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Health Care Maltreatment and Perioperative Suicidality Among Transgender Persons: A Phenomenological Investigation

Alma Theresa Knight
Walden University

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Walden University

College of Health Sciences

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Alma T. Knight

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Review Committee

Dr. Patrick Tschida, Committee Chairperson, Public Health Faculty
Dr. Peter Anderson, Committee Member, Public Health Faculty
Dr. Loretta Cain, University Reviewer, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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Phenomenological Investigation

by

Alma T. Knight

MSN, Walden University, 2014

MBA, University of Phoenix, 2012

BSB, University of Phoenix, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy Public Health

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November 2020

Abstract

The goal of this phenomenological study was to investigate the phenomenon of transgender suicide and how health provider transgender health knowledge deficits may have contributed to this public health disparity. The constructs of the Social-Ecological Suicide Prevention Model, the Perioperative Medicine Model, and the Perioperative Patient-Focused Model is the Tri-Model framework used to guide this research project in proposing the research question, the sub-questions, and contributed to the analysis of the results. This Triad-Model is also proposed as a framework to eradicate the health provider transgender health knowledge gap; to improve transgender health care delivery; enable physicians and nurses to recognize the transgender person who is at risk for suicide attempts; provide timely transgender competent suicide interventions, and augment desirable health outcomes that could reduce or eliminate perioperative suicides among transgender persons. Four adult postoperative transgender Americans were interviewed in-person or telephonically. Thematic analysis included workplace, family, and social rejection preoperatively and postoperatively, suicidal thoughts and suicide attempts before and after surgery, met health providers inept in transgender health care awareness, preoperative and postoperative health insurance coverage barriers, health provider, and health care systems transgender-aimed discrimination cordons. Participants recommended that medical and nursing schools add Transgender Health competence education and hands-on transgender health care residencies to the present curriculum. This adjunct is a positive social change for better health outcomes, upgraded quality of life, improved transgender health care practices individually and Community wide.

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Dedication

This dissertation is dedicated to the LORD GOD, Creator of Heaven and Earth Who opened the door to study the Doctor of Philosophy in Public Health degree, the One Who guided and sustained me throughout my dissertation journey. Thank you from the bottom of my heart to my faithful and patient husband of 41 years, Gary Knight, Sr. whose love, moral, and financial support encouraged me during the many difficult times along the way. I pray that GOD's abundant life, health, and joy be yours forever my beloved. I love you.

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Chapter 1: Introduction to the Study

Transgender suicide is a significant public health problem that affects 1.4 million of the total U.S. populace (Flores, Herman, Gates, & Brown, 2016). The Center for Disease Control and Prevention's National Center for Injury Prevention and Control, (n.d.) has (1) reported suicide as the primary cause of death among 21-34-year-old Americans, (2) designated suicide prevention to be a major focus in the public health industry using a population method (3) recommended that suicide prevention initiatives should integrate proven scientific evidence, and (4) implemented suicide prevention protocols from a collaborative, multidisciplinary perspective. Transgender suicides that may have occurred during the perioperative period of the gender reassignment process is the focus of this investigation. The expectation is that colleges and universities could use this study's results to add transgender appropriate health care paradigms to existing public health, medical school, and nursing school curricula. Furthermore, the social change potential of this investigation is that public health workers, non-public health care professionals, and policymakers could consider the nuances of this study when creating suicide prevention programs and health equity policies that are transgender-inclusive. As far back as 2001, Lombardi recommended that transgender individuals should have identity authentication, education and prevention resources, and improved access to transgender competent health care (Lombardi, 2001). In this chapter, I will present the historical five-step Public Health Approach to Prevention (Suicide Prevention Resource Center, n.d.) to guide this investigation and illustrate how public health professionals could work as a collaborative team with non-public health physicians and non-public

health nurses to provide holistic transgender-competent care. I will also list the interview questions, identify study assumptions, define transgender terminology, specify limitations, and clarify the significance of this study to public health practice. Likewise included in this chapter is a preliminary literature review that will reveal factors that past researchers concluded were major contributors to transgender suicides. A summary of this chapter will be provided to align the research question, literature review, methodology, and framework of this study.

Background

Researchers have recognized the higher suicide rates among transgender populations as an emerging public health problem (Barr 2015). The National Transgender Discrimination Survey has been referenced by researchers to confirm that suicide rates are higher among the trans population (James, Herman, Rankin, & Anafi, 2016) in comparison to suicide rates in the general (i.e., cis gender) population at a ratio of 41%: 4.6% respectively (Haas, Rodgers, & Herman, 2014). Furthermore, the National Transgender Discrimination Survey was the main source used by numerous researchers as their primary source for secondary data and transgender study participant information. Among the contributing factors to transgender suicides are gender-focused discrimination by health systems and health providers (Seelman et al, 2017; Stroumsa, 2014) and the negative stigma associated with being transgender (Hughto, Rose, Pachankis, & Reisner, 2017). These factors have constructed barriers that have negatively affected access to timely, gender-specific, medically appropriate health care for trans persons. Unfortunately, contemporary suicide prevention approaches are inappropriate (Haas et

al., 2014), ineffective, and deficient in transgender inclusive and need-specific interventions, rendering these approaches impractical (Seelman, et al, 2017) for this population.

Adding offense to the transgender health disparities dilemma is the absence of transgender-specific curricula in schools of public health, medical schools (Safer et al, 2017), and nursing schools (Haas et al., 2014; McDowell & Bower, 2016). Adams, Hitomi, and Moody (2017) and Haas et al. (2014) mentioned gender disturbances and postsurgical dissatisfaction as additional probable factors contributing to suicide among postsurgical trans persons. Thoughts of suicide among trans women (male-to-female or MTF) who admitted to past suicide attempts were reported to be 50% and 31% respectively (Adams, Hitomi, & Moody, 2017). Furthermore, trans women's suicidal thinking and suicidal attempts were also expressed as self-isolation, negative reactions to being rejected, and feeling victimized because of transgender related violence (Haas et al., 2014).

Eddles-Hirsch (2015) offered concise explanations for specific phenomenological philosophical schools of thought that are essential to understand the constructs guiding qualitative research. For example: (a) Husserl's transcendental (descriptive) phenomenology is the investigator's ability to lay aside or "bracket" personal preconceptions, to mitigate any personal biases, and the aptitude to focus on documenting the participant's descriptive perspectives, verbatim; (b) Heidegger's hermeneutic phenomenology is described as a method that utilized both interpretive and descriptive approaches; and (c) existential phenomenology is described as a philosophical thought

perspective that promotes intentional analysis and intentionality, in addition to combining transcendental perceptions. The various phenomenological schools of thought assisted qualitative researchers in choosing the appropriate philosophical construct to guide their research studies. The phenomenology research design, according to Daniel (2018), uses an analytical method based in lived experience. In this case, the focus is on the lived health care experiences of transgender men and women during the perioperative phase of the gender reassignment process.

Bauer, Scheim, Pyne, Travers, and Hammond (2015) declared that there are no standardized transgender demographical designations in health records, thus, transgender suicide rates may have been underreported due to this omission. Bauer et al. also introduced the term *transphobia* to describe the societal exclusion trends, unfounded fears, and hatred towards transgender persons that have resulted in discrimination and violence towards individuals in the transgender population.

Haas et al. (2014) provided transgender terminology for MTF clients as *trans women* and FTM clients as *trans men* and included statistical information about attempted suicides among trans persons. Then Adams et al. (2017) pointed out that some suicidal thoughts and suicidal attempts may have originated from past experiences with health institution-based discrimination. Seelman, et al. (2017) concurred that discrimination fears among transgender clients is another barrier to accessing timely, competent, transgender-focused physical and mental health care. Moreover, Klein and Golub (2016) explored rejection by the family and in other relationships as additional factors that may have contributed to transgender suicides. Kosenko, Rintamaki, Raney,

and Maness (2016) explored how the trans individual's perception of being stigmatized may have associated adverse effects on the trans individual's mental health state. Hughto et al. (2017) indicated that insufficient insurance coverage, lower educational status, and economic challenges were additional access barriers to post-surgical mental health care.

On the other hand, there are gender confirmation advocates who argue that gender reassignment surgeries are successful with no adverse effects (Tannerhill, 2016).

Christian et al. (2018) described the plight of transgender clients as being an invisible population, forced to function in an environment of non-inclusion within the traditional health care community. Hughto, et al. (2017) added the results of the Massachusetts study that was conducted with transgender adults who identified transitional health care as another health care access barrier. In an effort to mitigate the damages caused by the transgender health disparities fueled by health providers and institutions, the Centers for Disease Control and Prevention (2018) has created and made available to health providers a specific set of guiding principles and practice paradigms for transgender-specific health care delivery. Moreover, the Journal of Perioperative & Critical Intensive Care Nursing (2018) has also provided guidelines that can be viewed as being complimentary to the Centers for Disease Control and Prevention (CDC)'s guidelines because of the specific, perioperative patient protocols applicable to transgender patient care.

Problem Statement

The nonexistence of transgender-competent health care education in colleges and universities has produced few widely accepted protocols for transgender-appropriate care.

This lack is associated with augmented health disparities for this population (Safer, et al., 2017), including the use of ineffective suicide prevention procedures (Haas, Rodgers, & Herman, 2014) and ineffective suicide interventions (Virupaksha, Muralidhar, & Ramakrishna, 2016). Other health care disparities for transgender individuals consist of the stigma associated with being transgender as asserted by Hughto et al. (2017) and confirmed by Kosenko, Rintamaki, Raney, & Maness (2013), postsurgical regret (Heyer, 2016), and relationship rejection (Klien & Golub, 2016).

According to the CDC Behavioral Risk Factor Surveillance System (BRFSS; 2019), 1.4 million Americans self-identify as transgender (Flores et al., 2016). Higher suicide rates within the transgender population (Barr, 2015) is, according to Virupaksha et al, (2016) a significant public health problem. Unfortunately, the transgender person's negative experiences with the existing health care system include encounters with insensitive health providers who refuse to provide much-needed services (Tollinche et al., 2018). Also, there is a knowledge gap that relates to perioperative suicides amongst transgender patients, hence the focus for this study. Furthermore, Tollinche et al. (2018) declared that some transgender persons who had experienced psychological discomfort were withdrawn, felt disrespected, and were depressed during the perioperative process due to the thoughtlessness of their health care providers. Therefore, there is a need to understand, from each transgender person's perspective, the associated subtle factors experienced during the perioperative progression that prompted suicide attempts and thoughts.

Purpose of the Study

The purpose of this hermeneutic phenomenological (Eddles-Hirsch, 2015) qualitative public health research study is to identify and understand which factors within the perioperative phase prompted suicide attempts and suicides among trans men and trans women patients. Hopefully, the data from this study will: (a) provide credible, evidence-based information for educating multidisciplinary health care providers to deliver transgender-appropriate physical and mental health care, (b) impact improvements in transgender focused physical and mental health care, and (c) improve contemporary interventional procedures that that could result in the reduction of transgender suicides and the related health disparities.

Research Questions

RQ1: How do male-to-female and female-to-male transgender persons perceive their health provider's transgender-specific knowledge deficit and health provider transgender-related discriminatory attitudes as influences contributing to their suicidal thoughts and suicidal attempts during the gender reassignment process?

Sub-questions

Sub-question 1 How do MTF and FTM transgender persons perceive the quality of their health provider's knowledge about their gender-specific mental and physical health needs before, during, and after the MTF sexual reassignment process.

Sub-question 2. How do MTF and FTM transgender persons perceive the competence with which their health provider(s) met or did not meet their gender-focused mental and physical health needs?

Sub-question 3. What do MTF and FTM transgender persons perceive as obstacles to accessing gender-appropriate mental and physical health care during all stages of the gender reassignment experience?

Sub-question 4. What are the perceptions that MTF and FTM gender reassignments patients have about their encounters with health provider transgender discrimination that may have led to suicidal thoughts or suicide attempts during the transitional follow-up phase?

Theoretical Framework

The Social-Ecological Suicide Prevention Model

The Cramer and Kapusta's (2017) Social-Ecological Suicide Prevention Model (SESPM) is the primary model for this study to provide the foundational framework for creating transgender-specific suicide risk recognition procedures, suicide prevention protocols, and suicide intervention paradigms. Additionally, the SESPM could function as an educational instrument for training public health providers and non-public health providers in the nuances of competent, transgender-congruent health care. The two-fold focus here is to: (a) assist public health care providers and traditional medical provides to understand the lived mental health experiences of transgender patients who may have attempted suicide and may have entertained suicidal thoughts during the perioperative gender reassignment process, and (b) provide life-saving prevention intercessions in a timely manner.

Furthermore, the four constructs of the SESPM will guide this research project in addressing the research questions and sub-questions. Namely, (a) seeking to improve

suicide-related surveillance data from the United States Surgeon General's Office 2012 initiative (Cramer & Kapusta, 2017), (b) move towards individual, family, and community empowerment and health promotion campaign improvements, (c) augment community-based prevention services, and (d) provide supportive services in a time efficient manner.

In subsequent literature reviews I uncovered three theoretical models that are complementary to the SESPM and applicable to the is research project. The first complimentary theoretical model is the Public Health Approach to Suicide Prevention using a five-phase method to guide public health professionals. The second complimentary theoretical model is the Perioperative Medicine Model (PMM) set forth by The Royal College of Anesthetists (2014) that will direct non-public health, in-hospital physicians to include specific perioperative health care paradigms that are applicable to caring for trans male and trans female patients. The third complimentary theoretical model is the Perioperative Patient Focused Model (Association of Operating Room Nurses, [AORN], 2015), a perioperative perspective for surgical nurses that has placed trans men and trans women surgical patients at the nucleus of the perioperative scheme of transgender-congruent care. The reality is, transgender clients face gender-associated healthcare inequities (Reisner, White, Bradford, and Mimiaga, 2014). Hence, the constructs of each model will be indispensable to educate public health providers, non-public health physicians and non-public health nurses in the art of providing safe, respectful, holistic, transgender competent perioperative patient care. These three patient care paradigms (SESPM, PMM, & PPFM) will be dispersed via the five-step Public

Health Approach to Suicide Prevention process i.e., problem definition; researching causes, protective factors, and risks; formulating and testing need-congruent interventions, implementing successful, tested interventions, and evaluating interventions that were put into practice (Suicide Prevention Resource Center, n.d.).

The interconnectivity of these four models are indispensable for assisting public health and non-public health providers to accurately identify transgender persons who may be suicide risks. Hopefully, in the future, this novel strategy could contribute to decreasing transgender suicide rates, the associated health disparities, and move towards forming collaborative patient care teams among public health provider and hospital-based physicians and nurses.

The Funnel Approach. The principles of the 4-Stage Funnel Approach (Roller & Lavrakas, 2015) was used to integrate and align the SESPM, the PMM, and the PPFM with the research question and sub-questions to develop the interview guide. The interview guide assisted me in formulating relevant, semi-structured open-ended questions for the participants in this study. The results of the interviews could guide the construction of holistic transgender suicide risk recognition and suicide prevention paradigms. These paradigms could be added to college and university curricula to educate public health and non-public health care providers in trans person-competent perioperative care. Figure 1 below illustrates how I adapted the principles of the Roller & Lavrakas, (2015) 4-Stage Funnel Approach to create a Perioperative Triad Model (the Social-Ecological Model, the Physician's' Perioperative Medicine Model, and the Nurses' Perioperative Patient-Focused Model) as a new strategic paradigm for achieving

transgender-congruent perioperative care competence in policies and procedures for excellence in evidence-based transgender health care delivery.

