledge and response*) and two were barriers to health (*enacted stigma* and *racial disparities and intersectional insensitivity*).

Welcoming environments

Participants from each of the studies reported TGNC-affirming aspects of their treatment experiences. Competent HCPs and staff were seen as "positive, helpful, healing, and transaffirmative" (Elder, 2016, p. 181). It was important to TGNC persons that "their staff was knowledgeable around trans people, (including) the terminology" (Lyons et al., 2015, p. 12).

Among three qualitative samples of TGNC persons seeking counseling services, a significant theme of trans-affirmative care was identified (Benson, 2013; Elder, 2016; McCullough et al., 2017). Participants reported their mental HCPs were "accepting, advocating, and educating others about TGNC concerns," were "validating or affirming," and, importantly, did not "pathologize" their gender identity (McCullough et al., 2017, p. 428). After experiencing this level of acceptance with a mental HCP, participants reported they felt increased interpersonal comfort, were more forthcoming, and shared more openly during counseling sessions. Participants felt most affirmed when "they could talk freely about gender-diverse experiences" (Elder, 2016, p. 182). Some participants felt best served by mental HCPs who identify as LGBTQ, although some participants reported this was less important than an overall openness to and knowledge of TGNC care. Additionally, provider advocacy emerged as an important component of a welcoming environment. Participants felt welcomed when mental HCPs took the time to educate themselves, utilized a social justice approach in counseling, and helped educate others in the practice setting (McCullough et al., 2017).

In a qualitative study of TGNC persons receiving residential substance use services, participants reported feeling their gender identity was acknowledged and welcomed. These participants perceived this support through respectful interactions and assignments according to their identified gender in treatment groups and housing (Lyons et al., 2015). Indicators of welcoming environments described in two studies were an understanding of the gender

affirmation process, correct use of preferred names and pronouns, gender-sensitive rooming and cohorting decisions, and comfort and proficiency in openly discussing gender and gender non-conformity (Lyons et al., 2015; McCullough et al., 2017).

In their quantitative study of TGNC persons seeking gender affirmation care, Austin and Goodman (2018) found that 98% of respondents felt safe engaging in care with their mental HCP and 84% of respondents felt their mental HCP was knowledgeable about TGNC-specific issues. All respondents agreed or strongly agreed that their mental HCP was someone with whom they can share their gender identity concerns (Austin & Goodman, 2018, p. 23).

Participants in all studies reported that HCP knowledge and sensitivity was an important factor in their overall treatment experience. For many, it was the deciding factor in whether to seek or continue mental healthcare. Thus, this is a critical thematic finding that should inform the development of more inclusive mental healthcare environments and services.

HCP and staff knowledge and response

Several articles noted that there is an important role for HCP and staff intervention in matters related to enacted stigma (Austin & Goodman, 2018; Lyons et al., 2015). For some study participants, the presence or absence of appropriate response in conflict between patients was the deciding factor in whether to remain engaged in care. More commonly, participants encountered suboptimal HCP and staff response when the individual discussed challenging topics such as gender identity and past traumatic experiences.

Some participants reported feeling unsafe in the substance treatment setting due to threats of sexual and physical violence by other residents. Respondents in one study reported feeling generally supported by staff, but they felt staff were underprepared to sensitively address residents' gender identity and "they didn't know how to deal with it." (Lyons et al., 2015, p. 7).

One participant reported that "there was a guy that threatened me in there and told me he was gonna kill me…it was brought to staff… so the staff and me and the guy all sat down and they still kept the guy on the unit. I left because I felt unsafe there" (Lyons et al., 2015, p. 9).

Regarding outpatient mental HCPs, several studies' participants shared experiences that demonstrated an apparent lack of knowledge of TGNC issues and invalidations of TGNC persons' experiences. Participants told stories of providers that seemed "unaware that TGNC individuals frequently lack protection against hate crimes in many states, are prevented from using public restrooms, or fear going to the doctor because of the possibility of dehumanizing treatment by doctors and staff … Feeling angered by an interaction with a counselor, Taye said 'Do you even know what trans means? Do you understand the history? Do you understand the basic stuff?'" (McCullough et al., 2017, p. 429). One participant seeking mental health services stated, "'Most of them don't have any idea what to do … most counselors that I am familiar with end up trying to fit a person into a profile rather than develop the profile around who the unique person is … that's why I'm a little leery of being put in somebody else's box'" (Benson, 2013, p. 30).

For study participants, these types of experienced stigma and inadequate provider training led to "feeling disrespected," "mistrustful," and "less willing to reach out to other mental health providers again" (McCullough et al., 2017, p. 429). Thus, HCP and staff awareness of TGNC patients' experiences of stigma and discrimination, and resulting interventions as needed, may be important factors in the treatment success of the TGNC individual.

Enacted stigma

All the articles report that TGNC participants have had healthcare experiences that can be characterized as enacted stigma, defined in this review as incidents of discrimination that include

experiences of rejection or insensitivity, denial of services, and/or violence. Many of the studies' participants have experienced enacted stigma in mental healthcare contexts.

In residential substance treatment settings, participants reported experiences of name-calling, social rejection, and harassment from other residents. One participant described being "targeted" in the treatment setting, resulting in the respondent engaging in isolative behavior and ultimately terminating care early (Lyons et al., 2015, p. 7). No other articles in this review evaluated the experiences of inpatient mental healthcare. However, this finding highlights a potential problem for inpatient and residential settings, where patients interact with each other in the therapeutic milieu. This may create a higher likelihood of experienced stigma from other patients than in outpatient settings, where patients only interact with their providers.

When receiving outpatient mental health services, participants reported experiences of enacted stigma from their provider. Some participants experienced "experiential invalidations" from their providers, wherein the provider demonstrated "avoidance, interpersonal bias, discouragement, refusal to take clients seriously, and refusal to use correct gender pronouns" (McCullough et al., 2017, p. 429).

In a qualitative study of TGNC persons over the age of 60, all participants described their first experience in therapy as negative (Elder, 2016). Provider behavior was described by participants as "unhelpful or hurtful" and "homophonic and transphobic" (p. 182). Eight participants told stories of transphobic experiences in counseling. Two participants reported that their selected therapist refused treatment and was reluctant to write a letter for gender-affirming medical/surgical care.

When identifying barriers to mental health care among TGNC persons, one of the most significant barriers to care was concerns related to stigma (Benson, 2013). Additionally, among

TGNC persons a prior bad experience with mental health services or knowing a peer who had a bad experience decreased the likelihood of seeking care; respondents identified these factors as a primary reason they did not seek care at a time when they needed it (Shipherd, Green, & Abramovitz, 2010).

Racial disparities and intersectional insensitivity

Results indicated that TGNC persons who identify as racial or ethnic minorities experience more TGNC-related discrimination and insensitivity than their white peers (Kattari et al., 2017; McCullough et al., 2017).

Among TGNC persons seeking counseling, a significant qualitative theme of intersectional insensitivity emerged from one study (McCullough et al., 2017). The participants reported feeling "uncomfortable discussing the intersections of their racial and TGNC identities" among providers who "did not recognize the importance of the clients holding multiple marginalized identities," sometimes resulting in the client deciding not to talk about either identity with the provider (p. 429). Participants were distressed by their inability to locate a provider who could comprehend their experiences as TGNC persons of color. Black male respondents in particular "conveyed frustration about being unable to discuss their anxieties about their social transition from African American female to African American male, and the cultural biases and violence they now faced as Black men" (p. 429). Resultingly, participants felt the need to "compartmentalize and omit parts of themselves" (p. 430).

Another study quantitatively supports this finding, as statistically significant higher rates of discrimination were reported by TGNC people of color who engaged in services at mental health centers, drug treatment programs, domestic violence shelters, and rape crisis centers. Among this sample, TGNC persons who identified as bi-/multiracial or Latino reported

significantly higher rates of discrimination (5.5% to 17.0% and 10.4% to 19.03%, respectively) across all four treatment settings evaluated (Kattari et al., 2017). The authors noted that several previous studies have indicated that bi-/multiracial and Latino TGNC persons have been shown to experience disproportionate rates of discrimination in health care, homeless shelters, mental health services, HIV outreach, and substance abuse services (Begun & Kattari, 2016; Cabassa, Zayas, & Hansen, 2006; Lundgren & Delgado, 2008). While rates of reported discrimination in drug treatment programs were statistically significantly higher among Black/African-American TGNC persons (4.5%) than white TGNC persons (1.9%), rates of reported discrimination in the other treatment settings were similar between the two groups. Discrimination experienced by Asian/Pacific Islander TGNC persons was not significantly different than discrimination experienced by their white counterparts (Kattari et al., 2017).

Discussion

To date, little is known about TGNC persons' experiences of mental health care. Seven papers met search criteria, were systematically reviewed, and four themes emerged from the data, which collectively demonstrate that transgender patients had mixed experiences of mental health care. The findings suggest that TGNC persons have found acceptance, healing, and safety when receiving mental health services. However, TGNC persons have also experienced stigma, discrimination, and poor provision of safety when receiving mental health services. This indicates that there are existing strengths that mental HCPs can draw from to do the work necessary to expand their inclusivity and cultural competence in the care of TGNC persons.

TGNC individuals have a greater need for inpatient mental health services as compared to the general population, partially due to the impact of minority stress and discrimination, and secondary to disproportionate rates of hospitalization-warranting specific conditions such as

suicidality and substance use disorder (Walton & Baker, 2017). One study examined the experience of inpatient mental health services in an adult substance use treatment facility. However, our search did not yield any research that has specifically examined TGNC persons' experiences on an inpatient mental health/general psychiatry unit. This creates a gap in our understanding of TGNC persons' mental healthcare experiences and needs. Quality of inpatient mental healthcare is linked with hospital readmission rates, clinical improvement, treatment adherence, and patient prognosis (Akerele et al., 2017; Moss et al., 2014). Therefore, it is imperative to advance our understanding of how inpatient mental health care is experienced (positively and/or negatively) by TGNC populations as an important step in efforts to improve inpatient treatment efficacy and reduce mental health treatment disparities.

Findings from this integrative review suggest mental HCP, staff, and student training are necessary. Participants in all reviewed studies reported that provider and staff knowledge and sensitivity were important factors in their overall treatment experience. TGNC persons often found themselves in the position of needing to educate their provider, which some felt diminished their treatment experiences.

TGNC persons identify welcoming environments as a facilitator of their mental health treatment success, and accordingly benefit from inclusive, culturally competent practice. Several suggestions for TGNC-welcoming environments emerged from participant comments (Table 2). An important component of creating a welcoming environment includes appropriate assignment based on gender identity; that is, identifying men were assigned to male rooms and identifying women were assigned to female rooms. As rooming and cohort decisions carry potential safety implications for patients, this component of inpatient mental healthcare is worthy of further study to promote the provision on basic safety measure on care units.

However, TGNC persons also identify unwelcoming and/or untrained provider and staff behavior as a barrier to treatment. It is therefore clear that enhanced training in TGNC-affirming care would be beneficial to TGNC patients. This is supported by evidence that HCPs report feeling underprepared to serve TGNC people (Carabez et al., 2016), and that TGNC persons' experiences of stigma and discrimination within health systems is associated with HCP behaviors and institutional policies/practices (Rounds, Burns McGrath, & Walsh, 2013).

Moreover, there is some evidence from one of the articles reviewed that TGNC persons base their care decisions, in part, on whether they or their peers have had negative or positive experiences with that provider in the past (Shipherd et al., 2010). This is consistent with marketing science, which acknowledges that consumer-to-consumer word of mouth communication is a powerful determinant of consumer behaviors (Chae, Stephen, Bart, & Yao, 2016). This demonstrates that word of mouth may play a significant role in this population's decisions regarding care and adds an additional urgency for providers to enhance delivery of culturally competent care.