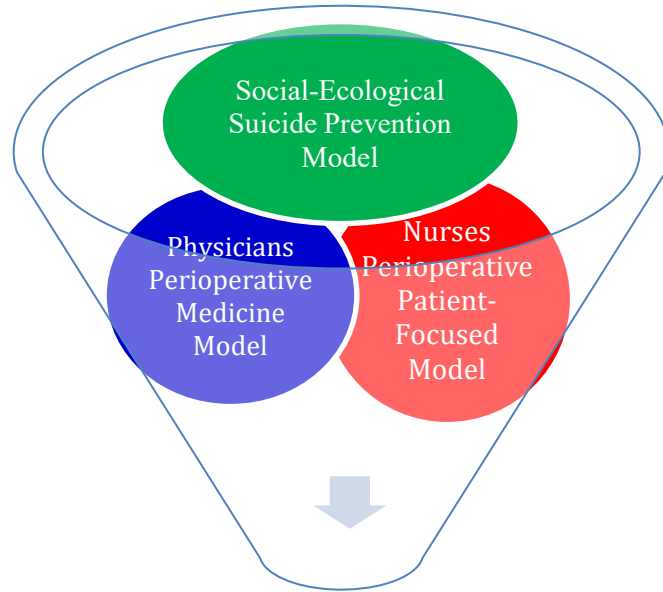


Figure 1: The Public-Health Perioperative Triad: Adapted to the Funnel Approach Process

The Funnel Approach Rationale

The rationale for using an adapted version of the Roller & Lavrakas (2015) 4-Stage Funnel Approach is the transportability of its introduction, integration, attitude awareness, and beneficial recommendation principles for transgender health improvement:

- Stage One: *Introduction:* The research purpose and proposed interview questions.
- Stage Two: *Integration* of the SESPM, the PMM, and the PPFM to drive the perioperative transgender suicide investigation.

- Stage Three: *Attitude Awareness*: Exploration of health provider transgender-directed discriminatory attitudes as perceived by trans clients.
- Stage Four: *Beneficial Recommendations*: A synopsis of stages one, two, and three to formulate beneficial recommendations for public health and mainstream health providers for improving transgender suicide prevention practices and upgrading health provider education in male-to female and female-to-male transgender compliant perioperative care.

The Transgender-Compliant Perioperative Care Process for In-Hospital Care

General Health Assessment for Transgender Patients

A two-part initial assessment will be important for identifying patients who may be categorized as high risk due to pre-existing medical and mental health issues, in addition to the potential surgical and anesthesia risks. After the trans person is officially scheduled for gender reassignment surgery, the assigned nurse will perform an initial head-to-toe physical assessment to gauge the patient's general physical health. An evaluation of the person's emotional health and mental health that will help to determine the level of the individual's suicide risk will be the next step in this general health assessment sequence. The third and fourth steps will be patient observation and conducting in-person interviews, two crucial tools used to identify the presence of any preexisting suicidal thoughts and retrieve first-hand or secondary information about past or present suicide attempts. A transgender-specific cultural assessment should augment the nurse's understanding of the patient's lifestyle norms and taboos. Cultural assessments should set the tone for respectful, compassionate, culturally competent care,

and good reciprocal communication. The rationale here is to avoid inadvertently or deliberately violating any cultural taboos that may be misconstrued as disrespect and may contribute to suicidal thoughts and attempts in transgender clients. The following generic preoperative nursing assessment document (Figure 2) could be adapted to appraise the preoperative transgender patient.

Preoperative Patient Assessment Summary		
		Date: ___/___/___
Name: _____	Age: ___	Sex: ___ Race: Hispanic White
Type of Feminizing Therapy Hormones: _____		

Proposed Surgery (circle one): Male-to-Female or Female -to-Male		
Have you had any of the following conditions? Circle Yes or No to all questions.		
Angina: Yes No	Heart attack: Yes No	Heart surgery: Yes No
Diabetes: Yes No	Kidney disease: Yes No	Addison's disease: Yes No
Asthma: Yes No	Bronchitis: Yes No	COPD: Yes No
Coronary artery disease: Yes No	Glaucoma: Yes No	Hypertension: Yes No
Bleeding Disorders: Yes No	Thyroid disease: Yes No	Cholesterol: Yes No
Systemic lupus: Yes No	STDs: Yes No if yes, explain _____	

HIV/AIDS: Yes No	Arthritis: Yes No	Ulcerative colitis Yes No
Mental Disorders		

Suicidal Thoughts: Yes, No	Suicide attempts: Yes, No
----------------------------	---------------------------

Figure 2. Sample Generic Preoperative Nursing Assessment Document

Male-to Female and Female-to-Male Transgender-Specific Health Care Evaluations

The transgender-specific assessment is designed to investigate the details of the transgender person's past and present health care history, past and present hormonal therapies, current pharmaceutical treatments for chronic diseases, and other gender-related medicines. Because some drugs are incompatible with certain foods and other pharmaceuticals, researchers Savkare and Wakhare (2017) issued a warning about the potential adverse effects. Fenway Health (2015) concurs and adds that FTM hormonal treatments may have a destabilizing effect on the chemistry of psychotropic pharmaceuticals that can cause noticeable deteriorations in the patient's mental states. So, the presurgical client will be required to provide a current list of all drugs (prescribed and over the counter) being taken at the time of the initial preoperative surgical consultation. The drug therapy stop date will be taken into consideration when deciding on an appropriate surgical date. The physician's and the nurse's responsibilities will include pinpointing when the use of feminizing or masculinizing hormone therapy began so that life-saving medication interruption could be a part of the patient care plan. The World Professional Association for Transgender Health (WPATH) (Fenway Health, 2015) recommended a minimum 2-year span between continual hormone therapy cessation and the proposed surgery to be eligible for surgery. The cessation of intramuscular estrogen treatments should happen 30 days prior to surgery. The cessation of transdermal and oral

estrogen therapy must be confirmed 14 days preoperatively. Estrogen is associated with life-threatening thrombosis formation. The nurse or physician should confirm whether the trans patient has completed at least one year of living as a trans woman or a trans man while on the feminizing or masculinizing hormones to gauge the patient's medical response and readiness for gender reassignment surgery (Fenway Health, 2015).

Multidisciplinary Collaboration

To prevent inadvertently creating any health disparities during the perioperative sexual reassignment process, public health care providers must work collaboratively with the non-public health medical-surgical team. This multidisciplinary collaborative strategy will ensure the provision of safe, complete transgender-congruent perioperative care and the seamless post discharge transition back to the public health care provider for gender-specific physical and mental health follow-up care. The preoperative phase begins when the decision is made to have surgery and includes patient care during admission to the preoperative suite. At this phase, public health providers will collaborate with the hospital-based physicians and nurses via a process known as clinical reasoning (Lambie, et al., 2015) to interpret and classify the data retrieved from the initial multifaceted assessment. Clinical reasoning will allow this multidisciplinary health care team to form a medical diagnosis, the first steps in creating a patient-focused plan of care. Lambie et al. (2015) refers to clinical reasoning as a process of looking at patient care through a holistic health lens and making sound scientific judgements that are beneficial for the patient to achieve the desirable health outcomes. The hope is that transgender patients whom health providers had identified as suicide risks will receive the kind of care plan

that includes mental health interventional procedures for suicide prevention. Another critical consideration for making accurate nursing and medical diagnoses when caring for transgender patients is being educated beforehand in transgender-congruent health care. The Lippincott Nursing Center (2015) asserted that health providers who are uneducated in transgender congruent health needs lay the foundation for the transgender patients' mistrust of health providers. Thus, creating and maintaining an atmosphere of mutual respect and transparency between the transgender patient and the health provider will encourage the trans patient to disclose current hormonal treatments that has the risk of fatal blood clot development. Blood clot prevention interventional therapy should be given prophylactically as needed to reduce the risk of deadly blood clots that may emerge during the surgical procedure. Hence, nondisclosure of this critical information augments the patient's mortality risk because there would be no thrombus preventing pharmaceuticals given to a patient as a clot-preventative measure (The Lippincott Nursing Center, 2015)).

Creating Holistic Transgender Care Plans

The holistic approach to health care for the transgender client includes being familiar with the culture of this population (Landry, 2016). Therefore, providing a safe perioperative environment for the transgender patient means adding culturally congruent health care paradigms in an atmosphere of respect, compassion, and non-judgmental acceptance. It is important that public and hospital-based health care providers collaboratively mitigate the damages inflicted by previous insensitive health providers. The preferred strategy involves using transgender-appropriate communications free of

erroneous assumptions and negative stereotypes (Landry, 2016). Furthermore, health providers who are skilled in creating patient focused plans of care will facilitate successful progress through the perioperative and public health transitional phases to achieve desired patient health outcomes. Besides, planned care for transgender women (MTF) and transgender men (FTM) should be customized according to intended gender.

Specific Plan of Care for Transgender Women: Male-to-Female

The specific care plan for MTF trans patient-specific care plan includes specific preoperative and post-surgical care for breast augmentation, liposuction, facial feminizing, orchiectomy (removing the testicles), penectomy (amputation of the penis), vaginoplasty (creating a vagina), and vulvoplasty (creating external female genitals). Mental health, psychological support, and grief counselling should be included to help the patient through the inevitable reality shock of losing the penis.

Specific Plan of Care for Transgender Men: Female-to-Male

In-hospital care strategies for FTM trans patients should include the specific pre-surgical and post-surgical care for post mastectomy chest reconstruction, abdominal or vaginal hysterectomy (removal of the uterus), bilateral salpingo-oophorectomy (excision of the right and left fallopian tubes and ovaries), vaginal and clitoral reconstruction to prepare for penis and scrotum creation, and repositioning of the urethra (Fenway Health 2014). Should the trans patient choose to keep the uterus and ovaries, routine gynecological follow-up and well-woman preventative care should be resumed postoperatively. Also, mental health, psychological support and grief counselling should be included to mitigate the reality shock of the masculinizing physical changes. The goal

is to ensure that a customized transgender-appropriate strategy of transgender client care will achieve desirable predetermined outcomes (Malley, Kenner, Kim, & Blakeney, 2015). Furthermore, patients who are confirmed suicide risks may need the services of a clinical psychologist or a psychiatrist to treat emerging mental health issues and a primary care physician to treat any co-existing medical problems.

Plan of Care Implementation

Plan of care will be implemented from the perspective of the quad diagnostic reasoning technique asserted by Nurjannah, Warsini, & Mills (2013), namely: *interpreting, verifying, labeling, and recording* the health care strategies that worked and unsuccessful strategies.:

- *Interpreting Data:* The process of interpreting the data retrieved from the assessment, the nursing diagnosis, the care planning decisions is a four-level process. In *Level I*, the care giver will identify patterns and indications of suicidal thoughts or protentional suicide attempts. In *Level II*, the care giver will recommend interventional strategies and decide at which point in the implementation process that the strategies will be put into practice.
- *Data verification:* The health provider will verify that the information retrieved from the assessment is accurate and free from provider bias and misconceptions.
- *Cationization:* The researcher will categorize retrieved information, assign names to the categories, and label themes for easy recognition.

- *Recording Data:* The analyzed results will be documented and the final report prepared.

Postsurgical Care Evaluation

The evaluation phase is the opportunity to review and measure the effectiveness of the patient care strategy employed. The health providers will appraise the success of the transgender health care at predetermined, incremental timeframes. An evaluation of the post-surgical phase will include information gleaned from Level III and Level IV. In the Level III stage, the health provider may evaluate whether the transgender care strategies met expected health outcomes. In the Level IV stage, ideally, the cause of perioperative transgender suicide could be confirmed or refuted. Once the review is complete, non-compliant procedures will be discarded and immediately replaced with workable transgender perioperative and transitional suicide prevention care approaches.

Two Models Guiding the Non-Public Health Care Providers

The Perioperative Medicine Model

Two relevant non-public health theoretical models that are complimentary to the SESPM are the Perioperative Medicine Model (PMM) as set forth by The Royal College of Anesthetists (2014) to guide all members of the surgical team. This theoretical paradigm promoted evidence-based excellence in perioperative care by a multispecialty coalition of physicians. The perioperative surgical team members include anesthesiologists, and surgeons, the associated non-surgical team physicians may function as consultants. Additionally, medical providers may, from the lens of their specialty in practice, diagnose and treat co-existing mental health and compromising

physical health conditions. One construct of the Perioperative Medicine Model relevant to this investigation requires an additional year of perioperative-specific training for anesthesiology residents (Kain, Fitch, Mets, and Pearl, 2017). Hence, this education requirement may facilitate upgraded transgender-appropriate, perioperative health care. Gender reassignment surgeries are high-risk surgical procedures that may lead to negative health responses. Hence, physicians are required to identify, treat, and provide management for any existing physical and mental health disorders in addition to providing gender-appropriate perioperative care. The surgeon performs the initial patient health needs assessment, diagnostic laboratory tests, and may examine the mental health evaluation results from either a clinical psychologist or a psychiatrist if applicable, prior to admission to verify the patient's mental health competence. The associate physician performs assessments related to the safe delivery of the anesthesia. The surgeon and anesthesiologist decide on the most appropriate anesthesia method (general, epidural, or spinal) to use. In many cases, general anesthesia may be too risky due to certain pre-existing chronic illnesses. The anesthesiologist and surgeon review the preoperative laboratory results. Laboratory results related to clotting time, hemoglobin level, and potassium levels help to rule out potential life-threatening arrhythmias.

A physician must also acquire and document the medical history, physical examination report, and laboratory results. Based on this examination, the physician will grant or deny medical clearance for surgery. If the patient is not medically cleared to proceed with surgery, the surgeon and the anesthesiologist will work in collaboration with the medical doctor to treat and correct any health problems preventing medical

clearance. The perioperative nurse who performed the perioperative assessment (The Royal College of Anesthetists, 2014) will work with the physician to determine the patient's level of surgical risk. The medical doctor, the anesthesiologist and the surgeon will collaboratively formulate an appropriate plan of care strategy that is medically safe transgender compliant. Once the presurgical medical issues are resolved, the patient will transition into the intraoperative phase when admitted to the pre-surgical suite. The anesthesiologist initiates safe perioperative patient care with the induction of anesthesia and will subsequently manage pain during the immediate, intermediate, and long-term postoperative phases (The Royal College of Anesthetists, 2014).

The Perioperative Patient Focused Model

Transgender clients face gender health care inequities (Reisner, White, Bradford, & Mimiaga, (2014). Hence the need for appropriate patient care paradigms. The Perioperative Patient Focused Model (PPFM; AORN, 2015) will assure competency for nurses caring for the trans patient during the preoperative, intraoperative, and postoperative surgical phases of the gender reassignment surgical process (Malley, et al., 2015). PPFM is the surgical nurse's systematic perioperative perspective that will place trans men and trans women patients at the nucleus of the perioperative scheme of care. (Association of Operating Room Nurses, [AORN], 2015). The PPFM is a physician-specific perioperative health paradigm that will guide the surgeon, anesthesiologist, and associated physicians to render transgender-competent care for the surgical trans man and trans woman patient. Likewise, the PPFM offers the guiding principles that nurses will use to provide transgender-congruent perioperative care during the sexual reassignment

surgical process. Therefore, the constructs of the SESPM, the PMM, and the PPFM will be pivotal components in training public health providers, non-public health physicians, and non-public health nurses in the art of providing safe, respectful, transgender-competent perioperative care. The transgender health policy at the Fenway Health (2015) facilitates the creation of a transgender compliant environment for mental and medical health care. The PPFM is unique because of the inclusion of a designated support person (a significant other or family member) as a collaborative partner in the planning and implementation of care. The designated support person could help prevent family or relationship rejection that may contribute to suicidal thoughts or attempts.

Nature of the Study

This phenomenological (Eddles-Hirsch, 2015) qualitative public health research study will seek to identify and understand which factors within the perioperative phase prompted suicide attempts and suicidal thoughts among trans men and trans women. The data collection method of choice was in-person interviews of adult postsurgical transgender men and transgender women. The rationale was to understand the mental health status from each person's perspective about their suicidal attempts and suicidal thoughts (Barr, 2015) during the perioperative phase (preoperative, intraoperative, and postoperative transitional; Journal of Patient Care, 2018) of the gender reassignment process. The sampling method of choice for this study was Criterion Sampling (Palinkas et al., 2015), a type of purposeful sampling to assist in recruiting transgender participants that fit the predetermined criterion for this study. Achieving the appropriate sample size for this phenomenological study depended upon data saturation, the point of information

redundancy when no new data emerged (Saunders et. al., 2018). Eligible participants for this study, were postsurgical transgender men and transgender women between 21 and 65 years old who read, wrote, and understood English, resided in the United States, and had either attempted suicide and/or entertained suicidal thoughts in the past.