Two articles included in this literature review address differences in treatment experiences between white and non-white TGNC persons. TGNC persons of color experienced more enacted stigma and found it difficult to receive care that acknowledged all aspects of their multiple minority status. Participants of color felt their mental HCP "did not inquire about, or understand, their experiences of holding multiple marginalized identities" (McCullough et al., 2017, p. 431). Quantitative data, though limited, also support this finding. Importantly, there is evidence to suggest that Latino TGNC persons experience the most widespread discrimination among all groups studied. This finding supports what is already known about mental health and access disparities among people of color. Mental health care disparities are already more

pronounced than other health disparities among racial and ethnic minority populations and mental illness remains one of the most pressing health burdens for minority populations (Dankwa-Mullan, Rhee, & Williams, 2010). As compared to people who identify as white non-Hispanic, people who identify as black, non-white Hispanic, or Asian experience significant disparities in three measure of mental health access – general mental health care access, outpatient mental health care access, and prescription medication access (Le Cook et al., 2017).

To promote health equity, further research into treatment disparities and/or differing experiences of treatment among persons who are of multiple minority status should be a priority. Mental HCPs must work to improve their cultural competence through education and training, including asking clients directly how they understand and experience their multiple minority status and not assuming a client's gender identity is of greater relevance than other identities (McCullough et al., 2017). Intersectional insensitivity warrants immediate attention from health researchers and providers, as non-white persons and TGNC persons already individually experience pronounced mental health disparities. Future research is needed to identify and address disparities experienced by people who identify as both a gender and racial/ethnic minority.

Lastly, a multidisciplinary lens is imperative to make a comprehensive impact on health outcomes. To date, the nursing discipline has remained largely absent from the ongoing dialogue within the healthcare system regarding strategies for developing HCPs' cultural competence and inclusivity in providing TGNC care (Merryfeather & Bruce, 2014). Among the articles retrieved for this review, none was authored by nurses. Current literature reveals that SGM content is inconsistently included in nursing education (Sung & Lin, 2013) and that nursing faculty feel underprepared to present SGM content in their classes (Lim, Johnson, & Eliason, 2015). Since

social justice is a core value in nursing (Grace & Willis, 2012), nurse scientists have an opportunity and indeed an obligation to contribute to the emerging body of knowledge in matters pertinent to TGNC patients. Moreover, nurse leaders and nurse educators have a responsibility to train a workforce that is prepared to implement culturally competent nursing care with patients of diverse gender identities.

Limitations

Limitations of this literature review include the reliance on the selected search terms for article retrieval, the effectiveness of the inclusion/exclusion criteria as previously defined, and the appropriateness of the databases selected for computerized searches. Although every attempt to capture relevant literature was made, such limitations (inconsistent search terminology and indexing problems) can reduce the articles yielded to only about 50% of actual articles meeting search criteria (Whittemore & Knafl, 2005). Thus, some existing knowledge may have been unintentionally omitted from this integrative review despite concerted attempts to capture all relevant material.

Several of the studies' methods utilized a convenience sampling process. In some cases, data collection was done in settings that may not fully represent the population; the settings were likely disproportionately skewed toward visible, proactive members of the TGNC community (i.e. transgender conferences) (Austin & Goodman, 2018; Benson, 2013; Shipherd et al., 2010). Several of the articles reviewed reported low racial, economic, and/or educational diversity among the samples (Austin & Goodman, 2018; Benson, 2013; Lyons et al., 2015; McCullough et al., 2017). The geographic settings pose additional limitations to the generalizability of the results, as some samples were collected in resource-rich environments.

Three of the studies included in this review reported a limitation of incorrect use of language. In one article, the authors noted that their survey used complex language that might not be accessible to people with low literacy levels (Kattari et al., 2017). Two other articles' authors noted that they developed study materials that used vague or incorrect gender terminology (Austin & Goodman, 2018; Benson, 2013). This may have had the unintended consequence of eliminating potential participants who either didn't understand study language due to its complexity, or who did not participate because they did not identify with the gender terminologies used in study materials. Future research should be conducted by investigators who utilize the most current language and terminologies related to gender identity, as this may enhance recruitment efforts and increase generalizability of results.

These factors collectively reduce the generalizability of the results disseminated. However, this review brings to light important directions for future nursing research, HCP training programs, and healthcare quality improvement.

Conclusion

TGNC persons experience significant mental health disparities. Despite the documented presence of such disparities, there is little existing representation of TGNC persons' mental healthcare experiences in the literature. Findings from this review highlight key health-facilitating and health-preventing factors. Interventions should focus on training of providers and staff to promote inclusive mental health services to TGNC persons. Practice settings and health systems should be examined for environmental cues to inclusivity. Future research is necessary to fully understand the unique experiences of TGNC persons seeking mental health services, particularly in inpatient mental health settings and among TGNC persons of diverse racial and ethnic groups.

Figure 1. PRIMSA diagram

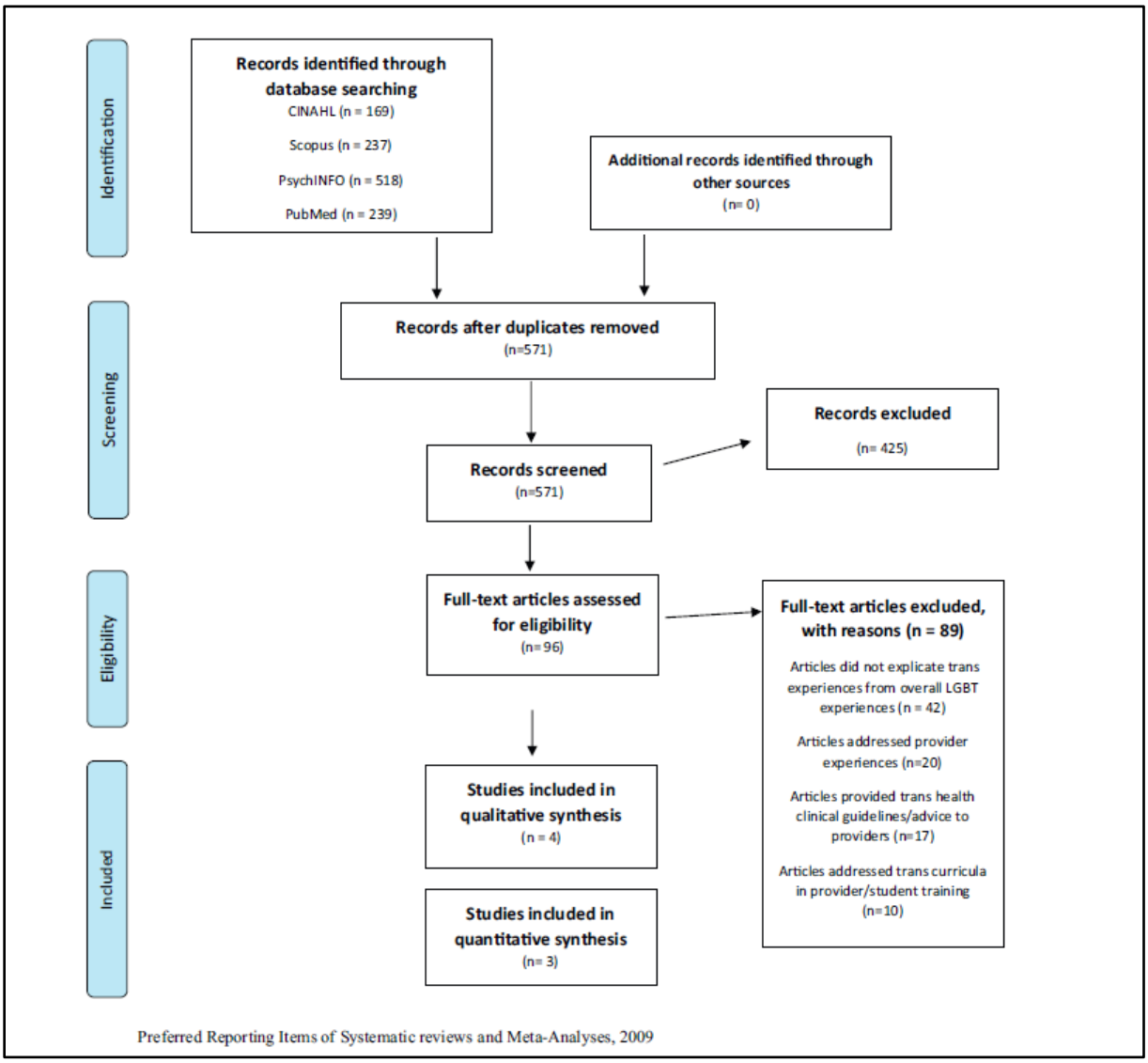

Table 1: Results summary

Author and Date	Evidence Type, Level, and Quality	Sample, Setting	Results	Findings That Help Answer the EBP Question	Limitations
Kattari, Walls, Whitfield, & Langenderfer Magruder, 2017	Quantitative Level of evidence: III Quality rating: A	• TGNC persons aged 18-98 • Random convenience sample using various electronic engagement strategies • n = 6451 • Self-report as TGNC • National sample	• Key racial and ethnic differences in experiences of discrimination in mental health care contexts	Differences in treatment in: • Mental health centers • Drug treatment programs • Domestic violence shelters • Rape crisis centers	• Single-measure items for complex concepts • Secondary analysis • Complex survey language noted by authors
Shipherd, Green, & Abramovitz, 2010	Quantitative Level of evidence: III Quality rating: B	• TGNC persons aged 22-79 attending a transgender conference • n = 130 • Self-report as TGNC and consumers of mental health services	Five results themes identified: • Cost • Bad experiences • Fear or dislike of treatment aspects • Stigma concerns • Time limitations	• Privacy concerns • Being seen as weak or broken • Prior bad experiences with MH services • Fear of hospitalization • Don't like talking about personal life	• Self-reporting measures in survey • No comparison sample • Sampling bias (attending conference)
Austin & Goodman, 2018	Quantitative Level of evidence: III Quality rating: B	• TGNC persons over age 18 attending a transgender conference • n = 65 • Self-report as TGNC and consumers of mental health services •	Themes identified: • Supportive • Knowledgeable • Trustworthy • Safety in care	• Importance of safe space • High level of trust in providers • Difficulty in accessing a trans-friendly provider	• Findings do not represent the diversity of experiences of all TGNC people • Low ethnic and educational diversity • Author reports using vague gender terms in study materials, thus limiting analysis by specific gender identity
Benson, 2013	Qualitative Level of evidence: III Quality rating: B	• TGNC persons aged 24-57 attending a transgender conference • Semi-structured interview • n = 7 • Self-report as TGNC and consumers of mental health services	Four results themes identified: • Purposes for seeking mental health services • Problems in practice • Therapist reputation • Transgender affirmative therapy	• Lack of provider training • Experiences of being stereotyped • Financial concerns • Importance of allies • Importance of affirmation and celebration of identity	• Author reports using incorrect gender terms in study materials • Low ethnic, educational, and socioeconomic diversity
McCullough, Dispenza, Parker, Viehl, Chang, & Murphy, 2017	Qualitative Level of evidence: III Quality rating: B	• TGNC persons aged 21-54 • Random convenience sample using various electronic engagement strategies • Semi-structured interview • n = 13 • Self-report as TGNC and consumers of mental health services	Four results themes identified: • Mental health provider identity • Transaffirmative approach • Transnegative approach • Support system beyond	• Mental health provider demographic identity • Transaffirmative care • Therapeutic alignment • Advocacy • Lack of knowledge	• Findings do not represent the diversity of experiences of all TGNC people • Disproportionately male-identifying sample

			counseling	• Experiential invalidations • Insensitivity	• Low educational diversity • Self-selected sample
Elder, 2016	Qualitative Level of evidence: III Quality rating: B	• TGNC persons aged 60-83 • n = 10 • Semi-structured interview • Participants recruited online have received "at least one significant psychotherapeutic experience" • Self-report as TGNC and consumers of mental health services	Ten results themes identified. Those addressing EBP question are: • Transaffirmative and healing experiences in therapy • Negative or transphobic experiences in therapy • Positive changes in the way therapy is conducted • Discrimination, harassment, and abuse • Recommendations to TGNC individuals seeking therapy • Recommendations to providers	• Experiences in therapy • Life experiences • Recommendations for providers	• Findings do not represent the diversity of experiences of all older TGNC people • Data not generalizable to younger TGNC people • Not a random sample • Participants live in a resource-rich health care region • Primary researcher conducted all coding of transcripts
Lyons, Shannon, Pierre, Small, Krusi, & Kerr, 2015	Qualitative Level of evidence: III Quality rating: B	• TGNC persons aged 24-47 • n = 34 • Semi-structured interview • Participants recruited from three open prospective cohorts of drug users and one open prospective cohort of sex workers • Self-report as TGNC and having exchanged sex for money or having used illicit drugs	Themes identified: • Social rejection, harassment, and violence as enacted stigma • Transphobia and felt stigma • Trans friendly and inclusive treatment experiences	• Experiences with other patients • Discrimination in treatment facilities • Sexual violence • Feeling of being "a disturbance" • Feeling unsafe in residential treatment settings • Experiences of respect and acceptance from staff	• Findings do not represent the diversity of experiences of all TGNC people • Low ethnic diversity • No member checking • Applicable only to substance use treatment facilities