Equality Florida (2018) and the Williams Institute (Haas, Rodgers, and Herman 2014) were two of several national organizations contacted for permission to communicate with their transgender members as potential study participants for my research project. The Division Manager of Trans Services, the executive Director of ALSO Youth, SurveyMonkey (2018), and the Director of Transgender Equality of the Equality Florida Institute expressed their commitment to assist me with my dissertation. The plan was to ask interested persons to complete this study's survey questions about their perioperative experiences. Unfortunately, these organizations were unable to move forward.

Suicide Prevention Using the Five-Step Public Health Strategy

The five-step public health strategy to suicide prevention were: search surveillance data to define the problem; look at the risk and protective factors to identify causes or contributing factors; formulate need-specific interventions for at risk transgender patients and test for effectiveness; implement effective interventions; and perform incremental appraisals of the interventions (Suicide Prevention Resource Center, n.d.). For example: problem definition is possible after an extensive peer-reviewed literature search about suicide rate within the transgender community; refining the search to uncover causal or contributing factors to trans persons' suicides may point to factors

that could be public health professional could reference to at risk persons; depending on emerging mental health and physical health needs, public health providers could create temporary test intervention and document the success or failure of each; implementing successful test interventions as permanent suicide prevention interventions; and put into practice trans male or trans female customized health objectives that were cost-efficient, measurable, timely, contemporary, and achievable (Suicide Prevention Resource Center, 2020).

Definitions

According to AORN (2015), the three-phase perioperative period refers to the preoperative phase that begins at the time the person decided to have the gender reassignment surgery, the initial consultation with the surgeon, and ends with the admission to the health facility on the day of the surgical procedure. The intraoperative phase will commence on the day of the surgical procedure when the client entered the surgical suite and will end with transfer to the post anesthesia care unit (PACU). The postoperative phase begins with the patient's admission to the PACU, through the time of discharge from the surgical facility. This last phase could continue through the immediate and intermediate transitional phases, ending 12 months post operatively (Malley, Kenner, Kim, & Blakeney, 2015).

A trans woman for the purposes of this study refers to a man who has had genital surgery to convert his penis into a vagina (Jackman, Dolezal, & Bockting, 2018).

Moleriro and Pinto (2015) define gender identity as the self-perception of being male or

female, and for the purpose of this study, transgender. Cisgender (Wylie et al., 2016) refers to any individual who do not identify themselves as transgender.

Assumptions

The following are the assumptions associated with this study:

1. Participants will sign the informed consent form.
2. Participants will remain for the duration of the study.
3. Participants will be truthful.
4. The participants will meet all eligibility requirements.
5. Participants will complete the study in its entirety.
6. The population size will be representative of the population of interest.
7. Data saturation will be achieved.
8. The thematic analysis will be the best data analysis choice.

Scope and Delimitations

Research Scope

The scope of this study was to investigate nurses and physician's transgender health knowledge deficits during the perioperative period and the trans person's perspective of their perioperative experience to uncover what triggered suicidal thoughts and suicidal attempts during this period. My purpose for this study was using a tried model strategy (the Social-Ecological Suicide Prevention Model, the Perioperative Medicine Model, and the Perioperative Patient Focused Model) as a foundation to initiate holistic, competent, safe, and culturally appropriate perioperative care for transgender

patients. The constructs of each of these models will be applied to meet the explicit needs of MTF and FTM transgender patients.

Research Delimitations

Transgender persons are a minority within a minority population (gay, lesbian, and bisexual community). Delimitations are assumed because there is so little credible research on transgender suicides during the perioperative phase. The Minority Stress Model was rejected because transgender suicidality issues could not be fully explored. All other theories are excluded for the same reason.

Limitations

Inclusions and Exclusions

Participants who meet the predetermined requirements were eligible to be included in this study. All others were excluded. The nine eligibility stipulations for this study were that all participants needed to be:

1. Between the ages of 21 and 65 years old
2. A United States citizen or legal resident
3. Able to read, write, speak, and understand English
4. A postoperative trans man or a postoperative trans women patient
5. Someone who attempted suicide in the past 12-24 months
6. Someone who entertained suicidal thoughts in the past 12-24 months
7. Someone who experienced transgender-related rejection after gender confirmation surgery
8. A victim of transgender-related discrimination

9. Someone who experienced regret following gender confirmation surgery

Significance

It is important for medical providers and public health professionals to understand the lived transgender perioperative experience, especially when creating realistic and holistic transgender health outcome protocols, and when identifying factors contributing to postsurgical transgender suicides (Adams et al., 2017). I hope that results from this study will make positive contributions to public health practice, improve medical and nursing providers transgender health knowledge, and upgrade transgender health care delivery competence. Another goal is to ensure that all presurgical transgender persons meet the eligibility requirements for the presurgical gender reassignment surgery.

Contribution to Public Health Practice

This study's results could serve as first steps towards developing transgender-specific suicide prevention protocols and legislation (Christian et al., 2018). Another goal is to achieve transgender health equity (Noonan et al., 2018). Moreover, the results of this study could facilitate collaboration among public health researchers, mainstream health care providers, and representatives from the transgender community to formulate realistic, transgender-specific suicide prevention protocols applicable to multidisciplinary health care settings. Additionally, data from this investigation could help improve health provider competence in caring for transgender patients by augmenting medical provider transgender health proficiencies (Noonan et al., 2018). Implementing medically appropriate transgender-specific health protocols (Safer et al., 2017) and decreasing the existing health disparities faced by this population are the ultimate goals. Integrating the

five-step public health strategy for suicide prevention means searching surveillance data to define the problem of transgender suicides; look at the risk and protective factors to identify causes or contributing factors; formulate need-specific interventions for at risk transgender patients and test for effectiveness; implement effective interventions; and perform incremental appraisals of the interventions (Suicide Prevention Resource Center, n.d.). Henceforth, public health care providers must work collaboratively with the non-public health medical-surgical team. This multidisciplinary collaborative strategy will ensure the provision of safe, complete transgender-congruent perioperative care and seamless post discharge transitions back to the public health care providers for gender-specific physical and mental health follow-up care. Moreover, the recommendation from this study is that all public health practitioners provide transgender clients, their significant others, and their families with suicide prevention resources. I distributed the National Transgender Suicide Prevention hotline number (Trans LifeLine, 2019) to the trans men and trans women who participated in this study.

Contribution to Public Health Knowledge

There is growing evidence of health professionals who have negative preconceptions and negative attitudes about transgender clients, as shown with pharmacy residents (Leach & Layson-Wolf, 2017) and nursing students (Lim & Hsu, 2016). The results of this study may be useful in encouraging medical schools, nursing schools, and schools training allied health care workers to add transgender-appropriate healthcare paradigms to their existing curricula (Kosenko, Rintamaki, Raney, & Maness, 2016).

Contribution to Social Change

Conflicts within the social, economic, familial, traditional health care institutions, or public health systems have augmented transgender health disparities (Christian, Mellies, Bui, Lee, Kattari, & Gray, 2018). This study will contribute to the positive social change paradigm that dismantles the present traditional, non-transgender-inclusive health care practices by improving individual, family, and community access to high quality, transgender-appropriate health care. Since only a few health care professionals were educated in transgender-specific medical care practice (Safer et al., 2017), health care discrimination towards transgender persons was the result. Consequently, this transgender health knowledge gap caused the use of ineffective suicide prevention protocols (Haas, Rodgers, & Herman, 2014; Virupaksha, Muralidhar, & Ramakrishna, 2017). Educating more medical health care providers about the specifics of transgender-compliant medical care is poised to begin the process of reducing transgender health disparities to: (1) improve this population’s access to competent health care providers who recognize transgender individuals at risk for suicidal attempts and suicidal thinking, and (2) proactively implement suicide prevention standards in a respectful, gender-appropriate, and timely manner. FTM transgender persons will hereafter be referred to as “transgender men” and MTF transgender persons will hereafter be referred to as “transgender women.”

Summary

Suicide is an emerging public health problem that affects 40% of the United States populace (Flores et al., 2016) who self-identify as transgender. The Center for

Disease Control and Prevention's National Center for Injury Prevention and Control, (n.d.) has (1) reported suicide as the primary cause of death among 21-34-year-old Americans, (2) designated suicide prevention to be a major focus in the public health industry, (3) recommended that suicide prevention initiatives should integrate proven scientific evidence, and (4) implemented suicide prevention protocols from a collaborative, multidisciplinary perspective. Unfortunately, the lack of medical provider transgender-specific health care education is associated with high levels of health disparities for this population (Safer, et al., 2017). This includes the use of ineffective suicide prevention procedures (Haas, Rodgers, & Herman, 2017), useless suicide interventions (Virupaksha, Muralidhar, & Ramakrishna, 2016), the stigma associated with being transgender (Hughto, Reisner, & Pachankis, 2016; Kosenko, Rintamaki, Raney, & Maness, 2013), postsurgical regret (Heyer, 2016), and relationship rejection (Klien & Golub, 2016).

The rationale for choosing the hermeneutic phenomenological (Eddles-Hirsch, 2015) qualitative methodology is to gain an understanding about which factors within the perioperative phase prompted suicidal thoughts and suicide attempts among trans men and trans women. The data from this study could serve as first steps towards developing successful transgender-specific suicide prevention protocols and legislation. This new legislation could help reduce transgender health care disparities (Christian et al., 2018) and achieve transgender health equity (Noonan et al., 2018). It may also prompt schools of public health, medical schools, and nursing schools to add transgender-appropriate healthcare paradigms to their existing curricula (Kosenko, Rintamaki, Raney, & Maness,

2016). Furthermore, this study may help expand the number of available transgender-compliant public health, medical, and nursing providers who could be instrumental in reducing transgender health disparities. This first chapter introduced a Triad-Model for transgender health care delivery, namely the Cramer and Kapusta (2017) Social-Ecological-Suicide Prevention Model, as the main framework to create transgender-specific suicide prevention protocols and suicide intervention paradigms; the Perioperative Medicine Model, which directed physicians to holistically identify, treat, and provide management for existing physical and mental health disorders during the provision of gender-appropriate perioperative care (Royal College of Anesthetists, 2014), and the Perioperative Patient Focused Model (AORN, 2015) to certify competencies for nurses caring for transgender patients during the preoperative, intraoperative, and postoperative surgical phases (Malley et al., 2015) of gender reassignment. The benefit for using an adapted version of the Roller & Lavrakas, (2015) 4-Satge Funnel Approach is the transportability of its introduction, integration, attitude awareness, and beneficial recommendation principles for transgender health improvement. Additionally, including the five-step Public Health Approach to Prevention in this study will ensure research alignment when utilizing data from public health surveillance resources to define the problem; to facilitate risk factor recognition of causes or contributors to suicidal thoughts and attempts; when creating need-based, gender-congruent interventions for preliminary testing; when implementing successful interventions; and when performing regular evaluations of implemented interventions gauge the protocol's effectiveness so that the

multidisciplinary health team could identify the benefits or deficiencies from the perspective of desirable health care outcomes for perioperative transgender clients.

Chapter 2: Literature Review

Introduction

The lack of public and non-public health provider education about transgender-specific health care methods has produced few widely accepted protocols for transgender-appropriate health care. This deficiency is associated with high levels of health disparities for transgender persons (Safer, et al., 2017). The use of ineffective suicide prevention procedures (Haas, Rodgers, & Herman, 2017) and suicide interventions (Virupaksha, Muralidhar, & Ramakrishna, 2016) are the results. Other health care disparities for transgender individuals include the stigma associated with being transgender as asserted by Hughto et al.(2016) and confirmed by Kosenko, Rintamaki, Raney, & Maness (2013), postsurgical regret (Heyer, 2016), and relationship rejection (Klien & Golub, 2016).

According to the CDC BRFSS, 1.4 million Americans self-identify as transgender (Flores et al., 2016). Higher suicide rates within the transgender population (Barr, 2015) is, according to Virupaksha, Muralidhar, and Ramakrishna (2016) a significant public health problem. Unfortunately, a transgender person's negative experiences with existing public health care and non-public health care systems include encounters with insensitive health providers who refuse to provide much-needed health care services (Tollinche et al., 2018). Additionally, there is a knowledge gap that relates to perioperative suicides among transgender patients, hence the focus of this study. Tollinche et al. (2018) declared that some transgender persons experienced psychological discomfort, were withdrawn, felt disrespected, and were depressed during the perioperative process.

The purpose of this hermeneutic phenomenological (Eddles-Hirsch, 2015) qualitative public health research study is to identify and understand which factors in the perioperative phase prompted suicide attempts and suicidal thoughts among trans men and trans women. Hopefully, the data from this study will: (a) provide credible, evidence-based information for educating multidisciplinary health care providers in providing transgender-appropriate physical and mental health care; (b) impact transgender focused suicide prevention policy development; and (c) improve contemporary interventional procedures that could result in the reduction of transgender suicides. Some transgender suicides could have been fueled by institutional-based and personal experience-based discrimination towards trans women (Adams, et al. 2017). Additional suicide contributing factors could be the trans person's: (a) failure to access physical health and mental health care due to fear of discrimination from medical providers (Seelman, et. al. 2017) and (b) failure to access postoperative transitional health care after gender confirmation surgery (Hughto, et al., 2017). Klien and Golub (2016) identified *being rejected* by significant others and family members as another factor that prompted suicidal thoughts and suicidal attempts. Kosenko, Rintamaki, Raney, and Maness (2016) reported that the trans individual's perceptions of negative stigma was associated with being transgender. Hughto et al. (2017) indicated that additional suicidal prompting factors included insufficient insurance coverage, lower educational status, and economic challenges that prevented transgender patients from accessing postsurgical mental health care. Also, Hughto et al. (2017) reported on a study of Massachusetts transgender adults who added transitional care access barriers to the list of factors that has contributed to

transgender health disparities. Christian et al. (2018) referred to transgender persons as invisible clients who are forced to function within an environment of non-inclusion. The Centers for Disease Control and Prevention (2018) has created guiding principles and practices for transgender-specific health care to mitigate the damages caused by misinformed health care providers.

A Social Change Strategy

Conflicts within the social, economic, relationship, or public health system augment transgender health disparities (Christian, Mellies, Bui, Lee, Kattari, & Gray, 2018). This study will contribute to positive social change paradigms that will dismantle present traditional, non-transgender-inclusive health care practices by improving individual, family, and community access to high quality, transgender-appropriate health care. Since only a few health care professionals were educated in transgender-specific medical care practice (Safer et al., 2017), health care discrimination towards transgender persons has resulted. Consequently, this transgender health knowledge gap has caused the use of ineffective suicide prevention protocols (Haas, Rodgers, & Herman, 2014; Virupaksha, Muralidhar, & Ramakrishna, 2017). Henceforth, educating more medical health care providers about the specifics of transgender-compliant medical care is poised to begin the process of reducing transgender health disparities to: (a) improve this population's access to competent health care providers who will recognize transgender individuals at risk for suicidal attempts and suicidal thinking and (b) implement suicide prevention standards in a respectful, gender-appropriate, and timely manner. Female-to-male (FTM) transgender persons will hereafter be referred to as *transgender men or trans*

men and male-to-female (MTF) transgender persons will hereafter be referred to as *transgender women or trans women*.

Impact on Public Health Practice

This study's results could serve as first steps towards developing transgender-specific suicide prevention protocols and transgender suicide prevention legislation to reduce transgender health care disparities (Christian et al., 2018) and achieve transgender health equity (Noonan et al., 2018). Moreover, the results of this study could facilitate collaboration among public health researchers, mainstream health care providers, and representatives from the transgender community to form realistic, transgender-specific suicide prevention protocols applicable to multidisciplinary health care settings. Furthermore, data from this investigation could help to decrease health provider incompetence in caring for transgender patients by augmenting medical provider transgender health proficiencies (Noonan et al., 2018). Hence, implementing medically appropriate transgender-specific health protocols (Safer et al., 2017) and decreasing the existing health disparities faced by this population are the ultimate goals. This may be accomplished by merging counselling, social work, hormone therapy, and surgical intervention with training medical providers to recognize and manage gender dysphoria during the first office visit (Atkinson and Russell 2015).