Table 2. Components of inclusive environments

- TGNC-affirming signage in prominent areas
- Gender-neutral bathroom facilities
- Provider and staff training in culturally competent TGNC care
- Forms and documents that allow people to express their preferred name, gender, and pronouns
- Provider advocacy on behalf of patient
- Appropriate staff response when enacted stigma is experienced
- Direct discussion of issues related to race and gender with TGNC persons of color
- Gender sensitivity in rooming/cohorting decisions

References

Refer to Cumulative Reference List

Chapter Four:

Transgender and gender diverse persons' inpatient mental health/substance treatment experiences: a qualitative descriptive study

Bradley Patrick White MSN, RN, CNE
Nadia Abuelezam, ScD
Jane Flanagan PhD, RN, AHN-BC, ANP-BC, FAAN
Susan Kelly-Weeder, PhD, FNP-BC, FAANP, FAAN
Holly B. Fontenot, PhD, RN/NP, FAAN

This manuscript replaces original research component of the traditional dissertation and is submitted to satisfy the data-based requirement of the manuscript-style dissertation. Bradley P. White will be the primary author on this manuscript; contributions include conceptualization of study, design of interview guide, recruitment, conducting study interviews, data analysis, and drafting of manuscript. Dr. Abuelezam will be the second author; contributions included contributions included conceptualization of study, design of interview guide, and critical appraisal/substantial contributions towards manuscript drafts. Dr. Flanagan will be the third author; contributions included conceptualization of study, design of interview guide, and critical appraisal/substantial contributions towards manuscript drafts. Dr. Kelly-Weeder will be the fourth author; contributions included critical appraisal/substantial contributions towards manuscript drafts, and directly supervising the completion of the study. Dr. Fontenot will be the fifth author; contributions included directly supervising the conceptualization of the study, design of interview guide, recruitment, interview processes, data analysis, and critical appraisal/substantial contributions towards manuscript drafts. This manuscript is in draft form and the target journal is Journal of Mental Health, a peer-reviewed journal with an impact factor of 2.604 (2018). Journal of Mental Health publishes original research papers on

important developments in the treatment and care in the field of mental health and that will have a direct impact on service provision and clinical practice. The journal is intended for all consumers and providers of mental health services. This manuscript represents a significant contribution to the dissertation work.

Introduction

Transgender gender diverse (TGGD) adults are among the most vulnerable populations in the United States (U.S) (Poteat, German, & Kerrigan, 2013; Stroumsa, 2014) and are at increased risk for suicidality, depression, anxiety, substance use disorders, and body dysmorphia than both the general adult population and the lesbian, gay, and bisexual (LGB) adult population (Institute of Medicine, 2012; Sevelius, Keatley, Calma, & Arnold, 2016; Su et al., 2016). Health research acknowledges several societal factors (including significant and chronic stigma and discrimination) that directly contribute to these negative health sequelae among TGGD persons, including high rates of stigma, bullying, violence, victimization, home displacement, and murder (Watson et al., 2019). These often occur in families, workplaces, schools, within families, and in health care environments (Reisner, Greytak, Parsons, & Ybarra, 2015).

It has been demonstrated that inadequate access to gender-affirming healthcare (GAHC) is a contributing factor to negative mental health outcomes (American Medical Association, 2019). Increased access to GAHC is associated with reduced symptoms of gender dysphoria, improved mental health, and enhanced sense of well-being (Hembree et al., 2017; Olson-Kennedy, Warus, Okonta, Belzer, & Clark, 2018). Additionally, TGGD persons with access to GAHC have significantly lower rates of suicidality than TGGD persons without such access (Allen, Watson, Egan, & Moser, 2019).

There is evidence to suggest healthcare providers are not currently meeting the needs of TGGD persons. One-third (33%) of TGGD persons in the U.S. report they have delayed or avoided preventative care due to health provider discrimination (Sevelius, Keatley, Calma, & Arnold, 2016). Access to high-quality comprehensive sexual services health services (a key

determinant of mental health) for TGGD persons across the lifespan is variable and inconsistent (Fontenot et al., 2020).

Mental health disparities most common among TGGD persons (e.g. suicidality, depression, anxiety, substance use disorder) may require an inpatient level of care, if experienced acutely. Accordingly, TGGD individuals may have a greater need for inpatient mental health and/or substance treatment services as compared to the general population (Walton & Baker, 2017). Very little has been disseminated regarding the inpatient mental health and substance treatment services of TGGD persons (White & Fontenot, 2019). However, it is acknowledged that GAHC is a key determinant in TGGD persons' health outcomes (Puckett et al., 2018). There is therefore a gap in current knowledge regarding how inpatient mental health and substance treatment services are experienced (positively and/or negatively) by TGGD adults.

While there are many distinctions between clients with mental illness and clients with substance use disorder warranting separate inquires, this study sought to understand the experiences of TGGD people who have been admitted for either a mental health or substance use concern. Each of these diagnostic areas contribute substantively and uniquely to the biobehavioral wellbeing of clients (Videbeck, 2019) and thus we would be remiss in excluding one. Moreover, dual diagnosis is common and there is often overlap between clients in these two distinct practice settings (Rossi et al., 2016). The American Psychiatric Nurses Association views mental health and substance abuse as commonly co-occurring and endorses substance abuse nursing as a component of mental health nursing (American Psychiatric Nurses Association, 2015). We therefore sought to better understand the both the subjective inpatient mental health and/or substance treatment experiences of TGGD persons. New research may illuminate best practices and identify opportunities for quality improvement in the

implementation of gender-affirming mental healthcare, thus potentially contributing to improvements in treatment efficacy, mental health disparities, and population health outcomes.

Study Aims

The aims of this study are to :

1. Understand the inpatient mental health and/or substance treatment experiences of TGGD individuals.
2. Identify and characterize facilitators of/barriers to gender-affirming care in inpatient mental health and/or substance treatment settings.

Theoretical Framework

The guiding framework for this study is Minority Stress Theory (MST). This theory suggests that external (distal) and internal (proximal) stressors experienced by members of marginalized groups have negative effects on individual and population mental health (Meyer, 1995; Meyer, 2003). In the U.S., stigma-related stress for TGGD persons is high, surpassing levels experienced by both the general population and cisgender lesbian, gay, and bisexual (LBG) persons. It is well-documented that chronic and prolonged exposure to incidents of stigma and discrimination are known to negatively affect the mental health of those experiencing them (White Hughto, Reisner, & Pachankis, 2015). In this study the MST concepts of distal stress factors, proximal stress factors, resiliency factors (Meyer, 1995; Meyer, 2003) were be used to guide data analysis to capture TGGD participants' descriptions of GAHC during inpatient admission for mental health and/or substance abuse treatment.

Methods

Research Design

The study used a qualitative descriptive design using a directed (deductive) content analysis approach as described by Hsieh and Shannon (2005) and Potter and Levine-Donnerstein (1999). Some theories and prior research do exist in the area of TGGD mental health, but further description of the phenomenon is required to enhance existing interventions, identify new interventions, and work towards enhanced population health through measurable outcomes and evaluation. This study could validate and extend MST concepts of proximal stress, distal stress, resiliency factors, and could potentially identify new relationships among these MST concepts.

Researcher characteristics and reflexivity

I am a registered nurse with practice experience primarily in mental health settings. Throughout my career, I have been directly involved in the care of many TGGD clients being treated for active mental health and substance abuse diagnoses. In my clinical practice I notice that TGGD clients report and characterize many types of daily societal stigma, including in healthcare. I have observed this with my own eyes as these clients interact with others in the treatment setting. However, in my experience TGGD clients also usually have incredible resiliency and coping strength. This tends to be enhanced when a client has a robust support system, inclusive health providers, and access to resources.

It is with all these factors in mind that the theoretical framework for this study, MST, was selected. MST recognizes that health outcomes are affected by the presence and severity of stigma (proximal and distal factors) and the level of support and coping strength (resiliency factors). Specifically, SGM and TGGD persons may experience both distal stressors (via enacted stigma) and/or enhanced resilience (through enhanced coping). A qualitative descriptive

approach using deductive content analysis was selected for this study, as it is considered an appropriate approach when there is little research in an area of inquiry and when using a theoretical approach to guide the analysis (Hsieh & Shannon, 2005).

Context

TGGD-identifying adults aged 18 or older who have been admitted to an inpatient mental health and/or or substance treatment unit in the U.S. within the last five years were eligible for participation in this study. Social media recruitment (SMR) was utilized to recruit prospective participants via a study-related Instagram profile. SMR has been shown to effectively engage hard-to-reach, hidden populations in research (Moreno, Goniu, Moreno, & Diekema, 2013). SMR has also been effective when recruiting participants with specific medical and/or mental health conditions (Eysenback et al., 2016). Additionally, SMR allows for a larger sampling frame than local engagement and may yield more diversity than local in-person engagement strategies (e.g. more geographic diversity [as people may live in any part of the U.S.] and health access diversity [Massachusetts is a state with high health access]).

Sampling strategy

To recruit participants into the study, a social media profile for the study was created. To gain profile presence the team occasionally posted articles/headlines on TGGD health/mental health and related disparities. An interaction campaign by the researcher (consisting of liking others' posts, re-posting others' posts, tagging profiles, and use of relevant hashtags) occurred with several social media profiles dedicated to TGGD health. Following the brief interaction campaign, the study's recruitment materials (and link to study) were posted to the social media profile (Appendix 1). Prospective participants who clicked on the study link were directed to the landing page containing the eligibility screener and informed consent questionnaire (Appendix

2). Upon completing the eligibility screener and informed consent questionnaire, consented participants were linked to a contact information questionnaire (Appendix 3). The research team contacted participants via their preferred method (phone, email, or text message) to schedule the date/time of the study interview and to subsequently confirm the interview two days before the scheduled meeting (Appendix 4). Participants were sent a link to attend the interview via a secure Zoom link.

Ethical issues pertaining to human subjects

The study was reviewed and approved by the Institutional Review Board where this study originated. Study procedures included several efforts to conduct ethical research. Regarding informed consent procedures, participants provided informed consent via a secure study landing page. Participants were sent electronic copies of their informed consent document and a confirmation of the study interview date/time prior to the interview. Questions were encouraged from prospective participants at any point during the interview. Informed consent materials and the purpose of the study were again reviewed before interviews began; participants were asked if they had questions related to the study, their privacy, and informed consent.