Augmenting Public Health Knowledge

There is growing evidence of health professionals who have negative preconceptions and negative attitudes about transgender clients, as shown with pharmacy residents (Leach & Layson-Wolf, 2017) and nursing students (Lim & Hsu, 2016). So, the

results of this study may be useful to encourage medical schools, nursing schools, and schools training allied health care workers to add transgender-appropriate healthcare paradigms to their existing curricula for ensuring health providers transgender health care competence (Kosenko, Rintamaki, Raney, & Maness, 2016). Shindell, Baazeem, Eardley, and Coleman (2016) recommended that medical school curricula include multi-generational human sexuality training, thus preparing future physicians who are transgender health care proficient.

Literature Search Strategies

The library at Walden University (2018) was the starting point for my literature search using the search terms: *transgender demographics, transgender United States population, transgender health disparities, transmen and transwomen suicide rates, transgender health articles on mental health, resilience, health provider discrimination, relationship rejection, post-operative health transition barriers, transgender suicide causes, and transgender perioperative care*. My search strategy also included peer-reviewed article searches for protocols to improve public health provider, medical provider, and nursing provider transgender-focused education. This social change approach will be useful for reducing and eventually eliminating transgender health care access barriers and trans persons' health care delivery disparities.

The Literature Search Process

The literature research strategies included peer-reviewed articles, and databases including EBSCO, ProQuest, and SocINDEX, which I accessed for information on gender studies. I also used Thoreau for searching Multiple databases. The National

Transgender Discrimination Survey was accessed for current and emerging health status and health disparities among transgender persons. CINAHL & MEDLINE combined research and the U.S. Department of Health and Human Services were accessed to retrieve transgender-specific health resources. The Indian Journal of Psychological Medicine provided information about the transgender experience with suicide-related issues. Supplementary key words employed encompassed transgender health disparities, gender dysphoria, regret, transgender discrimination, violence, transgender suicide statistics, transgender United States demographics, transgender perioperative care, transgender suicide interventions, transgender mental health assessments, access to transgender-healthcare, and transgender health provider knowledge and culturally competent transgender health. The Williams Institute (Flores et al., 2018), Fenway Health (2015), and Equality Florida (2018) provided transgender health and demographical information. The Centers for Disease Control and Prevention (2018) search yielded principles and best practices for achieving proficient transgender-specific health care guidelines.

The iterative research method is a seven-step journey, similar to my Ph.D. dissertation procedure: defining the problem (University of Houston, 2018) using the premise and the prospectus, reviewing the subject-related literature, deciding on a subject focus with a problem statement, choosing the qualitative research strategy proposal, conducting the research, analyzing and interpreting the results, and reporting the conclusions. The iterative process for germane scholarship is the method chosen to

acquire information relevant to my dissertation topic by means of focused literature searches.

Mitigating the Challenges of Limited Available Research

A good portion of the past 20 months was spent conducting peer-reviewed and scholarly article searches on contributing factors for trans women and trans men suicides. I found articles that briefly mentioned male-to-female suicide incidents and even less on female-to-male suicidal thoughts and suicidal attempts, but nothing substantive. So, my mitigation strategy for trans persons suicide research was conducting relevant research in categories retrieved from some documented contributing factors like: (a) limited health knowledge about transgender-specific health issues among healthcare professionals due to (b) the absence of medical school education (Safer, et. al., 2017 p.2) in transgender health care, (c) looking for any peer-reviewed literature focused on finding workable solutions for reducing transgender health disparities and suicides, (d) I categorized search components to find transgender suicide prevention protocols and looked for scholarly information on transgender suicides occurring during the perioperative phase of the gender reassignment surgical process.

Theoretical Foundation

The Cramer and Kapusta (2017) Social-Ecological Suicide Prevention Model framework guided this investigation. The SESPM provided the foundational framework for the creation of transgender-specific suicide prevention protocols and suicide intervention paradigms. Additionally, the SESPM could function as an educational instrument for training public health and traditional medical providers in the nuances of

transgender-specific health care. The two-fold focus was to: (a) assist public health and traditional medical health providers to understand the lived mental health experiences of transgender patients who may have attempted suicide and may have entertained suicidal thoughts during perioperative gender re-assignment process, and (b) provide life-saving suicide prevention intercessions in a time-sensitive method.

In subsequent literature reviews I uncovered two theoretical models that are complementary to the SESPM and applicable to the is research project. The first complimentary theoretical model is the Perioperative Medicine Model (PMM) set forth by The Royal College of Anesthetists (2014). The PMM is a physician-specific perioperative health care paradigm applicable to caring for trans male and trans female patients. The second complimentary theoretical model is the Perioperative Patient Focused Model (Association of Operating Room Nurses, [AORN], 2015). The PPFM is a systemic, perioperative perspective that will have trans men and trans women patients at the nucleus of the perioperative scheme of care. Transgender clients face gender-associated healthcare inequities (Reisner, White, Bradford, and Mimiaga, 2014). Hence, the constructs of each model will be essential to educate public health providers and non-public health physicians and nurses in the art of providing safe, respectful, holistic, transgender competent perioperative patient care.

Literature Review

Transgender Health Care Knowledge Gap

Safer, et al. (2017) declared that transgender health training in schools of public health, medical schools, and nursing school curricula to train physicians in the nuances of

competent, holistic gender-specific, mental, and physical healthcare for transgender persons is essential. Shindell et al (2016) recommended transgender health competency training via a multi-generational human sexuality curriculum in all medical schools. For nurses, the recommended plan was to incorporate transgender health care methods in five required baccalaureate program core nursing courses. (Safer, et al., 2017). Further research is needed to focus on teaching competencies in trans men's and trans women's health specifics as well as protocols for gender-appropriate interventional care (McDowell & Bower, 2016). More study is warranted to formulate precise protocols for identifying and treating trans persons who are suicide risks. Building on this knowledge, rules can be formulated to implement suicide prevention activities for trans men and trans women individuals preoperatively and postoperatively (Bauer, Scheim, Pyne, Travers, & Hammond, 2015). Fear of health care provider discrimination was a causal factor of transgender health disparities due to health provider transgender knowledge deficits (Seelman, et al. 2017). Also, there is a knowledge gap in existing literature about the long-term benefits of gender reassignment surgical procedures. Anderson (2018) criticized gender reassignment surgery as being a *quick fix* with no credible evidence of positive long-term mental health enhancing benefits. Anderson's premise was, even though the physical body was successfully altered to the desired gender (male-to-female or female-to-male), a mental conflict remained within the trans individual's psyche between *the at birth* gender mind set and the new gender mind set. For instance, the masculinizing hormone therapy (Mayo Clinic 2019) and the feminizing hormone treatment cannot align the trans individual's at birth psyche with the surgically altered

gender. Thus, the result was gender dysphoria. It was important to note that the term gender dysphoria is the updated version of the old term, gender identity disorder (Atkinson & Russell, 2015) formerly used to describe the distress caused by the conflict between the at birth gender and the preferred gender identity. Hence, the art of correctly recognizing and managing gender dysphoria will facilitate creating and sustaining respectful, trans individual-competent health care delivery paradigms.

History of Transgender Health Knowledge

The article entitled, “Review of the Transgender Literature: Where Do We Go From here?” Wanta and Unger, (2017) made bold, matter-of-fact statements about the lived stigma and the discrimination transgender persons has historically experienced in the 21st century United States. Numerous studies in transgender health care have documented the persistent practice of transgender discrimination by health care institutions and medical providers. Wanta and Unger also referenced The National Center for Transgender Equality and The National Gay and Lesbian Taskforce’s 2011 agencies reported that 35% of trans men and women were physically assaulted and 78% were harassed verbally. Transgender respondents to another survey admitted their experiences with medical treatment refusal. As many as 19% to 28% were harassed in a medical setting. Wanta and Unger also noted that there were knowledge gaps in surgery, geriatrics, pediatrics, and mental health due to the lack of focused transgender research. Little or no research exists about (1) MTF vaginoplasty (creating a vagina from a penis), any associated revisions, or the accompanying psychosocial outcomes, (2) psychiatric and comorbid risk factors, (3) mental health care access during transitional care, (4) the

long-term effects of gender affirming hormone therapy and gender reassignment surgery in the geriatric transgender patient, and (5) all levels of primary and continuing medical education in competent, respectful, and compassionate transgender health care instead of using an identity-based perspective instead of a disease-based standpoint. The diseased based perspective was utilized in 1953 as a catalyst for the first published transgender suicide report up until 1997 (Adams, Hitomi, & Moody, 2017). In the absence of credible evidence, medical professionals categorized trans persons as mentally ill persons with deviant behavior issues who were manipulating physicians into performing gender reassignment surgeries. Subsequently, forty-two Transgender health studies were investigated within a 19-year period so that Adams et al could develop a historical trend timeline to show the transition from the diseased based lens to the identity-based lens. Not using the disease-based lens allowed researchers to introduce female-to-male and male-to-female as new gender categories. The WorldCat data base was the primary source of data for this study, supplemented by Google search and Google scholar sources. Only English language research that focused on transgender health were eligible for inclusion in this study. The descriptive method was the tool for analyzing the 42 eligible documents and summarizing the transgender suicides statistical data. In addition to minority stress and resilience issues, the authors noted that more research is warranted for exploring transitional-related suicide interventional strategies, in addition to the promotion of safe, non-biased transgender-compliant research environments for participants.

In the Article entitled, “Sex Reassignment Doesn’t Work. Here is the evidence” Anderson (2018) pointed out the negative psychosocial impact arising from the malalignment of the birth gender identity and the preferred gender identity. Anderson also declared that there was concrete evidence of health provider knowledge gaps during the gender reassignment process that pointed out inevitable transgender psychosocial challenges. The author referenced a 30-year transgender follow-up study conducted in Sweden that highlighted post procedure mental anguish reported by participants that emerged as many as 10 years to 15 years postoperatively. The author reported that transgendered men and transgender women become feminized men and masculinized women. The conclusive statements from this study was documented by an Aggressive Research Intelligence Faculty (ARIF) at Birmingham University triggered by follow-up results of 100 postop transsexuals (page 2) there was:

- 1 No credible evidence of gender reassignment benefits to the individuals
- 2 No consideration given to alternative treatments
- 3 No follow-up of patients who may had committed suicide postoperatively
- 4 Many gender reassignment studies were rendered invalid because some patients simply fell through the cracks in the process.

5 The majority of those studies were one-sided because only desired results were reported. President Obama’s administration concurred with the AIFR conclusions. In 2016, the available clinical evidence did not prove benefits for having gender reassignment surgery. So, the Center for Medicare and Medicaid decided that poor outcomes and subsequent suicide were highly probable so all coverage appeals for sexual

reassignment surgeries were denied. According to Hess et al. (2014) of the 254 postsurgical satisfaction surveys issued to MTF post op clients, only 119 were completed and returned for evaluation. The satisfaction ratings among this group was high. Since many surveys (135) not returned, the researchers cautioned readers that the results may not be representative of the MTF population. One could speculate that the 135 trans women were not satisfied and may have regretted having the sexual reassignment surgery.

Heyer (2016) concurred with Hess et al. (2014) author of “Regret Isn’t Rare: The Dangerous Lie of Sex Change Surgery’s Success.” As in the case of Hess and colleagues, postoperative satisfaction survey results were not reliable because many trans patients were either unreachable or unresponsive. The inability to reach postoperative MTF and FTM patients was documented in 2004 a review of 100 transgender research studies consistently reported to have lost track of sexual reassignment clients. Hence the transgender health knowledge gap remains.

Researchers Atkinson & Russell (2015) introduced the term *gender dysphoria* to describe the identity disorder within the transgender person’s psyche that caused psychological conflicts between the at birth identity and the chosen identity. Cultural differences and the absence of a standardized definition for gender dysphoria were barriers to accurately evaluating the extent of gender dysphoria among transgender clients. The goal of this article was educating medical providers about the correct assessment techniques that established a mutually respectful provider-patient relationship, to correctly make a gender dysphoria diagnosis, conduct a mental health

assessment, retrieve a medical and sexual conduct history, and introduce the trans client to available support networks. The take-away was training general practitioners to understand gender dysphoria because this population risk of suicide continued to be extremely high.

Barbosa, Dominguez, & Chance, (2016) investigated a study conducted via a collaborative effort among the Community Health Research Initiative of Virginia Commonwealth University, the Virginia Department of Health, and the HIV Community Planning Committee. The 350 participants were trans persons who may have been physically attacked because of their gender choice in the context of suicidal thoughts and suicide attempts. Measurement themes included discrimination-based physical attacks, demographical information, illicit drug use, social support from families, planned or present psychotherapy, and suicide risk behaviors. Only 61% of the participants were 30 years and older. The study reported that physical victimization due to transgender related discrimination dramatically increased the participants' suicide risk. The limitations of this study were that the participant sample size was too small and was not representative of the transgender population. The authors recommended helping trans persons to improve access to health care, moving towards improved acceptance by medical providers, and creating transgender compliant interventions and suicide prevention paradigms as pivotal the attainment of better transgender health outcome goals.

In the article entitled "Why are Transgender People More Likely to Commit Suicide?" Barr (2015) took a different approach to ask, "how can knowing common transgender suicide risk factors be helpful to mental health care practitioners?" The two-

fold response was: Identify and monitor high suicide risk transgender clients and understand the suicide contributing factors to implement transgender-competent interventional care. Barr also included approximately 13 article references to substantiate this article's validity. Bauer, Scheim, Pyne, Travers, and Hammond (2015) reported the findings of a transgender suicide risk survey in Ontario, Canada. The strength of this study were the recommendations. Namely, evaluate the success suicide intervention and prevention strategies, increase inclusion in health and socially, remove transitional health care barriers, and reduce transphobic associated discrimination and violence against trans persons. This study's limitation was the vaguely documented participant age parameters (16+). It was unclear what the maximum age was and who among the under 18 respondents directly responded to the survey or through their parents. The respondents' answers by age group could have been more helpful to my project because my proposed participants' age range was 21 years to 65 years old. No minors.

The Beyond I Do Campaign (2018) was a short article that reported four laws in the State of Florida that promoted legal discrimination against the lesbian, gay, bisexual, and transgender community. Only one in 30 states provided protection for this population of 691,561 persons. Hence, LGBT persons can legally be denied medical services, fired, denied promotions, denied housing, be evicted without cause, and ejected from restaurants and other public establishments. These laws has created gender dysphoria and provided the foundation for suicidal ideation and suicide attempts in Florida.

The Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System was the source for the report published by Flores et al (2016) about

the percentage of survey respondents. Approximately 1.4 million of the United States adult population self-identify as transgender. The six top transgender person concentration by state from the highest to the lowest are Hawaii, California, New Mexico, Georgia, Texas, and Florida.

Dowing & Przeworski (2018) wrote this article to address the gap in knowledge about the specific health needs of gender non-conforming persons, female-to-male and male-to-female transgender clients. In this study, the 2017 analysis of the 2014-2016 CDCs BRFSS was the source of secondary information about a population consisting of 523,080 respondents identified as cis-gender and 2,221 transgender respondents from one United States territory and 31 states. Of the total respondents, male-to-female respondents equaled 0.24% and nearly half (0.14%) were female-to-male who were the most economically and educationally disadvantaged. This study did not include any suicide risk factor information.

In contrast, even though Haas et al (2014) included suicide related questions in the article, the authors preferred a yes/no choice to answer the question, "Have you ever attempted suicide?" Follow-up questions could have given respondents the opportunity to expand answers in detail. Also, providing multiple choice possible answers to the previous suicide question would have yielded more robust responses. Secondly, the researchers missed the opportunity to ask about and identify suicide risk factors. Using convenience sampling did not ensure that respondents represented the population. Finally, this study only focused on attempted suicide. Therefore, a completed suicide knowledge gap emerged.

James et al (2016) deemed the 2015 U.S. Transgender Survey, a follow-up study to the National Transgender Discrimination Survey was deemed a pioneer survey. The National Transgender Discrimination Survey reported the responses of 6,456 transgender persons' discrimination experiences in housing, education, health care, and employment, then concluded that trans people were resilient despite societal and health care maltreatment. According to the survey, 71% of respondents attempted suicide multiple times in their life time. The attempted suicide rate was 40% in contrast to the general population's 4.6 suicide rate and 24% admitted to making suicide plans within the past 12 months in comparison to the general population's 11%. Attempted suicides among transgender persons were seven percent (7%), one percent higher than the general population.

Jokić-Begić, et al (2014) examined the lack of transgender health care knowledge among new physicians and medical students in Croatia. Like transgender persons in the United States, discriminatory maltreatment of transgender persons in Croatia yielded the same negative experiences that transgender people experienced in the United States.

Kline & Golub (2016) recorded that family rejection of transgender persons was an area of study with very little research information. Another knowledge gap warranting further investigation to uncover the association between family rejection and suicidal thoughts and suicidal attempts.

This article by Wolford-Clevenger, et al (2017) explored the transgender suicide public health problem from a different lens than the previous researchers in this literature review. The authors highlighted the need for transgender research from and theoretical

and empirical prospective to gain a better understanding of the dynamics associated with trans person's suicides. The implied strategy for future researchers was to explore the limitations and strengths in contemporary literature for clues that addressed the knowledge gaps. For example, future researchers were urged to organize and measure suicidal thoughts as one variable then organize and measure suicidal attempts as another variable to uncover any correlations. The implied assumption was that current knowledge could be augmented with collaborations among qualitative researchers to understand lived suicidal attempts and suicidal ideation experiences of trans clients. This strategy, according to the authors could inform public health practitioners about how to formulate best practice paradigms for transgender suicide interventions. The recommendation was use current data to create desirable health outcomes via transgender-compliant medical and social transitional health care procedures.

The mental health status of a younger transgender population (18-26-year-olds) was the focus of Oswald and Lederer (2017). In this article approximately 12.2 million college students were under 25 years old, representative of 40% of the U.S. total population. During a six-year period, students enrolled at 429 higher learning institutions from all United States districts and nine foreign educational entities were randomly selected to completed web-based or paper surveys for this study. Only students who self-identified as male, female, or transgender were eligible to participate. The entire survey was completed by 581,603 students. At least one third of the transgender students documented negative health provider encounters. One quarter admitted that health provider discrimination fears prompted them to avoid health care seeking services. The

recommendation was to train college clinic staff in transgender-appropriate health care and to provide transgender inclusive health care services.

The Truth About Transgender, a web-based article by Tannehill (2015) who immediately identified five factors in research that increased suicide risks among transgender persons. These factors included physical and sexual abuse, family and friend rejection, discrimination, conflicting gender roles or gender identities, and internalizing transphobia. Similarly, unresolved issues with past or present sexual or physical maltreatment could cause feelings of shame, hopelessness, and low self-worth could make committing suicide look like a compelling option to end the hurt. Having been rejected by family and friends were added to the list of suicide risk factors. Conversely, Tannehill declared that when friends and family members were supportive of the trans man or trans woman, there was an 80% reduction in that person's suicide risk. Internalized feelings of transphobia indicated that the trans person was either in denial or was too ashamed to seek help. Thus, the risk of suicidal thoughts and suicide attempts increased. Negative experiences in society, with public health practitioners, medical providers, and health care institution-based discrimination diminished the trans person's self-worth and augmented their suicide risks.

According to Statista (2019), from 1950 to 2016 the male suicide rates were persistently reported to be higher than suicides in females. Of every 100,000 residents in the United States six (6) females and 14.2 males committed suicide. When I examined the research article by Vijayakumar, (2015) entitled "Suicide in Women" to get a better understanding of why suicide rates in men surpassed female suicide rates, the converse

was true. A research article by Vijayakumar, (2015) entitled “Suicide in Women” documented that the female suicide rates in China were higher than suicide rates in Chinese males.

Virupaksha, et al. (2016) consulted with experts, searched online data bases, and accessed catalogs to retrieve secondary data for their “Suicide and Suicide Behavior Among Transgender Persons” article. These researchers concurred with all the aforementioned suicide research findings and declared that suicide rates among transgender persons had decreased. Unreconcilable differences with relatives (14.3%), those who received a positive HIV diagnosis a few days prior to the suicide (2.4%), the end of an intimate partnership (64.3%), the gender reassignment choice was rejected by family (9.5%), and continued financial deficits (9.5%). Virupaksha, et al (2016) noted several character attributes that boosted resilience among non-suicidal transgender persons. Such as, financial stability, optimism, coping well spiritually, assertiveness, self-advocating, choosing not to be a victim, achievement of personal goals, a lifestyle of integrity, friendliness, and maintained self-control. The authors concluded that the collaborative efforts among a multidisciplinary team that included policymakers, key stake holders from the transgender community, as well as representatives from private and public organization was vital for reducing transgender suicides.

Structural, Public Health, and Non-Public Health Provider Discrimination

Researches Hughto et al. (2015) declared that stigma and transgender directed discrimination was pervasive within the transposon’s health care and social environments were major contributors to negative health outcomes for this population. Also, trans men

and trans women experienced rejection for being different, were negatively labeled, and stereotyped. Hughto, Rose, Pachankis, and Resiner (2017) added that denied access to standard and transitional health care was recorded by 364 online survey respondents. The authors used a modified Social-Ecological Model to establish how transgender stigma emerged in health care delivery structurally, interpersonally, and from individual health providers. Structural stigma blocked access to fundamental human services like employment, housing, and health care. Transgender interpersonal stigma included disrespect, harassment, and episodes of physical abuse. Structural stigma was identified as the political process that created laws and policies designed to legally limit or deny access to community and health care resources. Hence, the trans person developed chronic physiological responses like elevated stress levels, hypertension, elevated cardiovascular disease risks, diabetes, and increased mortality and morbidity. One recommendation was to expose medical providers about the health care barriers and the societal barriers trans persons faced via transgender-competent medical provider education. Another suggestion was to incorporate the Massachusetts Transgender Political Association's *I Am Trans People Speak* campaign video as a transgender awareness tool for diversity-focused public health education. The three suggested areas for subsequent research were stigma determinants, stigma mechanisms, and transgender compliant stigma intervention paradigms. Kosenko et al. (2013) concurred with the transgender stigma findings documented by Hughto et al., (2017). Kosenko filed the results of an online survey where 152 transgender adults reported their stigma experiences as: denied services, substandard care, and gender insensitivity.

Health provider difficulty to provide health care services and to correctly refer transgender persons to transgender-compliant critical services was impossible without prior transgender-competency training. Researchers Lin and Ohlin (2017) made use of the interview strategy to conduct a qualitative investigation of two transgender persons' perspective of social services. Their findings concurred with existing research from the health care perspective. The transgender participants in this study perceived the transgender health knowledge deficits of social service providers who were clueless about transgender appropriate pronouns (Mr., Ms., he, she, him, her, etc.) to correctly address the trans person. There were no efforts to make meeting environments comfortable for the trans patient. In fact, the opposite was true. Trans persons admitted having to suppress their true feelings and fake a brave demeanor to make the social services representative feel comfortable. Since this was a two-participant research project the researchers recommended choosing a different approach in subsequent studies.

The investigation conducted by Romanelli and Linsey (2018) focused on service denials in doctors' offices, mental health clinics, and emergency rooms for transgender persons who had attempted suicide. The source of these authors' secondary data was the information reported by the 4,190 respondents to the National Transgender Discrimination Survey. The researchers concluded that many transgender patients successfully coped with their first service denial experience. Unfortunately, these coping mechanisms were lost with repeated service denials. In some cases, service denial correlated with substance abuse as a coping tool. The recommendation was to create and

apply transgender specific policies, better transgender compliant health service access, and transgender inclusive health care maintenance delivery.

Safer et al. (2017) reviewed current literature to investigate the origin of access barriers for the transgender population. The major findings were transgender self-reporting barriers like, the non-availability of transgender educated medical providers, cultural incompetence, discrimination, health system barriers, socioeconomic barriers, and financial barriers. There was also a deficiency in medical providers' transgender health knowledge that rendered them incompetent to administer transgender hormone therapy. Add to that the insurance companies' refusal to pay for transgender specific services and medical care evaluation tools like laboratory services, and clinic services. Additional barriers identified were the existence of medical records that excluded a category for male-to-female and female-to-male transgender designations. Recommendations for future studies included research gaps investigation, transgender health care access, how to evaluate and address health provider transgender health knowledge deficits, explore the roles that stigma, environmental barriers, societal barriers and how these obstructions effected this population. One mitigation strategy offered was, assemble a multi-disciplinary team to create evidence-based strategies that could eliminate gaps in transgender health knowledge and improve medical providers' trans people health care competence.

The Williams Institute (2017) featured a document authored by Mallory, Brown, Walch, and Brown (2017) reported that respondents to surveys issued in the years 2010, 2011, 2016, and 2017 provided consistent documented experiences with transgender-

related mal-treatment, harassment, exclusion, and discrimination, in medical care, housing, and employment. Even though in Florida transgender and other persons within the sexual minority community have no legal protection, some Florida counties (Alachua, Monroe, Orange, Osceola, Miami-Dade, Palm Beach, Pinellas, and Volusia) prohibit employment discrimination because of sexual orientation and gender identity (p. 17). Furthermore, insurance companies could refuse coverage for transgender transitional care. Professional therapists were legally prohibited from facilitating gender identity changes or sexual orientation changes (p.22). The authors suggested that the Florida economy improve in a legal and social environment in favor of transgender people.

Health Provider Transgender Competent Health Education Deficit

The Affordable Care Act (2010) mandated that all patient care facilities and providers of Public health and medical services create protocols for easy health care access for all persons. Bachmann et al. (2017) published a ground-breaking article on the results of an interdepartmental collaborative at the Robert Wood Johnson University Hospital. The purpose of the collaboration was to formulate a transgender competent plan of holistic health care for a MTF and FTM trans patients who were admitted for gender conformation procedures. This multidisciplinary interdepartmental team consisted of Pre-Admissions Testing, Registration, Anesthesiology, Endocrinology, Perioperative Services, Nursing, Security, Housekeeping, Obstetrics / Gynecology, Psychiatry, Patient Relations, Bioethics, and Food & Nutrition Services. This strategy was utilized in many hospitals and termed *grand rounds* (MedicineNet, 2019).

The CDC (2018) began this article with the discrimination experiences of African American and Hispanic women who had unfortunate experiences with different forms of abuse, violence, and harassment. Two communication improvement and best practice resources were recommended for training physicians and staff in respectfully interacting with transgender clients: 1. Patient-Centered Strategies in Health Care (health needs and transgender identity information) and 2. Understanding Transgender People and their Health Needs (strategies for creating and sustaining a transgender compliant health care environment). The article also mentioned stigma, deficits in insurance coverage, discrimination, and few available transgender compliant health providers as health care access barriers. Respectful, transgender-competent health care should begin with patient registration / reception to find out the patient's preferred gender-salutation and record his or her response in the client's paper and electronic health record. Gender mismatches should be resolved in a compassionate, timely, and respectful manner. The Colorado Transgender Health Survey evaluated the extent that health disparities affected transgender residents in Colorado (Christian et al., 2018).

The Colomer, Pallisera, Fullana, Burriel, and Fernandez (2013) Reflective Learning article was included in this literature review because of the portability of this educational strategy to transgender compliant education for public health and non-public health practitioners, physicians and nurses. A form of transformative learning and reflective knowledge could facilitate the promotion of learning needs self-assessment; provide assistance to identify and change any prejudices and negative attitudes that could be counterproductive to delivering respectful, compassionate, and gender-inclusive health

care; simplify the diagnostic reasoning process so that public health and nonpublic health practitioners, physicians, and nurse-learners could formulate mitigation strategies to compensate for potential or actual problems associated with integrating new transgender paradigms into evidence-based professional practice.

The article by Felsenstein (2018) entitled "*Enhancing Lesbian, Gay, Bisexual, and Transgender Cultural Competence in a Midwestern Primary Care Clinic Setting*" addressed the absence of *alternative-gender identity* designations on health care forms and health provider LBGT cultural and clinical incompetence. The author suggested a quality improvement focus in LBGT health care at the primary care level that incorporated three competencies for LBGT care: improving the clinics LBGT patient-focused care, providing initial LBGT training (during orientation, diversity training), and mandate continuing education updates for medical providers and health care staff. Correspondingly, LBGT patients were empowered to individually identify himself or herself as lesbian, gay, bisexual, or transgender in a safe and non-judgmental health care setting. The goals of the preliminary and foundational assessments using the Joint Commission LBGT checklist was the benchmark standard. The clinic's staff knowledge, clinical environment, and intake questions were the three areas assessed. Ten Midwestern clinics, according to the author, were chosen for the quality improvement project by use of the Lippitt's Change theory.

In 2004, Kritsonis enumerated the seven-step theory by Lippitt as follows: 1. Problem diagnosis, 2. Motivation and capacity to change evaluation, 3. Evaluate the change agent's power to change, and the presence of resources to support and maintain

the change, 4. Formulate and establish realistic strategies and plans of actions for the proposed change, 5. Provide and clearly communication if the change agent will be an expert, facilitator, or a cheerleader, 6. Make the change sustainable, engage in reciprocal communication, and focused group coordination, and 7. Make the incremental withdrawal of the proposed change agent a signal that the change was the organization's new culture. Unfortunately, this project was not applicable to other settings because the sample size was only 11. Therefore, Felsenstein advised that change agents reinforce lessons learned and facilitate policy development.

The Fenway Institute (2015) identified *seven categories of care* for transgender or non-conforming (TGNC) patients who may have had or may not have had episodes of gender dysphoria during: 1. physical alterations of the body's sexual characteristics by trans-hormonal or surgical methods. 2. non-medical or surgical changes to the body that reflected the chosen gender (binding breasts or tucking the penis between the legs, etc.). 3. Making changes to personal identity papers that reflected the new gender and presenting oneself in the new gender role in social circles. 4. Hair removal, communication modifications, and voice therapy that reflected the new gender role. 5. counselling and psychotherapy to facilitate healthy mental health during and after the transition from one gender to the opposite gender. 6. Refer patient, interested family members, and friends to appropriate support services. 7. Refer TGNC to resources for in-person or online support groups and other need-specific services. Prior to the initiation of hormone treatments, the Institute recommended that physicians thoroughly assess transgender client's knowledge of gender identity and gender dysphoria. The objectives

of the cross-sex hormone therapy, and therapies designed was to affirm the desired gender. Physicians should retrieve a detailed history of mental health status and mental health treatments, medical health that included chronic diseases and pharmaceutical treatments, family health and disease, as well as past and present sexual and social practices. Lab tests should include the correct health screening paradigms and a thorough physical exam should be conducted to establish the transgender patient's anatomical and physiological status and to assign the correct medical codes from the problem list. For MTF (trans females) liver function tests, a basic metabolic test, and lipid panel tests were essential. For FTM (trans males), the Institute recommended STD screening and other tests were ordered at the discretion of the medical provider.

Graham (2013) created a set of health care guidelines for mental health providers and therapists as an instructional instrument about the transgender competent care of presurgical male-to-female and the presurgical female-to-male transgender patient. The premise of this pre-evaluation document was to understand the preoperative psychological preparation of the patient desiring gender reassignment surgery aimed at the improvement of postsurgical outcomes. Graham mentioned the gaps in research about what caused postsurgical regret and regrets related to hormone therapy. In contrast, an Italian Gender Clinic reported a 14-year history of high patient satisfaction levels. Surgery at this clinic was categorized as interventional medical treatment for gender dysphoria. The credit was given to the clinic's successful preoperative preparation program which included obtaining an informed consent, conducting two assessments (each assessment by a different clinician), the administration of pre and postop

psychosocial culturally-competent assessments by mental health providers, focused postsurgical follow-up transitional care, and excellent surgeons. The assessments identified co-illnesses and gender dysphoria, addressed, and solved unmet needs, provided linguistically competent caregivers, conducted mental health status evaluations, and obtained a sexual history to help clinicians create-individual-appropriate health care plans. Graham presented guidance for assessment results documentation and documented content samples. This study did not include any transgender suicide information.