Because of the potential vulnerability of this population, specific measures recommended by the American Psychiatric Association's (APA) Task Force on Research Ethics were utilized to ensure psychological well-being of participants (Appelbaum & Roberts, 2006). These measures included a clear explanation of potential risk and benefits, and clear plans to address any participant stress or discomfort (including an exacerbation of mental health symptoms). During consent procedures participants were informed that the interview may evoke emotions and memories related to their mental healthcare and were explicitly asked whether they felt they were prepared to experience those emotions and memories at the time of interview. Although

ultimately not needed during interviews, a plan was developed to access urgent care depending on level of need. In keeping with APA recommendations to develop and maintain a safety plan, the emergency plan called for any participant that had an acute need (with an imminent risk to participant or others), to be connected with care. Participants were provided with a $50 gift card stipend for their time.

Data collection methods, instruments, and technologies

A semi-structured one-on-one interview guide with open-ended questions was developed for this study (Appendix 5). Question development was informed by MST concepts of proximal stress, distal stress, and resiliency factors (Meyer, 1995; Meyer, 2003) as well as findings in relevant health literature (White & Fontenot, 2019). The interview guide contained questions related to participants' perceptions of the quality of patient care as related to their gender during their past hospitalization experiences; their experiences and relationships with staff and other clients (patients); and their perceptions of how gender-affirming care was or was not provided, and how it could be improved. Standard demographic questions were elicited verbally at the conclusion of the interview (Appendix 5). The virtual interviews were audio recorded only; the video recording function of the platform was disabled to protect privacy. Audio recordings were uploaded to NVivo Transcription for verbatim transcription.

Units of study

Of the 19 total people who visited the study landing page and began the eligibility screener and informed consent survey, eleven people consented to be interviewed and provided contact information to facilitate scheduling an interview. All 11 participant interviews occurred as scheduled.

Data processing and analysis

This study followed directed (deductive) content analysis guidelines as described by Hsieh and Shannon (2005). The researcher concurrently listened to interview audio recordings and read interview transcripts to ensure accuracy and become more immersed in data. Transcript data were analyzed using deductive content analysis and NVivo coding software. The structured process used MST concepts of *proximal stress factors*, *distal stress factors*, and *resiliency factors* to create initial coding categories and subsequent operational definitions. A first round of data coding was conducted with the broad goal of highlighting statements that were relevant to the research question, even if peripherally (e.g. societal stigma experienced prior to admission). The second round of coding subcategorized all content coded in the first round using the coding themes of *proximal stress factors*, *distal stress factors*, and *resiliency factors.* Any remaining statements (those identified in the first round but not further coded in the second round due to lack of relevance) were coded into a final category for further analysis.

Techniques to enhance trustworthiness

Several techniques were included to enhance trustworthiness of findings. First, data analysis included a first-round coding of transcripts without regard to the MST concepts used in the second round of coding. This enhances trustworthiness through ensuring unbiased identification of relevant text (Hsieh & Shannon, 2005). Second, the researcher has had a prolonged engagement (Lincoln & Guba, 1985) with this area of inquiry through clinical practice at an adolescent health center, an infectious disease outpatient clinic at an academic medical center, an inpatient community substance treatment program, and an inpatient psychiatric nurse at an academic medical center. The presence of TGGD clients in these contexts has been consistent, allowing the researcher to have an informed understanding of the phenomenon. Third, the research team has published several peer-reviewed articles related to TGGD health,

indicating mindful attention to and prolonged engagement in a program of research. Third, triangulation of sources (Lincoln & Guba, 1985) was conducted to compare findings with other sources that have examined TGGD persons' perceptions of health. Fourth, peer debriefing occurred on two occasions; uninvolved peers in nursing practice and nursing scholarship reviewed the transcripts and coding data to support or challenge assumptions made in the analysis process (Lincoln & Guba, 1985). Fifth, informal member checking (Lincoln & Guba, 1985) occurred when two participants expressed interest in providing feedback on the finished product. These two participants read through the coded themes document (codebook); they affirmed the content as being representative of their interview statements. Lastly, reflexive memos(Lincoln & Guba, 1985) were used by the researcher to document decisions made to study design or methods, and to prepare for/debrief interviews through self-reflection and self-directed feedback.

Results

Demographics

Eleven participants completed the study interview and were included in analysis. Interviews lasted 40 minutes on average. The interview guide was easily understood by participants and allowed for a natural flow during the interview. Participants ranged in age from 19 to 38 with a mean age of 25.9 years. Reasons for psychiatric admission included acute suicidality (N=5); 'panic attacks' or 'bad anxiety' (N=3); bipolar mania (N=2); treatment for 'addiction' (N=1); and 'an anger problem' (N=1). More specific demographic information in terms of race, ethnicity, income status, health insurance coverage, place of residence and living arrangements are provided in Table 4.1.

Themes identified

Data analysis was conducted deductively within an MST framework (previously described). In total, four themes were identified to describe participants' experiences in inpatient mental health and substance treatment settings. Three themes were created based on MST concepts (1. '*Don't ask, don't tell'* [distal stress factors]; 2. '*The problem doesn't always go away'* [proximal stress factors]; and 3. *'People who see me'* [resiliency factors]) while one additional theme (4. *'Nurses were around all the time but mostly stayed behind the desk'* [missed opportunities for nursing support]) was created based on the notable absence of nursing in participants' recollections during interviews and findings from previous health literature (Bauer et al., 2020).

1. 'Don't ask, don't tell': Distal stress factors

Although far more participant comments were made regarding affirming provider behaviors, several instances of stigmatizing healthcare experiences were also reported. Since all relevant instances of externally perpetrated stigma may be considered distal stressors (Meyer, 1995; Meyer, 2003), multiple client statements illuminating experiences of stigma in non-healthcare settings were also included in analysis.

Participants told stories of incorrect name and pronoun usage by non-clinical staff (n = 8), other clients in the inpatient community milieu (n = 3), and clinical staff (n =1). Efforts to acknowledge and redress the mistakes were varied. When an admitting psychiatry provider used an incorrect pronoun during their initial meeting, one participant reported "you could tell by his look he knew" and subsequently apologized for the error. However, this was not always the case. One participant reported that an individual (non-clinical staff) would visit the unit daily as part of their work responsibilities, and on one occasion used an incorrect pronoun ("he") when referring

to the client. Another client close-by on the unit interjected by stating "she prefers she," at which point the staff person disengaged from the conversation and, according to the participant, "he didn't so much as look in my direction again." Six participants disclosed they were called a name other than their preferred name (usually the name assigned at birth) during their admission. Three participants said they perceived that other clients on the unit were unwelcoming, and one participant described being verbally assaulted. The participant was called a slur by another client, but "that dude was going through a lot and he was yelling at everyone … the nurses took care of it, they came right over and took care of him" (P3).

More commonly than overt acts of stigma, participants described instances in which their gender identity was not discussed despite indications that it would be a relevant area to address. One participant, who was held in the emergency department for two days pending inpatient mental health bed availability, said "in the emergency (department) nobody even said anything about (my gender identity), it wasn't acknowledged. I was there trying to kill myself and nobody mentions what's probably the biggest reason I did that." Another client said their gender identity was often an unspoken subject, but one she sensed was on the minds of her providers – "it's lowkey like 'don't ask, don't tell'". The client described her subsequent hesitancy to be vulnerable and candid with such providers, although she noted there were several affirming provider interactions during her hospitalization (described in Theme 3). After discharge, three participants found their new outpatient providers to be "awkward" and "caught off guard" by their gender identity.

Seven participants reported experiences of homelessness or precarious housing in their life, with two participants currently experiencing homelessness. One participant noted that homelessness has been a way of life since adolescence, when her parents forced her to leave

home – "I'm saying, it's been all over the place. Some nights in a shelter, sometimes people's cars … I slept on my cousin's couch for two years". Another participant recalled episodic homelessness throughout life, stating "When I was in high school I had to leave home for a little while because my dad and I kept fighting so I stayed with a friend for two months, and then another friend for two months. And another time I stayed with my cousin for a month when I lost my job." Another participant noted that, although hospitalization was not an event that caused homelessness, she once needed to move from her apartment because the owner of her small apartment building was "just really repugnant, like you can tell he hated me". Participants who experienced homelessness said that the experiences made them question their value and self-worth, exacerbated depressive episodes, and increased their overall anxiety levels.

2. 'The problem doesn't always go away': Proximal stress factors

Seven participants described difficulties with the transition from the inpatient care to the outpatient care . During inpatient care, participants reported they worked on recovery and coping skills during therapeutic groups but "that sort of doesn't happen IRL (in real life) … there isn't a group of people waiting there to talk with me when I get home." Two participants stated they had no family or social support after discharge, making recovery seem more difficult to them. One participant reported being admitted to a mental health unit a second time, with the second admission occurring about three months after the first discharge. The participant shared that, after discharge, "at the end of the day I'm still struggling most of the time and honestly didn't have a really good place to go back to … it felt like the old problems were back but delayed."

Five participants described subtle ways they edit themselves (or restrict a full expression of gender identity) around healthcare providers, family members, friends, and society in general. One participant, speaking of healthcare providers, stated "if they're not asking about (gender

identity), I can pick up on it and I do have to say I hold back. It's sort like, I can tell it's not important to them so I don't feel comfortable bringing it up." One participant, displaced from her parents' house as a teenager, said she could only return if "I kept pretty quiet about the real me." One participant spoke of being accustomed to "the random double takes that people do all the time" after seeing them. And speaking of societal interactions in general, one participant noted "I don't really talk a lot about myself or trying to draw attention to myself because I'm not really wanting to talk about it (gender identity) all the time."

3. 'People who see me' (Resiliency factors)

All 11 participants in the study described various welcoming and affirming aspects of inpatient mental health/substance treatment experiences. These affirming aspects of care were generally related to providers' interpersonal skills and attitude (n = 8); directly addressing and validating their experience as a TGGD person (n = 7); conscientious efforts to provide privacy and safety (n = 7); support from other clients receiving treatment (n = 6); and staff/provider response to stigmatizing behaviors of others (n = 5).

Eight participants said they had providers that treated them kindly, displayed empathy, and actively listened during conversations. Participants' descriptors of providers also included "woke, "very capable and kind," and "welcoming." As one participant, hospitalized for depression, described, "you always sort of know when someone is half paying attention, and I didn't get that there." This participant reported that they subsequently trusted the referrals made for post-discharge care because of their providers' authenticity. Another participant, hospitalized for substance treatment, said that they appreciated the "nonjudgmental" nature of their treatment providers "whether we talked about my drug use or whether we talked about my private life." When probed to elaborate on the provider qualities that were nonjudgmental, the participant

stated "Like my psychiatrist … he got me. He listened and never seems to be judging … and he also asked me about how being transfeminine factors into everything going on in my life right now and what could he do to support me." A direct and gender-affirming provider approach was observed by another participant, who stated "(the provider) was like really direct about it and I like that. He asked how he could support me and I didn't really have an answer for him. I think him asking that question was probably the best thing he could have done." A participant favorably compared their treatment in a mental health setting to a time they were admitted for an emergency appendectomy: "When I had surgery, no one really asked about (gender identity) or brought it up I don't think … my psychiatrist wanted to discuss all of it."

Indeed, multiple participants described providers who directly addressed their gender identity, and proactively discussed the relationship between the stress of living as a TGGD person in the U.S. and mental health symptoms. One participant, hospitalized for a series of panic attacks, said "when the nurse and I were talking about anxiety, she said 'how could you not be anxious when you face daily struggles as a trans person?' … it was an aha moment … (the nurse) helped me see that anxiety is normal given my life, and I shouldn't push (anxiety) away … I have a right to be anxious". In total, seven participants reported that a provider proactively brought up societal stigma as a factor influencing TGGD persons' mental health symptoms and created conversations to address participants' perspectives on this.

One participant described the admissions process when she was hospitalized for suicidality. After transferring from an external organization's emergency department to the inpatient mental health unit, the participant described the standard body and belongings safety screening process - "After the ambulance dropped me off … two women came in to check to make sure I was safe … (and stayed) when I needed to change my clothes. I appreciated the

privacy (from male staff)" Another participant noted that they had a private room "even though I don't know if anyone else did" and wondered whether that was "a good or a bad thing."

Participants did not always recall the role of various providers they interacted with. When probed, one participant could recall a specific nurse who stood out (as previously described validating the client's anxiety). However, participants overall reported that when providers were comfortable discussing gender and acknowledged mistakes when they occurred, it contributed towards a welcoming and accepting experience for them.

Lastly, several participants described the impact of connecting with peers, either on the mental health unit or in daily life. Two participants in this study disclosed they were roommates, and one had referred the other to the study social media profile. One of the roommate participants noted the value of enhanced resiliency and coping through the support of others, stating "I have a roommate who's also an emerging woman like me and so we have gotten really tight. I am learning all the time about accepting myself and haven't been too depressed about it either (laughs)." She went further, stating "having a roommate who is going through the same thing as I am or at least something similar, it's been the best." One participant found emotional support and gained insight through their connection with another client on the mental health unit, stating "I really connected with one dude who just really listened well and was older and had a lot of perspective that I learned on."

4. 'Nurses were around all the time but mostly stayed behind the desk': Missed opportunities for nursing support

The brief final theme identified as part of this deductive content analysis was related to nursing presence and missed opportunities for support. As previously described as their "aha moment," one participant recollected an impactful conversation with a nurse regarding anxiety

wherein the nurse validated the participant's anxiety and pointed out the insidious effect of societal stigma on anxiety levels. Another client said the actions of a nursing assistant were instrumental in their eventual improvement: "an aid was encouraging me to get out of bed pretty much every time she came to check on me, so I did (get out of bed). I think being around other people was really good them because I started feeling better right after that." However, these were the only instances of participants recollecting a specific examples or anecdotes in which a nurse or nursing staff featured prominently. When specifically probed about whether any specific nurses stood out to them, most participants could not recollect such a nurse. In response to the nursing probe, one participant stated "the nurses were around all the time but mostly stayed behind the desk so (it's) really the nursing assistant you talked to most of the time. (Nursing assistants) seemed overworked to be honest with you but they were all very kind. They all rotated around, some of them I only saw once or twice … But I don't think I got to know anybody really well in terms of the nursing assistants and nurses."

Discussion

We conducted interviews with 11 TGGD participants who had been admitted to inpatient mental health and substance treatment settings. MST- and literature- informed deductive content analysis led to four themes. Three themes represented MST concepts of distal stress factors, proximal stress factors, and resiliency factors; the final theme of *missed opportunities for nursing support* represents statements of participants in this study and aligns with recent literature demonstrating nurses have been largely absent from interdisciplinary efforts to enhance TGGD population health (Bauer et al., 2020; Eliason, Dibble, & DeJoseph, 2010).

MST suggests healthcare settings and providers may serve as either distal stress factors or as resilience factors – or both (Meyer, 1995). Findings from this study support providers were both. Multiple clients recollected specific instances of gender affirmation by their attending provider, usually mentioned as the psychiatrist. Although all healthcare providers can play a pivotal role in the well-being of TGGD persons (White Hughto, Reisner, & Pachankis, 2015), in mental health settings the unique role and influence of the psychiatrist/therapist has been supported by the findings here. Participants had largely positive interactions with staff, but specifically recollected the affirming behaviors of their psychiatrist. This highlights the importance of provider awareness and implementation of gender-affirming care concepts and reiterates the need for all providers to assess their own preparedness in competently caring for TGGD persons and seek training to enhance knowledge and skills related to gender-affirming care (Videbeck, 2019). Effectively accomplishing this would reduce the likelihood of providers functioning as 'distal stress factors' and increase the likelihood they function as 'resiliency factors,' as posited in MST (Meyer 1995, Meyer, 2003).

Beyond the psychiatrist role, few participants made further distinction among provider type. Despite probing, study interviews revealed a general lack of memorable interactions with nurses. Some participants appeared to describe nurses and nursing assistants (milieu counselors) interchangeably, indicating milieu staff roles may not have always been clear to participants. Historically, nursing as a discipline has not been at the forefront of healthcare efforts to enhance TGGD population health (Bauer et al., 2020; Eliason, Dibble, & DeJoseph, 2010). One potential contributor is an under-prepared nursing workforce. Medical schools have done more to include TGGD content in their curricula, as approximately 65% of medical schools offer some level of TGGD-related education; 20% of schools that offer this education do so in voluntary courses

(Krisberg, 2018). Literature suggests there is no consensus regarding the inclusion/exclusion of TGGD curricula in schools of nursing, and undergraduate nursing students report inconsistent learning opportunities and a desire for further training in this area (Paradiso & Lally, 2018). However, ample existing research demonstrates nurses overwhelmingly would like to provide gender-affirming care (Paradiso & Lally, 2018). Barriers identified in the literature include non-standardized curricular delivery of gender-affirming care to nursing students (Sherman et al., 2021), nursing faculty feeling underprepared to teach such content (Lim, Johnson, & Eliason, 2015), and practicing nurses often feeling under-trained and under-resourced to effectively provide such care (Paradiso & Lally, 2018). It is imperative, therefore, that nursing academic institutions implement measures to mitigate these circumstances through efforts in nursing practice, education, research, and policy (Bauer et al., 2020).

As several participants in this study reported being mis-gendered and/or mis-named by staff resulting in feelings of stigmatization, this study supports that accurate sexual orientation/gender identity data collection is imperative. Inconsistent SOGI data collection is a persistent limitation for healthcare providers and scholars (McCann & Brown, 2018; Meerwijk & Sevelius, 2017) and has many implications for the advancement of effective population health delivery; client care is compromised when the vulnerability of the target population is not accurately identified as such (Donabedian 1988, 2005). All clients should be asked their preferred name, their sexual orientation, their gender identity, and their preferred pronouns; this data should be stored in electronic health records, updated as needed, and referred to frequently by providers.

Participants in this study found value in sharing their story with others (e.g. roommate, other clients), attending groups, and interacting with supportive staff. This supports the concept

of the healing structure of the therapeutic milieu (Videbeck, 2019), including efforts to create physical spaces that are welcoming and inclusive (White & Fontenot, 2019). As primary managers of the 24-hour therapeutic milieu, mental health nurses must lead efforts to display signs of inclusivity on the unit, educate staff, serve as models of compassionate professionalism, and create gender-inclusive individual and group therapeutic interventions. Although participants in this study did not indicate whether they noted inclusive images in the care settings, efforts should be made to include representative images on websites, milieu walls, brochures, and other literature. Other cues such as gender-neutral bathrooms, routine SOGI collection, and staff identification badges providing staff members' preferred pronouns would indicate to TGGD people that the health setting is a safe space and is prepared to provide gender-affirming care. Doing so would enhance the quality of TGGD persons' treatment experiences and would assert inpatient mental health treatment settings as a 'resiliency factor' as posited in MST (Meyer 1995, Meyer, 2003).

Participants also described specific concerns related to effective health maintenance after discharge, including a low perceived level of available support and discontent with the quality of the outpatient therapy provider. Literature shows that TGGD clients often face a lack of support in the community (White Hughto, Reisner, & Pachankis, 2015) and from mental health providers (Benson, 2013; Elder, 2016; White & Fontenot, 2020). One participant was readmitted to the mental health unit two months after their first admission. This is consistent with work that suggests readmission is a persistent problem in mental health care. High rates of readmissions in inpatient mental health care known, as a 'revolving door,' are a chronic and persistent problem since the mental health deinstitutionalization movement of the 1960s (Videbeck, 2019). Given that TGGD persons experience multiple population mental health disparities as previously

described, discharge planning should conscientiously address the increased risk TGGD persons and plan for robust post-discharge supportive services. When available, linkages to TGGD support services could enhance sense of community, reduce the risk of mental health readmission, and in turn function as a 'resiliency factor' (Meyer 1995, 2003)

Participants also described multiple instances of homelessness. This is consistent with existing literature that shows TGGD are at high risk of homelessness (Ashley, 2019), often resulting in increased risk behaviors such as sex work (Kattari & Begun, 2017). This has many implications for population health and wellbeing, and currently functions as a 'distal stress factor' for many TGGD persons. Care providers for the TGGD population should be aware of the prevalence of this problem and specifically assess TGGD clients' access to safe housing and refer to community organizations for housing support as indicated. Affirming housing services designed specifically for TGGD persons, although aspirational, would mitigate this (Shelton, 2015) and could assert safe, stable housing as a 'resiliency factor' (Meyer 1995; Meyer, 2003) for TGGD persons.

There were several limitations of this study. This study was originally designed to conduct participant recruitment through a network of participating mental health providers, However, recruitment and data collection occurred during the COVID-19 pandemic, thus jeopardizing participating providers' ability to continue participation. The recruitment strategy was adapted and pivoted to a digital one; ultimately, social media was used to recruit participants. Other recruitment strategies, e.g. word of mouth or provider referral as originally planned, may have yielded a higher sample size.

Despite an overall achievement of data saturation, it is likely that a larger sample size, more age, race and ethnically diverse population would have provided additional insights.

Relatively low representation of Black, Indigenous, and Persons of Color (BIPOC) participants limits the generalizability of findings. Moreover, the finding from Chapter 3 regarding intersectional identity was not fully elicited due to lack of participant comments in this domain. Participants lived mostly in Massachusetts and New York and thus results are not geographically representative of all care in the U.S. One participant was admitted for treatment of substance use disorder, thus reducing these findings' generalizability to substance treatment settings.

Implications

There are several implications for future work in this area. There is a paucity of work on the experience of TGGD who are hospitalized in the mental health setting across races, ethnicities, socioeconomic condition, religions, age or region of the US. Each of these factors alone may result in widely variable experiences and should be considered in future work with a larger, more diverse sample

Conclusion

TGGD persons are at disproportionate risk for experiencing multiple mental health events, such as suicidality and overnight hospitalization. Little is known about TGGD persons' inpatient mental health/substance treatment experiences. Semi-structured interview design and deductive content analysis were used to elicit and describe TGGD adults' inpatient mental health and substance treatment experiences. Eleven persons participated in the study, revealing both affirming and stigmatizing aspects of care, as well as experiences internal stress and self-doubt. Four thematic findings supported by MST (Meyer 1995; Meyer 2003) concepts and current literature (Bauer et al., 2020) were identified– 1) 'Don't ask, don't tell': Distal stress factors; 2) 'The problem doesn't always go away': Proximal stress factors; 3) 'People who see me':

Resiliency factors; and 4) 'Nurses were around all the time but mostly stayed behind the desk': Missed opportunities for nursing support. The findings from this work indicate that more must be done to create affirming, healing environments for TGGD people in health settings. Conscientious and specialized discharge planning from an acute psychiatric care setting to a community setting is indicated to serve to reduce hospital readmission, prevent home displacement, strengthen TGGD persons' internal coping, and improve access to community support.

Table 5.1: *Demographic characteristics*

Participant	Gender identity	Age	Race/ethnicity	History of homelessness	Current stable income	Current health insurance	State of residence	Setting of residence
1	Trans woman	22	'White'	Yes	No	Yes	Massachusetts	Suburban
2	Trans woman	26	'Mixed Brazilian'	Yes	Yes	Yes	Massachusetts	Suburban
3	Trans woman	31	'White'	Yes	Yes	Yes	New Jersey	Urban
4	Non-binary	19	'White'	No	Yes	Yes	Massachusetts	Urban
5	Trans woman	34	'White'	No	No	Yes	Massachusetts	Urban
6	Trans man	22	'Puerto Rican'	Yes	Yes	Yes	New York	Urban
7	Trans woman	24	'White'	Yes	Yes	Yes	Massachusetts	Urban
8	Trans man	30	'White'	No	No	Yes	New York	Urban
9	Non-binary	38	'Black'	Yes	No	Yes	New York	Urban
10	Gender fluid	20	'White'	Yes	Yes	Yes	Massachusetts	Urban
11	Trans woman	19	Persian	No	Yes	Yes	Ohio	Urban

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References

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Chapter V
Summary of the dissertation

Bradley Patrick White, MSN, RN, CNE
Boston College William F. Connell School of Nursing

Discussion

Stigma, in its many forms, is common in the lives of TGGD persons in U.S., including in healthcare settings (Austin & Goodman, 2018). MST suggests stigma, while not entirely causative, is linked to reduced health outcomes and wider health disparities. Indeed, TGGD persons currently experience multiple biobehavioral health disparities compared to cisgender persons. The most urgent of the mental health disparities is rate of suicide; more than 50% of TGGD persons in the U.S. will consider suicide in their lifetime, while roughly one-third will attempt to die by suicide (Herman, Brown, & Hass, 2019; James et al., 2016; McCann & Brown, 2018). MST further suggests that health outcomes are affected by one's internal coping skills and by level of support available from affirming others (Meyer, 1995; Meyer, 2003).