Noonan et al. (2018) addressed the problem of transgender health knowledge deficit among medical professionals. The recommended strategies were collaborate with the transgender community and inform medical school and nursing schools how to develop transgender competent curricula using the *World Café Model*. The Agency for Healthcare Research and Quality (AHRQ) (n.d.) asserted that the World Café Model was a small, facilitator-driven collaborative groups assembled to identify the community and primary care links to gaps in research, promote changes in policy, establish benchmarks that measure linkage success, and facilitate publishing worthwhile health care models. Furthermore, Noonan et al. (2018) reported that the University of Louisville School of Medicine was in the hot seat at the 2015 Community Forum on Transgender Health Care. This forum was comprised of 59 representatives from the transgender population and health professionals who conversed and recommended transgender health care improvements and medical education strategies. The forum participants successfully exhibited that transgender health care delivery in that area was substandard and non-inclusive. The one hundred individuals who participated in the post-forum survey

analysis identified intervention improvement priorities, common perceptions about transgender persons pervasive among health providers, and themes that could inform nursing school and medical curriculum in the nuances of competent transgender health care delivery. Additionally, the recommendation directed medical students to interact with transgender patients and the general transgender population as a field-experience education supplement to enhance their in-class transgender health care instruction.

In the article, “Comparing Methods of Diagnostic Reasoning in Nursing,” Nurjannah, et al. (2013) outlined two methods of diagnostic reasoning that could be applied to competent, patient-focused transgender care practice from the nurses’ perspective. Namely, the four-step method and the six-step methods for the nurses. It is important to note that both methods could be important tools to incorporate transgender competent health care paradigms to nursing school curricula and to upgrade transgender health care in nursing practice. The four-step method interpreted, verified, labeled, and recorded (p. 89) nursing care activities. Perioperative nurses could utilize this four-step method after the preliminary nursing assessment to customize individual plans of care for the trans male or trans female patient on a case by case basis. During the initial assessment, vital signs, a head-to-toe assessment, and a health history should be obtained. The nurse should consider the patient’s laboratory results and use diagnostic reasoning to *interpret* the patient’s current health status. The nurse should also *verify* his or her findings with the physician / surgeon/ anesthesiologist. In the case of allergies, the nurse should attach an allergy alert bracelet to the patient’s wrist and prominently *label* such in

the patient's medical chart. The final step also involved *recoding* all patient encounter activities in the nursing notes.

The second diagnostic reasoning method was the six-step method: to classify the information, make a nursing diagnosis, conduct an appropriate literature review to become familiar with the patient's problem, assign a category or categories, and clearly label the patient's chart with the diagnosis for easy identification to facilitate patient-specific health care planning. The six-step method incorporated the information retrieved from the four-step method to complete the plan of care for the transgender patient. For instance, to *classify the information*, the perioperative nurse would make a specific plan for the MTF patient or the FTM patient because each would require a different gender-specific plan of care. *A nursing diagnosis should be activated* that is compliant with MTF or FTM health requirements in collaboration with physician-order directives. The perioperative nurse should *read and become familiar* with the patient's health care needs; follow a category "A" plan as a nursing diagnosis guide along with the hospital's policies and procedures for safe, competent, perioperative care delivery confirm, and add a gender-specific (MTF or FTM) *label* to ensure the correct nursing diagnosis.

In the article entitled, "Survey of Community Pharmacy Residents' Perceptions of Transgender Health Management," Leach and Layson, (2016) sought to identify gaps in transgender education for these pharmacy students, to measure how each student acceptance of transgender education, and to measure each students' transgender health care attitudes. A four-week time frame was allotted to pharmacy residents who anonymously completed a 34-question online survey. The purpose was to evaluate the

pharmacy residents' level of transgender health care knowledge, the pharmacy residents' attitudes towards transgender persons, and if these students were in favor of having transgender health education integrated into the pharmacy curriculum. Overall, the results were: 36.2% of the pharmacy residents admitted feeling transgender health care competent; 82.7% agreed that transgender health care knowledge is vitally important; 98.2% concurred that transgender health is an important pharmacy practice responsibility; and 71.4% admitted to no transgender-specific education during their pharmacy school training. Curiously, the respondents to the 34-question survey also listed two barriers to transgender persons accessing health care: a deficiency in provider transgender health care knowledge and transgender-focused discrimination by health providers.

Lim and Hsu (2016) conducted a study to examine attitudes held by nursing students towards sexual minorities (LGBT). The authors used of secondary data retrieved from electronic databases with include Ebsco-Host Medline, Web of Science, PubMed, PsycInfo. One of the 12 studies examined documented neutral attitudes, six of 12 reported nursing students with negative attitudes, and only five percent documented positive attitudes towards LBGT persons. Even though the authors declared that the current trend in attitudes were skewed in a positive direction, looking retrospectively, the authors concurred that negative health provider attitudes were pervasive among studies published prior to the year 2000.

In 2015, the Lippincott Nursing Center published a continuing education article entitled, "Culturally-Sensitive Care for the Transgender Adult" a reminder of the nurses'

responsibility to deliver *individualized, holistic* patient care. The section entitled “*Culturally-Competent Standards of Care in the Perioperative Suite*” was an integral educational component to improve the attitudes, knowledge, and skill sets for nurse providers to provide culturally competent nursing care for transgender patients. The authors referenced the Joint Commission’s 2011 mandate entitled, *Advancing Effective Communication, Cultural Competence, and Patient-and-family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LBGT) Community*. The goal was to promote community and health provider engagement and transgender education in the provisions of care, leadership, services and treatment, data collection, data management, workforce supervision, and positive family support. The Association of Perioperative Nurses (AORN) published a Patient Safety declaration that stated, in part: “... *every patient has the right to receive the highest quality of perioperative nursing care in every surgical or invasive procedure setting*” (p. 2). Thus, the ethical position of AORN is creating and maintaining a safe practice environment. Distinctions between sexual preference, the gender of the person’s sexual attraction, and gender identity, the individual’s internal male or female self. The reader was introduced to the transitioning process from FTM or from MTF through surgical alterations, cross-dressing, feminizing hormone treatments, and masculinizing hormone therapies. When the decision for surgically assisted gender reassignment was confirmed, the perioperative care of the transgender patient commenced. It is important establish a culture of trust and mutual respect between health providers and transgender patients because many transgender patients had past experiences with negative health provider attitudes resulted in mistrust and incomplete

health information disclosures. Trans patients who failed to disclose information about their hormone therapy inadvertently compromised their perioperative safety. With full pharmaceutical treatment disclosure, the administration of life-saving anti-thrombolytic pharmaceuticals would prevent dangerous blood clot formations. Finally, the author recommended seven points for achieving cultural competence and trust in caring for transgender patients. The health provider should conduct a critical self-assessment, become transgender-friendly, obtain transgender health education information, do not make assumptions about clothing preferences, ask the trans person about how his or her preferred pronoun salutation (him / her/ Ms./Mr.), make no assumptions about gender based on outward appearance, identify yourself as a LGBT-friendly provider in the Gay and lesbian Medical Association's online directory.

The Suicide Prevention Resource Center, (2020) presented the five-step Public Health Approach to Prevention as an organized method to direct public health providers in setting up a customizable method for transgender suicide prevention. Specifically, the public health practitioner was instructed to extrapolate information from surveillance entities to accurately define the problem; research appropriate literary resources to uncover possible factors that prompted suicidal thoughts and suicidal actions that may lead to completed suicides; develop suicide related interventions and conduct preliminary tests; implement successful post-test interventions; and conduct regular, incremental evaluations of the implemented suicide prevention intercessions to monitor and ensure that the program's success will be sustainable.

In the article, captioned, “*Delivering Culturally Sensitive Care to LGBTQI Patients*,” Landry (2016) made bold statements about health care providers whose attitude of avoidance was responsible for threatening the mental and physical health of persons in the lesbian, gay, bisexual, transgender, and queer individual community. Landry included statistics from a Centers of Disease Control and Prevention report that asserted that LBGT students were 23% more likely to attempt suicide. The problem highlighted included health provider education deficits in transgender health care needs, incorrect LGBTQI terminology, and violations of LGBTQI cultural norms and taboos. Unfortunately, the United States military’s “Don’t Ask, Don’t Tell” policy was adopted by medical practitioners. The fear of discrimination from health providers has also contributed to the high rate of health disparities among this population of people. Fortunately, the National LGBT Education Center: Fenway Institute is the originator of *inclusive quality health care strategies* for health providers caring for LGBTQI patients. Health practitioners in every industry should have respectful, realistic communication expectations by asking about the preferred pronouns to correctly address the person and document the response, avoid stereotyping, avoid assumptions, ask about other names used in the past when there is a name or gender mismatch on current or past medical records, and be non-judgmental.

The Perioperative Patient

The perioperative patient is at high-risk in the surgical environment. According to Malley et al. (2015) multidimensional communication is paramount to comprehend the patient’s vulnerabilities, to manage their expectations, and having the ability to mitigate

gaps in knowledge and practice. Patient vulnerabilities would usually surface during the initial nursing assessment. Additionally, communication errors during the transitional phases (preoperative, intraoperative, and postoperative) augmented the patient's vulnerability. The author chose Meleis' theory of transitions as the guiding framework to address the complex culture of the perioperative (preop, intraoperative, and postop) setting. It is unfortunate that this study had major limitations due to the small sample size (only 24 participants) at a single location and did not include all perioperative nurses as participants.

McDowell and Bower (2016) surveyed least 1,000 baccalaureate United States nursing school faculty who reported that nursing schools failed to make transgender health education a priority. The excuse for this transgender health education deficiency was limited information about strategies for integrating transgender health into existing nursing curricula. John Hopkins University's School of Nursing created a student-faculty partnership termed the Transgender Health Curriculum Integration Project. The objective of the project was become transgender-friendly, create, and implement transgender health care education paradigms for nursing students. Three introductory transgender health classes covered gender-affirming language, best practices, preventative health, hormone usage, mental health, prenatal care, gender affirming interventions, and health inequities. Three semesters were designated to add the five new transgender health courses: two clinical specialty courses and three transgender health introductory courses. A 20-minute online introductory module provided an overview of gender affirming surgery, hormone interventions, health institution transgender-focused discrimination, name and pronoun

preferences, and respectful physical assessment best practices. The pharmacology courses covered hormone therapy, hormone monitoring, and hormone administration objectives. The study was triangulated using transgender health experts, community members, peer-reviewed literature, and evidence-based transgender health guidance. Comprehensive transgender health care training was needed for all faculty members.

McIntosh (2015) recounted the assessment process conducted at Toronto Canada's Gender Identity Clinic for potential sex reassignment patients who were covered by the province's health insurance. A physician or clinical psychologist facilitated the three-fold assessment as an eligibility requirement. Either a diagnosis or a differential diagnosis and readiness assessment had to be included.

Moleiro and Pinto (2015) asserted that pathologizing LGBT persons as mentally ill was not only passé, but offensive. The authors also noted that the World Health Organization deleted the term "*homosexuality*" from the ICD-10 International Classification of Disease Register in 1992. Thus, the current school of thought declared that gender-dysphoria was not an indication of homosexuality, but a description of the distressful experience of incongruence between present gender and desired gender. Positive efforts are in progress to promote transgender compliance in health care, heterosexual-based biases against transsexual persons persists. Therefore, the authors recommended that educators focused on augmenting clinical competence in transgender health. Shindell et al. (2016) explored contemporary trends in cis-gender and non-cis-gender sexual health education in medical schools. The strategy was to review secondary sexual education data inclusion for faculty, curriculum development, education platforms

formats, learning methodologies utilized, as well as for program and student evaluation approaches. The authors discovered that human sexuality education remained transgender health deficient for medical students, an oversight that rendered them ill-prepared for future transgender-inclusive health care practice. The findings were consistent with current the deficits recorded in competent sexual minority health care that could inform medical school curriculum development. Namely, across the life-span management of sexual minority health needs, the associated legal issues, sexual abuse, contraception, abortion, HIV, other sexually transmitted infections, and understanding the cultural practices within the LGBT community are essential education components. A multiplicity of learning styles using the adult learning program was recommended for achieving gender-specific, sexual health proficiencies. T'Sojoen, Motman, Arcelus, and Bouman (2017) concurred with the preceding authors and recommended the inclusion of transgender patients as participant partners with allied health professionals and clinicians in transgender health research projects. Wylie et al. (2016) endorsed the early introduction of standardized, transgender health best practices, as recommended by the World Association for Transgender Health (WPATH). Also, being knowledgeable about the benefits of mental health provider collaboration, knowing which surgical options existed, and the ability to select a service delivery model appropriate for the MTF or FTM client.

Health Institution-Based and Health Provider-Based Transgender Discrimination

Existing literature declared that healthcare providers caring for transgender patients have discriminatory attitudes towards the LGBT population (Stroumsa, 2014;

Seelman et al., 2017). Regrettably, these discriminatory attitudes may have contributed to the negative stigma associated with being transgender (Hughto, Rose, Pachankis, & Reisner, 2017). Thus, there is a need to create strategies that would facilitate healthcare provider education in providing, gender-specific, culturally competent, respectful, and compassionate transgender-congruent care for trans men and trans women. System-wide health provider knowledge deficits contributed to transgender health disparities (Adams et al., 2017; Seelman, et al., 2017). The authors' impression that further research was warranted for transgender-specific support groups was concurred by Breuer, Lee, De Silva, and Lund (2015). Twenty-first century health records should refer to surgically altered sexual reassignment patients as male, trans male, woman, trans woman (Breuer, et al. 2015).

Subsequently, authors Watkinson and Sutherland (2017) concluded that health provider discrimination and societal ostracism of transgender persons resulted in postponed health care seeking actions among this population. The authors referenced the Equality Act of 2010 that included gender reassignment persons as a protected demographic. Conversely, health provider negative attitudes, inappropriate gender pronoun use, and non-inclusive health entity cultural environments continue to be health care access barriers for transgender persons. Health systems transgender-focused disparities included the lack of transgender terminology standardization in health records and forms for health referral. Even though physicians prescribed pharmaceuticals in the trans person's preferred name, many pharmacists printed the person's birth name on the prescription label instead. This oversight led to incongruent health care protocols to

address present mental and physical health needs that augmented inappropriate transgender service delivery. The authors charged health providers with the responsibility of collaborating with each patient to formulate a customized, holistic health care plan that addressed present illness, co-existing mental health issues, physical health conditions, and proposed treatment modalities.

Watkinson and Sunderland (2017) concluded that health provider discriminatory attitudes and knowledge deficits in transgender competent healthcare procedures threatened positive health outcomes for this population. Denial of equal access to need appropriate health services by discriminatory health bureaucracies contributed to health disparities experienced by transgender health care-seekers. Recommendations for health provider education were diversity and equality education, transgender awareness training, how to incorporate tools to identify gender dysphoria, transgender people's rights awareness, and how to make appropriate referrals for transgender clients.

Miller and Grollman (2015) asserted that transgender people in the United States have historically been socially and medically stigmatized, and have experienced harassment, discrimination, physical threats, and other abuses, daily. Hence, transgender persons were predisposed to self-harming behaviors (illicit drug abuse and suicide). The authors also introduced the term "*stigma-visibility*" to describe the visible characteristics that link a person or population to an established stigmatized societal status. Self-identified transgender individuals who were at least 18 years old and were respondents to the National Transgender Discrimination Survey (NTDS) were the selected participants for this online study and included recruits from legal-aid clinics, homeless shelters, and

mobile health clinics. The categories for measurement were: transition status (those who attempted suicide); type of gender non-conformity (associated with suicide attempts); social status (have attempted suicide), health-harming actions like suicide attempts (44%), drug abuse (27%); and transphobic discrimination experienced (71%).

Baral (2018) focused on the transgender patient's emergency room experience and declared that discriminatory attitudes and staff knowledge deficits in proficient transgender health care. Especially highlighted were the lack of knowledge about hormone therapy side effects and possible complications associated with postsurgical sexual reassignment procedures. Fortunately, augmented transgender awareness had positively impacted initial and continuing education in transgender health proficiencies for medical and nursing professionals. The author identified Kentucky's University of Louisville School of Medicine's *eQuality Project*, as a transgender compliant health training curriculum for first- and second-year students. Ohio's Case Western University implemented a mandated LGBT-congruent patient care instruction paradigm as a four-hour module that introduced transgender terminologies, bias recognition, and bias mitigation instruction. San Francisco's University of California created transgender health care delivery guidelines retrievable from the university's Center of Excellence for Transgender Health. Two Universities in New York implemented innovative transgender health programs: 1 The New York University Langone Medical Center used human transgender health patient actors as a staff and student training strategy to add authenticity to their transgender proficiency programs. 2 Mount Sinai Hospital's Center

for Transgender Health Medicine and Surgery, a psychiatry and surgery fellowship in transgender care, the only program of this kind in the United States.

Authors Rodriguez, Agardh, and Asamoah (2018) utilized the National Transgender Discrimination Survey as a study participant resource to analyze 6106 transgender persons of whom 59.3% or 3608 were male at birth. The authors also asserted that persons who were recognizably (obviously) transgender experienced a higher rate of discrimination when they sought help for rape treatment, domestic violence, drug treatment and drug prevention services, at mental health clinics, emergency rooms, medical providers, paramedic services, and physician offices. The age range for the study was 18-to-65years and older. The ethnic demography included African American, Alaska Native, American Indian, Arab, Asian, Black, Hispanic, or Latino, Middle Eastern, Mixed, Multi-Racial, Pacific Islander, and White. The statistical analysis revealed that nearly 10% of respondents worked in a *street-economic culture* like the sex-trade industry, 80% had more than a secondary school education, at least 15% were ex-convicts, and 24% were HIV positive. Health environment discrimination (33.1%), at physician offices or hospitals (28.7%), 4.7% experienced discrimination at domestic violence clinics, in emergency rooms (16.8) rape treatment facilities, and at mental health clinics (14%). It was discovered in this study that sex-workers who were HIV positive or ex-convicts accounted for the higher health provider and health system discrimination experiences than their transgender counterparts. Self-report-related biases and misclassification of information due to the absence of validation measures were limitations for this study. Another limitation was the inability to specifically determine

who the discriminators were. The recommendation was that transgender health care curriculum in medical should provide training in the creation and maintenance of a therapeutic physician-patient relationship that is therapeutic for transgender clients. Henceforth, policymakers should incorporate multiple sources of the qualitative and quantitative transgender research results to formulate transgender inclusive, needs-compliant public health policies.

Sedlak, Boyd, and Gay (2016) submitted a position statement that supported the reduction of barriers for transgender individuals (TI) seeking health care and recommended that nurses be educated in recognizing and reducing health access barriers. Health care providers and policy-creators were urged to identify and implement strategies to make health access navigation user-friendly for TIs. Thus, the plan of action should include the reduction of transgender health disparities, to upgrade transgender health access, and to improve transgender health outcomes comparable to their cis gender contemporaries.

Greene, et al. (2018) examined the health care student's self-assessment of his or her competence to care for lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons. The authors declared that the gap in research extended across nursing, medical, and dental health specialties within the formal training, comfort level, and attitude domains. A panel of LGBTQ medical, dental, and nursing students from top-level United States universities collaborated with the authors to create a survey with 12 items. The 1010 survey-respondents were full-time nursing, dental, and medical students. The results showed that: less than 50% thought that the schools' LGBTQ curriculum in transgender

health training was adequate, 70-74% felt comfortable caring for LGBTQ patients, students who were interested in receiving LGBTQ compliant education were 71.1%, and medical students showed more interested in formal LGBTQ health care training than dental students. The authors recommended that medical schools and nursing schools utilize the information from this study as a guide in creating LGBTQ inclusive healthcare training.

Politically speaking, Alonzo-Zaldivar (2018) suggested the addition of health care to job bias, military service, and bathroom use to the list of social issues faced by transgender Americans. During the Obama administration, the transgender population rose from obscurity to achieve improved social and political acceptance. Hence, gender identity breaches became a form of sex discrimination and a violation of civil rights laws. The author revealed that the Trump administration was making plans to repeal and rewrite present gender identity discrimination laws. The expected negative domino effects included loss of transgender-specific transition health care benefits (like hysterectomies for FTM patients). Under that anti-discrimination segment of the Affordable Care Act. In 2018, the Lancet (2018) concurred with this author and highlighted the scarcity of medically proficient medical providers. Medical students were transgender health care incompetent because these students received less than six hours of LGBT health-issue training. Similarly, the rising insurance rates caused transgender individuals to be priced out of health insurance coverage.

Stroumsa and Wu. (2019) discussed health system barriers that included health providers lack of transgender health knowledge and non-inclusive verbiage on health

intake documents. The authors referenced a study in the Journal of Medical Education that refuted the school of thought that there was no correlation between more hours in transgender health education and improved health provider proficiency. Fifty percent of study participants caring for transgender patients had no transgender health training. Untrained medical providers were admittedly biased, transphobic, and engaged in discriminatory behaviors when caring for transgender persons. Providers should understand that some trans patients may need to access providers from women's health care professionals for regular OBGYN attention for pap smear screening, fertility issues, pre-natal visits, gender transition treatments (hormonal therapy), and menstrual cycle or menopausal management. The recommendations were to implement gender-inclusive language, use gender neutral terminology in women's health, create and maintain transgender-inclusive health care atmospheres.

The National Association of Nurse Practitioners in Women's Health (NPWH) Board of Directors (2018) promoted transgender persons, gender non-conforming person's, and cis gender person's rights to have access to a health gender identity, sexuality specialist, as well as high-quality, evidence-based reproductive and sexual health care. The Nurse Practitioners also acknowledged the higher rates of depression and suicide attempts among transgender clients. Provider education in transgender health should include cervical and prostate cancer screening, sexually transmitted disease screening, contraceptive use, reproductive life planning services, mammogram screenings, gender-affirming hormone therapies, surgical treatments, and mental health care. The recommendation was for NPWH to obtain a transgender competent health

education team to train staff and set up sources of referral to transgender competent health care providers.

Dubin et al. (2018) analyzed 1272 documents from five different data bases for literature about transgender health in medical education. Only 119 documents met the predetermined criteria. The authors concluded that a strategy shift in transgender health medical education fluctuated from short-term improvements to long-term proficiencies that augmented transgender health care delivery strategies for better trans patient health outcomes.

Summary and Conclusions

I chose this transgender study because I needed to understand the lived perioperative healthcare delivery experiences from the trans person's perspective. I expected this perspective to uncover specific contributing factors to trans persons' perioperative suicidal plans and suicide attempts. Transgender health disparities are well-documented by existing literature. My literature review was directed towards identifying presurgical and postsurgical transgender patients who may be at risk for committing suicide and to recognize factors that prompted suicidal thinking and suicidal attempts. I was able to uncover several gaps in peer-reviewed transgender literature and past scientific research about the health care experiences of transgender populations. Current literature stated that there were no transgender-specific curriculum according to Safer, et al. (2017) in medical schools to train medical providers about transmen and transwomen health needs; no transgender specific educational courses available in nursing education (McDowell & Bower, 2016) to teach trans patient healthcare delivery protocols to

nursing students and practicing nurses; no suicide prevention protocols (Bauer, et al. (2015) to guide the care of transgender persons; no training, no policies, and no procedures available to address the trans persons' fear of health provider discrimination as an access barrier (Seelman, et al., 2017), and the non-availability of 24-hour, seven (7) day group support (Breuer, Silva, & Lund, 2016) that included transgender-specific health emergency protocols. Moreover, health access barriers were created by health systems and health providers who had actively or passively discriminated against transgender clients. Unfortunately, the historical trend of medical, nurse, and health worker transgender knowledge gaps were well documented by credible researchers. The recommendation was for public health practitioners, researchers, and healthcare providers to collaborate, articulate, and put into practice realistic suicide risk recognition, and suicide prevention solutions that could help in arresting the growing transgender suicide rates.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study is to investigate the transgender suicide phenomenon and how the lack of medical health provider education in the specifics of competent transgender health care delivery may have contributed to this public health disparity (Safer et al. 2017). Special attention was given to identifying suicides that may have occurred during the perioperative phase of the gender reassignment process. Another aspect of this study was to determine other possible factors that may have contributed to perioperative transgender suicidal thoughts and suicidal activities. This chapter included the research design rationale for choosing the thematic analysis strategy, my role as the researcher for this investigation, and the methodology selected to drive this study. Furthermore, the exclusion and inclusion criterion for sampling and selecting the transgender participants, the ethical procedures, and the credibility checks and balances were discussed in detail. A synopsis of the major components established the foundational trajectory for this transgender perioperative transgender suicide investigation in Chapter 4 and will simplify the resultant data results to be revealed in Chapter 5.

Research Design and Rationale

The research design and rationale are embodied within the following research question and four sub-questions:

RQ1: How do male-to-female and female-to-male transgender persons perceive their health provider's transgender-specific health care knowledge deficit and health

provider transgender-related discriminatory attitudes as influences contributing to their suicidal thoughts and suicidal attempts during the perioperative phase of the gender-reassignment process?

Sub-Questions

- Sub-Question 1. How do transgender women and transgender men perceive their health provider's knowledge about their gender-specific mental and physical health needs before, during, and after the surgical gender reassignment processes?
- Sub-Question 2. How do transgender women and transgender men perceive the competence with which their health provider(s) met or did not meet their gender-focused mental health and physical health needs?
- Sub-Question 3. What do transgender women and transgender men perceive as obstacles to accessing gender-appropriate mental health and physical health care during all stages of the perioperative gender-reassignment experience?
- Sub-Question 4. What are the perceptions that transgender women and transgender men have about their encounters with health provider transgender discrimination that may have led to suicidal thoughts or suicide attempts during the transitional postoperative follow-up phase?

Central Study Concepts and Design

The data from this qualitative investigation concerning perioperative transgender suicide is projected to be an essential component for augmenting transgender health care competence among public health care, traditional medical, and nursing providers. The results of this study could be used to (a) prompt universities and colleges to educate

persons within the public health, medical, and nursing professions about the explicit health needs that are exclusive to transgender persons by incorporating transgender-specific health needs education as a specialty course, (b) make contributions to transgender competent public health practice, (c) help to grow transgender suicide risk factor awareness among medical and nursing professionals that includes suicide risk recognition and health care intervention competencies for multi-specialty health care providers as an annual continuing education update, and (d) effect positive social change by collaboratively working with multidisciplinary nursing, medical, allied health care professionals, and policy-makers to formulate transgender-inclusive, compassionate, and respectful health care access and intervention protocols.

This qualitative study applied the hermeneutic phenomenological (Eddles-Hirsch, 2015) design as the research method to identify and understand, from the trans person's perspective, which factors within the perioperative phase prompted suicide attempts and suicides among trans men and trans women patients. The data retrieval strategy included unstructured face-to-face and telephone interviews of four postoperative transgender adults. This interview method permitted trans people the freedom to describe their individually lived transgender experiences during the perioperative process in their own words (Barr, 2015). The chosen sampling method for this study was Criterion Sampling (Palinkas et al., 2015), a type of purposeful sampling that assisted with recruiting transgender participants who fit the predetermined criterion for this study. Even though the appropriate sample size for this study was small (4 participants) data saturation was achieved. Data saturation is that point where new information became redundant

(Saunders et. al., 2018). Eligible study participants were postsurgical adult transgender men and transgender women who were 21 to 65 years old, were able to read, write, and understand English, were United State citizens or legal United States residents, and who either attempted suicide or have entertained suicidal thoughts.

Equality Florida (2018) and the Williams Institute (Haas, Rodgers, & Herman, 2014) were two of several national organizations that were contacted for permission to recruit their transgender members as prospective study participants for my research project. The Division Manager of Trans Services, the executive Director of ALSO Youth, and the Director of Transgender Equality at the Equality Florida Institute originally expressed their commitment to assist me with my transgender dissertation project. At that time, the recruitment plan was to have interested persons answer survey questions about their perioperative experiences with health provider transgender health knowledge, perioperative health provider transgender discrimination attitudes, and the perceived factors that caused suicidal thoughts and suicidal attempts. SurveyMonkey (2018) was to be the assistive recruitment tool and the questionnaire location for prospective research participants to complete online. Unfortunately, these organizations did not follow through, so contingency plans were immediately implemented.

The Role of the Researcher

My initial researcher was to follow my contingency plan to acquire a new participant recruitment source. As the participant and primary instrument for this study, I retrieved first-hand information concerning the views and frames of mind of postoperative transgender persons (Sutton & Austin, 2015) via semi-structured in-person

and telephone interviews. It was also my responsibility to explain I had to understand the perioperative experiences from trans people's perspective about what factors may have prompted suicidal thoughts and actions. I described to each participant the research confidentiality protocols, the purpose of the informed consent, assured them that their participation was voluntary, and that they could rescind their consent to participate at any time and for any reason without explanation or consequence. I was available to answer questions or concerns prior to, during, and after the study. The chosen population was adult, postsurgical, transgender persons with a history of suicidal thoughts or suicidal activities prior to data collection. I obtained approval from Walden University's International Review Board (IRB) on January 17, 2020 (approval number 01-17-20-0287729) before recruiting, questioning participants, or collecting data. None of the prospective research participants were known to me prior to this study. There were no financial, ethical, or other conflicts of interest associated with my conducting this transgender research project.

Bias Mitigation

Kumar and Yale (2016) provided examples of bias that were considered elusive: (a) *Choice-of-question* bias that lead to a specific result, (b) *Bureaucracy* bias or Institutional Review Board (IRB) bias when research information was retrieved exclusively from one set of participants. Population bias was a red flag alert that research participants may not be representative of the entire eligible population, making the study results invalid due to credibility violations.

The mitigation plan for transgender selection bias was recruitment questionnaires were equally available online to all transgender people and the random selection of respondents who met the predetermined eligibility requirements. I created and maintained a culture of ethical practice and

transparency in research practice and design (Simundic, 2013). Sarniac (2015) offered the following strategies to identify and eliminate researcher related biases:

- a. *Confirmation bias* happens when researchers manipulate respondents' interview or survey answers to agree with researcher prejudices. Mitigation: Eliminate preconceived conclusions and adhere to the ethical guidelines for researcher and researchers.
- b. *Culture bias* emerges when personal values, racial, cultural, or ethnic prejudices are the standards for evaluating the merits of participants who have a different culture, race, ethnicity, philosophical assertion. Mitigation: Be non-judgmental.
- c. *Question Order Bias*: questions are worded so respondents are passively or deliberately coerced into providing identical answers to questions. Mitigation: ask positive general question first, then ask specific negative (perioperative) experience questions for the best results.
- d. *Leading Question and Wording Bias*: Bias mitigation: document respondents' answers- verbatim, make no assumptions, and do not summaries or edit their verbiage.

- e. *The Halo Effect Bias*: Do not use one positive or one negative answer as the criteria for making conclusions about the entire interview or survey.

Mitigation: each answer should be accepted and evaluated on its own merit for its contribution to the entire study results.

The Researcher's Ethical Responsibilities

The first ethical consideration as a researcher was to conduct an honest self-assessment to identify and eliminate any personal, professional, or conflicts of interests including, but not limited to having no previous or current relationships with any chosen or potential study participant, establish and maintain the culture that ensured the privacy and human rights of the study participants. My ethical responsibilities as a researcher (Sanjari, 2014) was to ensure that only willing, voluntary participants who met the preestablished criterion were utilized, clearly explained the participants' research rights and responsibilities, to obtained signed, informed consents, protected each participant's confidentiality, provided participants with the anonymity, clearly stated that the participant's option to willingly participate or withdraw from this study at any time, for any reason, without any adverse consequence. I established and maintained a culture of compliance with federal human research participant laws and Walden University's research protocols, every effort was made to identify and eliminate any research bias. I obtained approval from Walden's IRB before beginning research activities.

Ethical Dilemma Mitigation Strategies

Ethical dilemmas were mitigated with the practice of continuous reflective cognizance due to my changing researcher-role of insider-outsider or leader-subordinate

(Råheim et al., 2016) at various times throughout this study. Reflective cognizance on a continual basis during this study involved taking into consideration the major factors that contributed to transgender suicides and the trans person's personal perioperative and health provider experiences to understand this public health phenomenon (Colomer et al., 2013). Another ethical concern was being transgender-culturally competent (Lippincott Nursing Center, 2015) by creating and maintaining an atmosphere that is respectful and nonjudgmental.