There is much we do not know regarding what types of stigma experienced by TGGD persons are most prevalent and most damaging and how health care providers, and mental health providers in particular, can provide affirming support and evidence-based interventions to mitigate population health disparities. The purpose of this manuscript-style dissertation was to: 1) to better understand the relationship between stigma/discrimination and SGM population health, and 2) to better understand the experiences of TGGD persons who receive mental health services. The research outlined here contributes to knowledge advancement towards the dissertation's above-stated purposes. Potential research inquiries have emerged from this process that will help healthcare providers become more knowledgeable and better prepared to meet the needs of this at-risk population through implementation of evidence-based health interventions.

This discussion provides an overview of dissertation findings as they relate to the theoretical framework (MST) concepts of distal stress factors, proximal stress factors, resiliency factors, and outcomes (Figure 5.1). Findings are summarized in the following areas: 1) TGGD Stigma: Examples and sequelae; and 2) Health care experiences of TGGD persons seeking care for mental health and/or substance use services. Following the discussion, future implications related to *nursing practice*, *nursing education*, *nursing scholarship*, and *nursing policy* will be addressed. Recommended next steps will be identified in each of the above-mentioned four nursing domains based on dissertation findings, the theoretical framework (MST), and other relevant health literature.

TGGD stigma: Examples and sequelae

In the U.S., stigma and discrimination are frequently experienced by TGGD people and present challenges in multiple aspects of life. Stigma has been previously shown to be perpetrated on TGGD people in political, social, religious, familial, and/or healthcare contexts (Institutes of Medicine, 2011; Poteat, German, & Kerrigan, 2013; Stroumsa, 2014). This dissertation's findings add to a growing body of literature highlighting the specific types of stigma encountered by TGGD persons and subsequent strategies to mitigate them. Specifically, this dissertation further articulated the presence of TGGD stigma in state-level public policy (Chapter Two), mental health treatment settings (Chapters Three and Four), and during inpatient hospitalization for mental health and substance treatment settings (Chapters Three and Four).

In Chapter Two of this dissertation, relationships between level of state LGBTQ inclusivity and self-reported mental health and risk behaviors of LGBTQ adults in the U.S were explored using a well-validated and robust sample. Many states have led the way with innovative

LGBTQ policies, while some states actively restrict LGBTQ inclusivity. An ecological secondary analysis of the BRFSS data set showed statistically significant relationships between LGBTQ persons' state of residence (and the state's level of LGBTQ inclusiveness, as evidenced by more than 50 relevant policy indicators) and self-reported mental health symptoms and risk behaviors of the LGBTQ persons who live there. Descriptive statistics, chi square tests, and regression model results indicated there are significant relationships between state level of inclusivity and general health, number of depressed days in the last month, smoking, and drinking. Results were consistent with MST; restrictive state policy environments were shown to function as a distal stress factor and inclusive state policy environments were shown to function as a resilience factor. These findings support previously published findings demonstrating that state policy environments affect the mental health of LGBTQ persons (Bialer & McIntosh, 2017).

In Chapter Three of this dissertation, integrative review results suggest that TGGD persons experience incidents of stigma and discrimination in mental health treatment settings. When participants shared sensitive personal information such as gender identity and past traumatic experiences, their providers often did not know how to respond or responded with non-therapeutic ways (Austin & Goodman, 2018). TGGD persons reported experiences of name-calling, social rejection, and harassment (including threats of sexual and physical violence) from other residents in inpatient substance treatment settings, and that staff "didn't know how to deal with it." (Lyons et al., 2015, p. 7). Some participants experienced subtle "experiential invalidations" from their providers (McCullough et al., 2017, p. 429), while others said their providers were actively "homophonic and transphobic" (Elder, 2016, p. 182) resulting in two instances in which a therapist refused treatment and was reluctant to write a letter for gender-

affirming medical/surgical care. These stigmatizing experiences were identified by participants as the primary reason they terminated care early (Lyons et al., 2015) and did not seek care at a time when they needed it (Shipherd, Green, & Abramovitz, 2010). When considering these findings within an MST framework, it becomes apparent that negative healthcare experiences once again assert themselves as distal stressors, in turn leading to reduced health engagement and unfulfilled health outcomes.

In Chapter Four, stigmatizing care experiences were reported. Eight participants reported that at least one provider used incorrect pronouns during their admission while six participants disclosed they were called a name other than their preferred name during their admission. Some people experienced discomfort around other clients, and one person was called a slur by another client. More than overtly stigmatizing acts, participants described instances in which their gender identity was not discussed despite indications that it would be a relevant area to address.

Experiences of TGGD persons seeking care for mental health and/or substance use services

The second aim of this dissertation was to better understand the experiences of TGGD persons who have sought care for mental health and/or substance abuse services. This aim was addressed through integrative literature review (Chapter Three) through original qualitative research (Chapter Four). Findings in those chapters suggest that TGGD persons have positive and negative experiences in mental health/substance treatment settings, supporting the MST theoretical framework. Mental healthcare experiences, if negative, may function as a 'distal stress factor'; mental health care experiences, if affirming, may function as a 'resilience factor'.

In Chapter Three, an integrative review of the literature was conducted to ascertain TGGD persons' first-hand mental healthcare experiences. Four themes emerged from the literature review; *Welcoming environments* and *healthcare provider knowledge/response* were

identified as facilitators of health, and *enacted stigma* and *racial disparities/intersectional insensitivity* were identified as barriers to health. The findings suggest TGGD persons have diverse experiences when accessing mental healthcare. Some TGGD persons have found acceptance, healing, and safety when receiving mental health services. Some TGGD persons have experienced stigma, discrimination, and poor provision of safety when receiving mental health services. When analyzed within an MST framework, this indicates that mental healthcare experiences, when affirming and welcoming, function as a resilience factor. When unwelcoming or stigmatizing, mental health care experiences function as a distal stress factor. Thus, there are existing strengths that mental HCPs can utilize to reduce their clients' stigmatizing experiences in mental health settings (decreasing the incidence of MST's 'distal stress') and in turn create welcoming, affirming care environments (increasing the incidence of MST's 'resilience factors').

All 11 participants in Chapter Four's study described various welcoming and affirming aspects of inpatient mental health/substance treatment experiences. These affirming aspects of care were generally related to providers' interpersonal skills and attitude; directly addressing and validating their experience as a TGGD person; conscientious efforts to provide privacy and safety; support from other clients receiving treatment; and staff/provider response to stigmatizing behaviors of others. However, some participants reported a need for enhanced discharge planning to avoid care gaps. Several participants also reported ongoing or previous home displacement and homelessness, sometimes occurring when in adolescence. Unwelcoming behaviors from other clients in inpatient treatment settings were also noted by participants.

Implications for nursing

More than a decade ago, the nursing discipline was put on alert regarding its 'silence' in addressing the urgent population health needs of people who identify as LGBTQ (Eliason,

Dibble, & DeJoseph, 2010). The words of those authors, and others, served as a call to action for nurses to implement innovative, multi-faceted efforts aiming to reduce the many alarming health disparities among SGM persons in the U.S. and globally. Nurses were implored to "commit to redressing the past silence and start addressing the harm done by that silence" (Eliason, Dibble, & DeJoseph, 2010, p. 216) through advances in nursing education, scholarship, and professional organizations. While broader SGM population health should and does remain a priority for healthcare providers (Office of Disease Prevention and Health Promotion, n.d.) and for nurses (ANA Ethics Advisory Board, 2018), nursing initiatives to meet the unique needs of arguably the most vulnerable subgroup within the SGM umbrella – TGGD persons – remain minimal (Bauer et al., 2020).

The results of the dissertation support the idea that change is indicated in *nursing practice, nursing education*, *nursing scholarship*, and *nursing policy*. To address the needs of TGGD persons, innovations are required in these four domains (Bauer et al., 2020). However, nurses may feel overwhelmed when considering the many health disparities experienced by TGD persons, and the resulting impact on human flourishing. Nurses may not know what they can do to help (Sherman et al., 2021). Social justice is a "moral responsibility" for nursing and "continues to be asserted as an obligation" in our profession (Grace & Willis, 2012, p. 198). As such, it is critical that nurses of all types conceptualize their role in meeting TGGD persons' needs; work to catalyze an effective nursing response to healthcare discrimination faced by TGGD persons in the U.S. and globally; and endeavor forward to ultimately improve population health outcomes.

Implications for nursing practice

Chapters Three and Four in this dissertation added to this body of knowledge through the investigation of TGGD persons' mental health treatment experiences. The results of those chapters complement existing health literature in highlighting several ways practicing nurses can create inclusive and welcoming atmospheres in mental health treatment settings (Figure 5.2).

First, it is critical to collect accurate data. The three discrete projects described in this dissertation were all limited in part due to inconsistent and/or outdated methods of collecting sexual orientation and gender identity (SOGI) information. Inconsistent SOGI data collection has been consistently shown in health literature to be a limitation for scholars (McCann & Brown, 2018; Meerwijk & Sevelius, 2017) and has many implications for the advancement of effective population health delivery; outcomes design, interventions, and effective assessment using validated scales are all compromised when the vulnerability of the target population is not accurately identified as such (Donabedian 1988, 2005).

Another important implication for practice is regarding the therapeutic milieu, or efforts to create physical spaces that are welcoming and inclusive (White & Fontenot, 2019). Images on websites, waiting room walls, brochures, and other literature should include representation of people of diverse gender identities. These visual cues indicate to TGGD people that the health setting is a safe space and is prepared to provide gender-affirming care. Staff should provide their preferred pronouns when meeting all new clients to model the behavior and to create a safe space for clients to self-disclose their gender. Staff ID badges and email signatures should also provide preferred pronouns to reiterate this practice. Gender-neutral restrooms, private changing spaces, and trauma-informed practices (especially during procedures involving sensitive topics and body parts) further contribute to welcoming practice environments.

Clinical nurse educators employed in direct care settings regularly provide a variety of competency training to health professionals (Harper et al., 2019) and should implement interprofessional clinical education addressing the needs of TGGD persons and best practices for creating welcoming environments. Training should explicitly discuss the how concept of gender is distinct from sex and sexual orientation. Staff should be required to use clients' preferred names and pronouns, and there must be administrative consequences for unwelcoming behaviors towards TGGD persons (Reisner et al., 2016).

Larger healthcare organizations would benefit from the implementation of gender liaison role. A gender liaison could provide consultation and gender-affirming care recommendations to staff in the context of individual client circumstances and needs. Similar liaison roles have been successfully implemented in hospitals for clients with disabilities (MacArthur et al., 2015) and for clients with substance use disorder (Reeve et al., 2016). These and other liaison roles can provide a model for implementation of a gender liaison role in healthcare organizations.

Implications for nursing education

Findings of this dissertation show that clients have had positive and negative health interactions with nurses. This is consistent with ample existing research showing that nurses overwhelmingly would like to provide gender-affirming care (Paradiso & Lally, 2018). However, these concepts are not delivered in a standardized curricular way to nursing students (Sherman et al., 2021), nursing faculty feel underprepared to teach such content (Lim, Johnson, & Eliason, 2015), and practicing nurses often feel under-trained and under-resourced to effectively provide such care (Paradiso & Lally, 2018). It is imperative, therefore, that nursing academic institutions implement measures to mitigate these circumstances (Figure 5.2).

Concepts related to TGGD population health should be embedded throughout the curricula in schools of nursing, including when using simulated learning environments, utilizing standardized patients as actors, in case studies and other applied learning activities. Standalone classes may not be realistic, but TGGD content can be effectively and strategically placed within existing courses. One graduate sexual health nursing course included specific content on gender-affirming care (White, Abuelezam, Dwyer, & Fontenot, 2020) resulting in significantly enhanced student comfort, confidence, and preparedness in meeting the needs of TGGD persons. Formal opportunities to achieve expert distinction in TGGD nursing (e.g. certificate programs, specialty program tracks, fellowships) should be implemented to accelerate the pace change in academic settings. Nurse-led interdisciplinary educational events (e.g. seminars, conferences) would allow students, faculty, healthcare providers, and community members to share perspectives and work as mutual partners in advancing population health goals.

Academic and community partnerships have been shown to improve health outcomes (Schneider, Stephens, & Semenic, 2017) and provide a mutual benefit to the academic institution and community (Tyndall, Kosko, Forbis, & Sullivan, 2020). Schools of nursing should work collaboratively with community agencies to create such partnerships and mindfully create safe spaces for client interactions in the community setting. This may more effectively reduce barriers to care based on previous negative experiences in health settings (White & Fontenot, 2019) and mitigates power imbalances inherent in clinical settings. This strategy may be particularly effective for adolescent and young adult TGGD persons who may be more comfortable accessing care in a community agency rather than in a traditional health setting (Fontenot et al., 2020).

Implications for nursing scholarship

Previous innovations in gender-affirming nursing practice have been based primarily on results of qualitative inquiry and commentary (Dwyer et al., 2021). This has been an effective way to justify change in specialty and local practice settings, and it remains important to continue to advance knowledge development related to TGGD subgroups (e.g. persons with intersectional identities across multiple marginalized groups) and among the nursing specialties (e.g. pediatric nursing, mental health nursing). However, broader change across all health settings to address mental health disparities requires a rigorous program of nursing scholarship (Figure 5.2).

Despite a recent emphasis on LGBTQ population health for healthcare providers (Office of Disease Prevention and Health Promotion, n.d.) and for nurses (ANA Ethics Advisory Board, 2018), nursing initiatives to meet the unique needs of arguably the most vulnerable subgroup within the LGBTQ umbrella – TGDD persons – remain minimal, heterogenous, and vague (Bauer et al., 2020). The lack of nursing voice in TGGD population health may be due to a poorly articulated roadmap for gender-affirming research and scholarship (Bauer et al., 2020). An enhanced program of nursing scholarship could contribute and serve as a lever to inform evidence-based nursing practice and education. When training and education are provided, rigorous evaluation methods should be used to measure the effectiveness of academic curricula and practice-based training (Dwyer et al, 2021). If implemented concurrently with SOGI data collection and with psychometrically sound scales to measure health/wellness (e.g. gender euphoria scale), a dynamic hypothesis-driven research agenda could lead to harmonized definitions, processes, client outcomes and evaluation methods (Khanassov et al., 2016; Lal, 2020).

Implications for nursing policy

There are several ways nurses may address health disparities and improve the mental health of TGGD persons through advocacy and policy (Figure 5.2). Despite the presence of the Gay & Lesbian Medical Association, there are no nursing organizations with the express missions of elevating LGBTQ providers to enhance their visibility and advocacy and reducing LGBTQ population health disparities. Other groups, such as the National Black Nurses Association, highlight the effectiveness of nursing organizations in empowering providers and optimizing population health. Additionally, existing nursing organizations should create LGBTQ working groups to provide consistent input and raise awareness. Nursing professional organizations can also use their voice to advocate for change through the creation and dissemination of position statements regarding TGGD health equity. An informal literature search revealed that only three nursing organizations have released position statements advocating for improved healthcare for TGGD persons.

Conclusions

This dissertation explored the mental health of TGGD persons through a Minority Stress Theory (MST) conceptual framework, including potential distal stress factors, proximal stress factors, and resiliency factors (Meyer 1995, 2003). This program of research has made substantial and meaningful contributions towards an enhanced understanding of TGGD mental health experiences, sources of TGGD stigma, and sources of coping/resiliency. In each chapter, findings suggested the presence of MST concepts of distal stress factors, proximal stress factors, and resiliency factors. Nursing remains underrepresented in health literature, and dissertation results highlight ample opportunities to advance TGGD population health through nursing practice, nursing education, nursing scholarship, and nursing policy.

Figure 5.1. Dissertation findings within MST framework

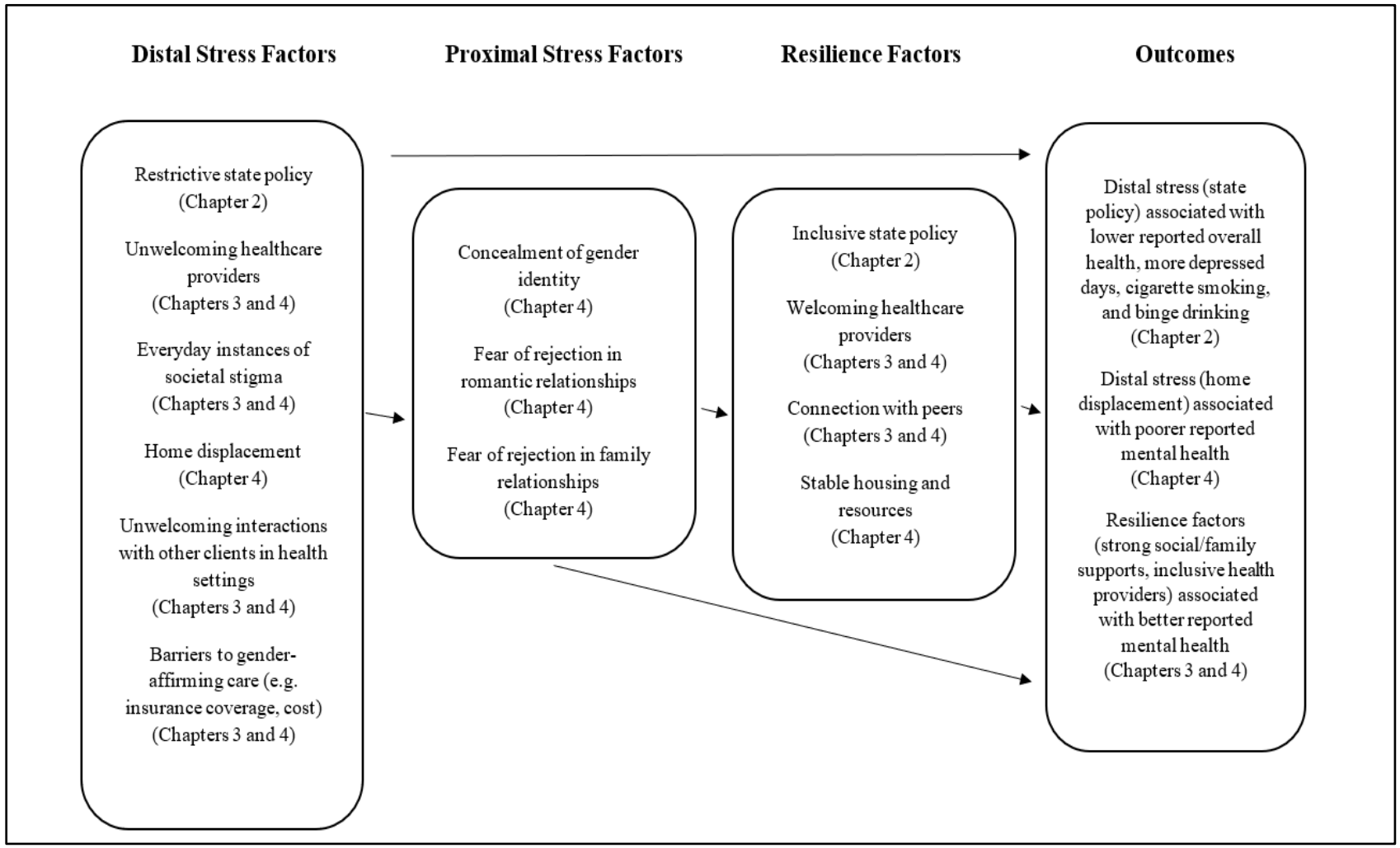

Figure 5.2. Implications and future directions for nursing

Nursing clinical practice

- Implement best-practice SOGI data collection in practice organizations
- Create inclusive atmospheres in local practice settings, including use of pronouns, signage, gender-neutral language, and staff training
- Design and lead clinical education and professional development curricula in gender-affirming care at healthcare organizations
- Implement a Gender Liaison/Consult role in healthcare institutions

Nursing education

- Development TGD curriculum in Schools of Nursing (simulation, standardized patients, case studies, didactic learning).
- Nurse-led transdisciplinary educational approaches, including in community-based academic partnerships.
- TGD population health certificate programs and fellowships in Schools of Nursing

Nursing scholarship

- Enhanced scholarship regarding the TGD health needs through lens of various nursing specialties (e.g. oncology nursing, surgical nursing, school nursing, mental health nursing).
- Develop psychometrically sound scales to measure health/wellness
- Develop evidence-based population health outcomes.

Nursing policy

- Form gender-affirming care working committees in existing nursing professional organizations.
- Create and disseminate nursing professional organizations position statements regarding TGD health priorities
- Create a national nursing organization dedicated to TGD health
- Develop a distinction of expertise in TGD care, such as certification

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Cumulative Reference List

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Appendix 1: Social media ads and messages

Ad #1

Help improve mental healthcare for trans people

We are conducting interviews with adults 18 and older who identify as transgender or gender diverse and have received inpatient (overnight) mental health and/or substance treatment services in the last three years. We want to hear your experience, so we can help make healthcare better! Prospective participants who meet eligibility criteria and participate in one interview (60-90 minutes) will receive an Amazon Gift Card for their time.

If you're interested and would like more information, DM @trans_health_nurse on Instagram [or Facebook].

Look forward to hearing from you!

Ad #2

Help make healthcare better for trans people

We are conducting interviews with adults 18 and older who identify as transgender or gender diverse and have received inpatient (overnight) mental health and/or substance treatment services in the last three years. We want to hear your experience, so we can help make healthcare better! Prospective participants who meet eligibility criteria and participate in one interview (60-90 minutes) will receive an Amazon Gift Card for their time.

If you're interested and would like more information, DM @trans_health_nurse on Instagram [or Facebook].

Look forward to hearing from you!

Ad #3

Your experience will help others

We are conducting interviews with adults 18 and older who identify as transgender or gender diverse and have received inpatient (overnight) mental health and/or substance treatment services in the last three years. We want to hear your experience, so we can help make healthcare better! Prospective participants who meet eligibility criteria and participate in one interview (60-90 minutes) will receive an Amazon Gift Card for their time.

If you're interested and would like more information, DM @trans_health_nurse on Instagram [or Facebook].

Look forward to hearing from you!

Appendix 2: Study Eligibility Screener and Informed Consent

Introductory statement:

The purpose of our study is to better understand the perspectives of transgender and gender diverse persons who have received inpatient mental health and/or substance treatment services within the past three years. We want to understand the experience you had with this care as related to your gender/ gender identity.

If you are eligible, available, and willing to participate in our planned online interview (60-90 minutes) you will be asked to talk to us about your experiences and your thoughts and beliefs about your care- there are no right or wrong answers. Our goal is to learn from transgender and gender diverse people, and how to help make mental healthcare a more affirming and gender-friendly experience.

Question 1

Are you age 18 years or older?

a. Yes
b. No

* Skip logic. If NO, then send to thank you- you are not eligible to participate

Question 2

Do you identify as cisgender (your gender identity is the same as your sex assigned at birth?).

a. Yes
c. No
d. Don't know

* Skip logic. If YES, then send to thank you- you are not eligible to participate

Question 3

Do you identify as Transgender and/or Gender Diverse (this is an inclusive term to reflect a wide array of non-cisgender identities [e.g. non-binary, gender fluid, genderqueer, transgender, trans masculine, trans feminine]).

a. Yes
b. No

* Skip logic. If NO, then send to thank you- you are not eligible to participate

Question 4

Have you received inpatient mental health and/or substance treatment services in the previous three years? *This would mean you spent at least one overnight while receiving this treatment.*

a. Yes
b. No

*skip logic. If NO, then send to thank you- you are not eligible to participate

Question 5

Did you receive the previous treatment(s) from Question 4 in the United States?

a. Yes
b. No

*skip logic. If NO, then send to thank you- you are not eligible to participate

Question 6

Are you interested in participating in a 60- to 90-minute online interview (audio-recorded) with the researcher at a time that is convenient for you? *This will require you to have Internet access (phone, tablet, or computer).*

a. Yes

b. No

*skip logic. If NO, then send to thank you- you are not eligible to participate

Study Informed Consent

Study Protocol Title: Transgender and Gender Diverse Persons' Inpatient Mental Health/Substance Treatment Experiences: A Qualitative Descriptive Study

Principal Investigator: Bradley White MSN, RN
Co-PI: Holly B. Fontenot, PhD, RN/NP, FAAN
*** Flesh-Kinkaid readability grade level 9. Should be easily understood by 14 to 15 years old.*

Consent to Participate

Principal Investigator (PI): Bradley White MSN, RN

Contact Information: whitewo@bc.edu; 617-308-8096

1. *Study Purpose:* The purpose of our study is to better understand the perspectives of transgender and gender diverse persons who have received inpatient mental health and/or substance treatment services within the past three years. We want to understand the experience you had with this care as related to your gender/ gender identity

Your opinions and ideas will help identify ways to improve the quality of mental healthcare that is available to transgender people in the United States.

- Your participant in this study is voluntary.
- You can contact the Principal Investigator (contact information above) at any time with questions.

2. *Procedure and Duration:* If you agree to take part in this study, you will be asked to participate in one interview that is 60 to 90 minutes in duration. During the interview, you will be asked to recollect and describe your inpatient mental health and/or substance treatment experiences as they relate to your gender. An example of a question in this interview is: "Thinking now about how your gender identity was respected and affirmed while you were at the hospital, how would you say the hospital, providers, and staff did at creating a welcoming environment for you?" You are eligible to participate if you: 1) are 18 years or older; 2) reside in the United States; 3) self-identify as transgender and/or gender diverse; 4) have been admitted to an inpatient mental health or substance treatment unit in the United States within the past three years; and 5) have Internet access to participate in a Zoom interview via a personal computing or mobile device. If you agree to participate, you will be contacted by the investigator to set up a time for the interview. During the interview, you will be free to withdraw or skip questions for any reason, without penalties.

3. Potential Risks and Discomfort: We do not anticipate that anything bad will happen to you during this study. However, there may be unknown risks. For example, participating may be

emotionally uncomfortable for you to share your experience. You can take a break anytime you need one or skip any questions you'd prefer not to answer.

4. Potential Benefits: There are no direct benefits for participating in this study, but your thoughts and opinions will help shape future interventions to enhance the gender-affirming care available among mental health and substance use providers. You might also benefit from being in this study because you will be telling your story and sharing how various events made you feel. Often, when people share their story, there is some benefit felt by the person. You may also have enhanced sense of community belonging by contributing to the general scientific effort to improve healthcare for transgender persons.

5. Compensation: There is NO cost to participate in this study. All participants will be compensated with a $50 Amazon gift card for their time. The PI will email the gift card directly to your email at the end of the discussion. If you choose to leave the study prior to the half way point (30 minutes) you will receive a $25 Amazon gift card; if you participate for greater than 30 minutes you will be paid the full $50.00 Amazon gift card.

6. Assurance of Privacy and Confidentiality: The demographic questionnaire and focus group discussion is *confidential* and your participation is *voluntary.* Your confidentiality is one of the researcher's top priorities. This interview will be audio-recorded and will be kept secured. The Institutional Review Board at Boston College and internal Boston College auditors may review the research records. State or federal laws or court orders may also require that information from your research study records be released. Otherwise, the researchers will not release to others any information that could indicate your identity unless you give your permission, or unless we are legally required to do so. Your privacy will be protected in many ways. (1) All data will be kept on secure, password-encrypted servers and on a secure, encrypted iPad that is password-protected. (2) Any contact information or identifiers (your email and/or phone number) that you provide to the PI for research coordination and distribution of payments for study participation will be kept confidential. (3) Audio recordings of your interview will be transcribed into text and will then be erased, we will not use names or any identifying information in the recordings. (3) All members of the research team that interact with you have been trained in ethical conduct of research. The researcher will save and store the text of the discussions for no more than 3 years after the completion of the study. All the interviews (up to 50) will be summarized together and may be used in future reports, publications, or presentations. No identifying information will ever be reported.

7. Voluntariness. It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you decide to withdraw before this study is completed the information you provided will be retained by the researcher. If you appear to be in distress during the interview, the interview may be terminated by the PI without your consent.

If you have any questions or concerns regarding this research, you may contact Bradley White, the Principal Investigator, at whitewo@bc.edu or 617-308-8096. If you have any questions about your rights as a research participant, you may contact the Office for Research Protections, Boston College, at irb@bc.edu.

Before agreeing to be part of the research, please be sure that you understand what the study is about. We will give you a copy of this document for your records (or you can print a copy of the document for your records). If you have any questions about the study later, you can contact the study team using the information provided above.

This study was reviewed by the Boston College Institutional Review Board and its approval was granted on _____.

If you are ready to participate and agree to the statements above, please answer the question below "Yes, I consent". You will then be contacted by the study PI, Bradley White, to set up a convenient interview time.

Thank you!

Question 7
I understand what this study is about and my questions so far have been answered. I consent to take part in this study.

a. Yes, I consent
b. No, I do not consent

*skip logic. If YES, then send to concluding statement- you are eligible to participate
*skip logic. If NO, then send to thank you- you are not eligible to participate
Concluding statement: Thank you indicating your interest in this study. You are eligible to participate. Please visit this link to provide your contact information so the researcher can contact you to arrange your interview: (INSERT "CONTACT INFORMATION QUESTIONNAIRE" QUALTRICS LINK HERE).

Appendix 3: Contact Information Questionnaire

Question 1
Please provide your contact information. This information will be used by Bradley White (study Principle Investigator) to contact you to arrange a convenient time for your interview as well and to send you an Amazon Gift card at the completion of the interview.
Preferred FIRST name _____
E-mail _____
Phone _____

Question 2
Do you prefer to be contacted by phone call, text message, or e-mail?

a. Phone call
b. Text message
c. E-mail

Appendix 4: Reminder Emails

Email #1

Dear XXX,

Thank you for agreeing to participate in research being conducted at Boston College. Based on the questionnaire you took online, you meet eligibility requirements for the study. I am Bradley White, the study researcher.

I am writing to set up a time for your interview. We should plan for 90 minutes. Do any of the following times work for you for an interview? (LIST FIVE CHOICES FOR INTERVIEW APPOINTMENT TIME).

- Choice 1
- Choice 2
- Choice 3
- Choice 4
- Choice 5

Kindly let me know when you're free to meet. I am very much looking forward to meeting virtually and talking.

With thanks,
Bradley White
Boston College

Email #2

Dear XXX,

Thank you for participating in research being conducted at Boston College. Your interview will be invaluable to the research being conducted. I am writing to provide your compensation for the interview. Please see information below regarding your $50.00 ($25.00) Amazon gift card.

Thanks again for your generous participation. Be well.

With thanks,
Bradley White
Boston College

Appendix 5: Interview guide

Transgender and gender diverse persons' inpatient mental health/substance treatment experiences: in-depth interview guide

Welcome

1. Welcome participant to virtual meeting.
2. PI introduces self with name and pronouns.
3. Ask participant to introduce self with their name and pronouns, if they hadn't done so already.
4. Ask client if they have reviewed informed consent information that was previously mailed/emailed. As client if they have any questions regarding the study.

Informed consent process

1. Review study purpose and procedures with participant.
2. Review/read informed consent form with participant.
3. Ask participant if they have any questions and answer all questions.
4. Show client informed consent form via screen share function.
5. Ask client verbally if they consent to participate. If needed, prompt client for a yes/no.
6. PI will attest (sign and date) to verbal consent on the part of the participant.

Interview Guide

Part I: Introduction

"I wanted to thank you for reaching out to me and for being here today. Before we start the interview, I'd like to just let you know that you're in a safe space. As a TGGD person who has utilized hospital care, you're in expert in how gender-affirming care was or was not available to you during your time in the hospital. I am here to listen to your story and learn from it, and I am not here to judge you for any reason. Talking about mental health and substance use and gender identity is very sensitive and perhaps uncomfortable, and I promise to be respectful of that throughout our conversation. I am always open to questions and feedback throughout the conversation. If you'd to take any breaks or would like to postpone a question and come back to it later, we can do that. What questions do you have for me right now?"

Part II: Questions

1. "It would be helpful to first hear about your overall experience when you were in the hospital/treatment center. I'd like to hear your story, as much as you're comfortable sharing. I am interested in anything you would like to tell me about."
    - Probe: "Would you say a bit more about what you were going through the days and weeks before you were admitted?"
2. "Thinking of your stay at the hospital/treatment center, can you walk me through what you recall about it? Anything you would like to share with me, from when you arrived at the hospital to when you were discharged from the hospital, would be helpful."
    - Probe: "Would you describe the admission process a bit?"
    - Probe: "How were things were between you and other clients on the unit?"

3. "Thinking about all the staff and healthcare providers you interacted with while you were at the hospital, how would you characterize your interactions with them?"
    - Probe: "Would you tell me about any nurses who stood out?"
    - Probe: "Would you tell me about any doctors who stood out?"
    - Probe: "Would you tell me about any therapists who stood out?"
    - Probe: "Would you tell me about any other staff members who stood out?"
4. "Thinking now about how your gender identity was respected and affirmed while you were at the hospital, how would you say the hospital, providers, and staff did at creating a welcoming environment for you?"
    - Probe: "Were there any ways they could improve in creating a welcoming environment?"
    - Probe: "Were there any aspects of your care that were welcoming?"
5. "Did you feel safe to express your gender identity on the unit?"
    - Probe: "Did you select specific clothes or presentation based on the setting?"
    - Probe: "Did you feel comfortable talking with others about your gender identity with others while you were there?"
6. "Are there any other parts of your identity (race, religion, trauma history, etc.) that you felt affected your hospital stay?"
7. On a scale of 1 to 10, with 10 meaning you have all the resources you feel you need, what is the current level of support and resources in the community in which you live?
8. "Is there anything else at all you would like to tell me?"

Part III: Demographics:

PI will note any demographic statements participants make during interview and follow up for clarification and will state: "Thanks for sharing all that information and history with me. To wrap up, I would like to ask a few basic demographic questions. You can always feel free to not answer any of them if you'd prefer that."

9. Which term(s), if any, do you use to describe your gender?"
10. "What's your current age?"
11. "Which race(s) do you identify with?
    - Probes: Federal categories
12. "Which ethnicity(s) do you identify with?"
    - Probes: Hispanic or Latino/a
13. "Have you ever had a time when you didn't have a place to stay or experienced homelessness?"
    - If yes: "Was that in the past, or is that current?"
    - Do you currently have a stable place to live?
14. Do you have a stable source of income right now?
15. What state do you live in?
16. Do you live in an urban area, suburban area, or rural area?
17. Do you have health insurance?
    - Did it pay for your hospitalization?
    - Does it cover GAHC?
18. If you feel comfortable with this, would you be willing to share what diagnosis was assigned to your hospital stay?
    - Probe: Examples include substance use, depression, suicidal thoughts, anxiety.

Conclusion of interview.