Methodology

The population for investigation was adult postoperative transgender reassignment adults age 21-65 years old who had entertained suicidal thoughts or who may have attempted suicide at any time during the three-phase perioperative period of the gender transformation process. Data saturation (Saunders et al., 2018) was achieved despite having only four participants. Criterion sampling, a type of purposive sampling (Palinkas et al., 2015) was the sampling method. Postsurgical transgender adults from the pool of transgender recruitment survey respondents who met the eligibility requirements established for this study were randomly chosen. The same eligibility requirements automatically eliminated selection bias so that study participants were representative of the transgender population.

Identifying the Population

The multifocal points of this research project: (a). identified transgender perioperative patients who were suicide risks, (b). sought to understand what factors contributed to trans patients' suicidal ideas and suicidal attempts during the perioperative

phase, and (c). investigated how trans males and trans females perceived health care provider transgender health competence and discriminatory attitudes contributed to perioperative suicidal activities and thoughts. The SurveyMonkey (2018) administrators self-eliminated from this study as a research participant recruitment source.

Sampling Strategy

Criterion sampling was be utilized in this research project to acquire eligible prospective study participants from the transgender community. The mandatory eligibility criteria were that participants were postoperative transgender male-to-female or postoperative female-to-male transgender persons, who were within the 21-65-year-old age range, able read, write, and understand English. The objective was to identify at which age and which factors may have prompted suicidal thoughts and suicidal attempts during the gender reassignment perioperative process. All participants were unfamiliar persons to me and I to them. Prospective participants voluntarily contacted me using contact information from posted internet recruitment flyers.

Data Collection and Recruitment Strategies

The data collection strategy for this study was two-fold namely, a questionnaire for recruitment purposes and the use of collected information from the interviews (Abawi, 2013). The number of participants at the data saturation point represented the correct sample size for this study (Saunders et al., 2018). Misty, a trans female executive at the SunServe organization consented to make my transgender health improvement recruitment flyer/questionnaire available online to their transgender members across the United States. The questionnaire was equally available online to all eligible participants

(Ellard-Gray, Jeffery, Chouback, & Crann, 2015). Hence, only trans persons who were not post-surgical gender reassignment patients, were not able to speak or understand the English language, who did not meet the 21-65 years age requirement were ineligible to participate in this study.

In the second part of the data collection activity I conducted semi-structured in-person, interviews of adult, English-speaking post-surgical trans men and trans women between the ages of 21-65 years old who have had or who were entertaining suicidal thoughts or who considered suicidal attempts. The rationale for this two-part data collection strategy was to retrieve information from a multigenerational perspective to find out the degree to which encounters with negative health providers during the perioperative period contributed to suicidal thoughts or suicidal attempts for transgender patients.

Data Saturation and Sample Size: The Relationship

The criterion for two qualitative milestones for data saturation and sample size were met when data saturation is achieved: (a) information becomes redundant and (b) the number of participants at that point of data saturation will represent the appropriate sample size for this study (Saunders et al., 2017). Each trans person's perspective was essential to help me identify any circumstances that may have contributed to suicidal thoughts and suicidal attempts during the perioperative period. I created non-leading, open-ended questions for the postsurgical transgender clients who would participate in this study.

Data Collection Instruments

I was the data collection research instrument to retrieve the responses from face-to-face semi-structured interviews (Abawi, 2013), and interviews by telephone. During the interviews the participants were given the opportunity to expand their responses via crafted story-telling (Crowther et al., 2016) to help me understand the lived individual transgender experience in his or her new gender role during the perioperative phase. The contingency plan for recruitment was necessary because the SurveyMonkey team contacted me via email and stated that it was determined that the transgender population was less than one percent, too small to honor their team to assist me in my research of this population. The Equality Florida (2018) representative who had previously consented to assist me during my participant recruitment activities was persistently unresponsive to my emails and phone messages. Hence, my researcher developed instrumentation contingency plan was immediately implemented. Two other transgender organizations (SunServe and Compass) were contacted. Both organizations were willing to participate. At first, I met with a trans woman executive at SunServe who, without hesitation consented to assist with my internet recruitment strategy. Then, I met with the administrators of the Compass organization who were excited about this research project and assented to partner with me to recruit study participants. Regrettably, the Compass transgender members were teens who did not meet the 21-65-year age range eligibility requirements and could not participate in this study.

Recruitment Plan

On January 16, 2020 I obtained Walden University's IRB approval (01-17-20-0287729) to begin data collection. With a timeframe of two to five weeks, I made radio announcements, distributed flyers at churches, college campuses, and at community events to recruit transgender research participants. With assistance from the SunServe my contact information and my recruitment flyers were posted on the organization's website using the following criteria:

- Must be between the ages of 21-65 years old.
- Must be able to read, write, and understand English.
- Must be a United States citizens / legal resident
- Must be a postoperative trans man or trans woman
- Must have attempted suicide within the past 12-24 months.
- Must have entertained suicidal thoughts within the past 12-24 months.
- Must have experienced transgender-related rejection after having gender confirmation surgery.
- Must have experienced some form of transgender-related discrimination.
- Must have experienced regret following gender confirmation surgery.
- Other: _____

Eligible respondents who provided their preferred email address received the IRB approved consent form. Many opted out of the study without explanation (as was each person's right to do so) and ceased any subsequent communication. Additionally, to promote researcher-only access, to protect the privacy, and keep identity confidentiality of each participant, I provided my cell phone number and created an email address exclusively for prospective transgender research respondents to use for reciprocal communications between researcher and participant. Those who returned signed consents were schedule for either an in-person or telephone interview at a mutually, agreed upon time and place.

Data Collection Protocols

I conducted one-time, in-person, 25-35-minute interviews to collect data using a combination of audio-recording and field notes to ensure accuracy. This was a qualitative phenomenological research project. So, the Phenomenology research design, according to Daniel (2018) utilized the "lived experience method of analysis, in this case, the lived health care experiences of transgender men and transgender women during the perioperative phase of the gender reassignment process. The final sample size was less than 10 eligible participants. Therefore, a small sample size of 10 or less in the Phenomenology research design was acceptable (Daniel, 2018). Participants were able to contact me before and after the interview with any additional questions and concerns. Even though there were no planned follow-up data collection procedures, opportunities for a follow-up activity did not emerge during the individual interviews.

Data Analysis Plan

Thematic analysis was the chosen data analysis method. The theme focus was embodied within the research question, “*How do male-to-female and female-to-male transgender persons perceive their health provider’s transgender-specific knowledge deficit and health provider transgender related discriminatory attitudes as influences contributing to their suicidal thoughts and suicidal attempts during the gender reassignment process?*” Thus, the thematic analysis provided a blueprint for a sequential, incremental process where: (a) I read interview transcripts, (b) chose themes for codes and categorize, (c) organized categories into themes, (d) individually extrapolated and classified quotations, (e) performed an analysis, synthesized data and deduced the main points in the individual transcripts (Cassol et al., 2018). Hence, I identified the main points, categorized, and assigned themes, codes, and sub-codes to determine why transgender persons entertained suicidal thoughts or attempted suicide during the gender reassignment surgical process. Any noteworthy results obtained from the combination of in-person face-to-face and telephone interview transcripts, as well as individual narratives were the primary data sources for this qualitative transgender perioperative suicide investigation. Subsequently, I included figures and tabular denotation units (Erlingsson & Bachmann et al. (2017) as a part of my research documentation.

The interview time frame was extended to approximately one hour and fifteen minutes to allow for participant’s expanded explanations. I obtained email and telephone contact information for the eligible trans persons who successfully completed the study. Follow-up interviews were not warranted. The interview questions were created from the

research questions and sub-questions using the four-stage Funnel Approach (Roller & Lavrakas, 2015) namely, Stage 1: study introduction, Stage 2: general perioperative suicide information, Stage 3: possible contributing factors to suicidal thoughts and suicidal actions, and Stage 4: targeted suicide prevention and interventional strategies and recommendations. Roller and Lavrakas (2015) declared that the funnel approach gave interviewers the flexibility to begin the interview with suicide-related questions, then, incrementally progress to more specific perioperative suicide questions. The research questions served as the foundational themes and codes for data analysis development:

Theme I: Question 1. How would you describe your experiences before, during, and after your male-to-female or female-to male sexual re-assignment surgery as it related to suicidal thoughts or suicidal attempts?

1) Code 1: What is your Perioperative Experience(s).

Sub-Codes

1.1.Preop

1.2.Intra-op

1.3.Post-op

Theme II: Health Provider Transgender Health Competence

Question 2. What was your assessment of (a) your health provider's knowledge about your specific transgender health needs and (b) the competence with which your health needs were met or not met?

2) Code 2: Your Health Provider(s) Transgender-Appropriate Health Knowledge

Sub-Codes

2:1 Medical staff: Surgeon, Anesthesiologist

2:2 Nursing staff: Pre-op, Intra-op, post anesthesia recovery unit, surgical unit / intensive care.

2:3 Support staff. Admissions, transporters, discharge planners.

2:4 Other (Explain)

Theme III: Perioperative Health Care Barriers

Question 3. Can you describe any obstacles that you encountered during any phase of your male-to-female gender re-assignment experience?

3) Code 3: Your Perioperative Obstacle Experience(s)

Sub-Codes

3:1 Preop Phase

3:2 Intra-Op Phase

3:3 Post-Op and Transitional Phases

Theme IV: Suicide Ideation

Question 4. Have you ever experienced any suicide thoughts within the last 12 to 24 months? Explain.

4) Code 4: Suicidal Thoughts Experienced within the Last 12 Months.

Sub-Codes:

4:1 Pre-Op or Post-Op: Months 1, 2, or 3.

4:2 Pre-Op or Post-Op: Months 4, 5, or 6.

4:3 Pre-Op or Post-Op: Months 7, 8, or 9

4:4 Pre-Op or Post-Op: Months 10, 11, or 12

Theme V: Suicidal attempts

Question 5: Have you contemplated suicide or attempted suicide during the last 12-24 months? Explain.

5) Code 5: Reason(s) for Suicide Attempts During the Last 12 Months

Sub-Codes (Participant-Specific Experiences)

5:1

5:2

5:3

Discrepant Data Management

Even though there are five standardized themes and associated code for this investigation, three new themes emerged during the interviews. So, additional themes and codes were assigned to the new information that represented additional contributing factors to transgender perioperative suicides. The latest information was added showing the new codes and sub-codes for analysis.

Data Integrity

To protect the participant's privacy, I employed a combination of paper and electronic storage formats. One computer was designated solely for this research project, where participant information was kept in a password protected efile assessable only by me, the researcher. I created and maintained secure data storage in a locked file cabinet that was assigned for field notes and interview transcripts. I honored the Walden University's Ethical Guidelines for research and applied Walden's Litmus Test, prior to

seeking IRB approval for data collection. After gaining IRB approval, I distributed recruitment flyers at various locations and on multiple media channels. Respondents were able to self-identify as ineligible or eligible prospective research participants using the recruitment flyer information as an eligibility guide. Eligible participants initially contact me by telephone or via email (Alma.Knight@waldenu.edu). The strategy was to randomly select 10 respondents to the flyer for inclusion in this study. Each respondent was notified by his or her preferred communication method. I will shred and securely disposed of all research data after the six-year period following the completion this investigation as directed by Walden University. Even though no participant became distressed during the interview, the transgender-focused suicide prevention hotline number: 1-877 -565-8860 was provided. Participants were assigned a pseudo-name to establish and maintain their confidentiality. Participants were reminded that participation in this study was voluntary, without coercion. An informed consent was read, understood, signed, and returned to me prior to interviews. Participants were encouraged to call me with any post interview study-related concerns. I obtained each person's permission to contact them if a follow-up interview became necessary.

Issues of Trustworthiness

Ethical Procedures

To establish trustworthiness, three ethical practices were mandatory: (1) I had to successfully complete the Public Health Research Participant Training module, (2) obtain IRB approval prior to data collection, and (3) give prospective participants the IRB approved consent form. This consent form summarized the research details and advised

the participant of his/her option to withdraw from the research at any time, for any reason without explanation or repercussions. As Korsjens and Moser (2018) recommended, I established a research culture of trustworthiness dependability, confirmability, transferability, transparency, credibility, and reflexivity (transparent) with no preconceptions of biases. So, this investigation is (a) *Dependable and Confirmable*: the results of this research should be easily replicated by other researchers using this study as a template. (b) *Transferable*: other investigators should be able to apply the conceptual frameworks to different qualitative research investigations with complementary results. (c) *Transparent and Credible*: Attestations were clearly documented to refute conflicts of interests and funding sources. Each participant read, understood, and signed an informed consent, a procedure that protects the rights and privacy of human subjects. (d) *Reflexive*: I identified, managed, and eliminated any actual or perceived conflicts of interests and biases at all stages of this project's development.

Ethical Procedures

Forero et al. (2018) suggested the following strategies to establish confirmability, credibility, and dependability:

Confirmability via Triangulation: (1) Investigator triangulation: I discussed, in general, my qualitative research methodologies and theoretical framework with two different Ph.D. level professor-evaluators from the University of Phoenix. One evaluator, a Walden University Ph.D. graduate provided guidance on how to achieve and maintain internal validity during the interview and documentation process.

Credibility: (2) My credibility as an authorized researcher was established when the IRB approved my application to begin data collection. Subsequently, I set specific interview protocols; established and adhered to Walden University and Federal human research protocols; implemented start, finish, date, and time-frame parameters; securely managed and preserved interview transcripts, field notes, and audio recordings. I attended a university-hosted doctoral student workshop (facilitated by Dr. Gail Ali at the University of Phoenix) where faculty members and my peers interrogated me about my chosen research methodology and challenged me to justify my decisions. *Dependability:* Subsequent researchers should be able to use the methodology and interview questions for a different group of transgender males and transgender females study participants with congruent results.

Areas for Ethical Concerns

My strategies for ensuring ethical, reliable and valid analysis for this investigation were: (a) I compared and contrasted the new themes then added the new themes to the original list of classifications, and use the iterative process to confirmed information accuracy; (b) I triangulated my research by enlisting the assistance of two different Ph.D. educated faculty reviewers from non-public health specialties; (c) these faculty members were qualitative experts who were not familiar with transgender health disparities or the transgender suicide problem, and (d) these qualitative experts conducted a comparative theory validation review (Cassol et al., 2018) that ensured that my interview questions and data collection results could be successfully replicated. Solved ethical concerns was always my ability to create and maintain security of participants' data. Additional data

security measures like, a dedicated five-draw locked file cabinet that maintained the confidentiality regarding the details of this study and the participants' personal information.

Summary

This qualitative study made use of the hermeneutic phenomenological (Eddles-Hirsch, 2015) design to spotlight the factors that may have contributed to suicidal thoughts and suicidal attempts. From the MTF and FTM transgender person's perspective, I gained insight about the circumstances that prompted suicidal thoughts and suicidal efforts. The individual accounts of such incidences facilitated my understanding of the mental health status (Barr, 2015) of each transgender patient during the perioperative phase of the gender reassignment process. My researcher role included choosing the phenomenological design, the Criterion Sampling (Moser & Korstjens, 2018) method and I was the primary data collection instrument. Walden's Institutional Review Board (IRB) was my research conscience that guided me through the process of adherence to the United States federal standards that ensured ethical, socially responsible, and safe research practices for my research participants, at all times (Walden University, 2018).

Additionally, researcher my role required strict adherence to continual ethical practice, creating a culture of safety, reliability, transparency, transferability, and reflexivity. I promoted and maintained anonymity for study participants, secured and upheld data security procedures, and gave the volunteers the option to withdraw from this project at any time for any reason without penalty. Hence, this qualitative research

investigation about Perioperative Transgender Suicide investigation was completed. The results will be discussed in Chapter 4.

Chapter 4 Results

Introduction

This chapter is a summary of the results of this hermeneutic phenomenological (Eddles-Hirsch, 2015) qualitative investigation. The goal of this study was to understand, from the trans male and trans female perspective, which factors precipitated suicidal thoughts and suicidal actions during the perioperative phase of the gender reassignment process. The setting(s) in terms of the socio-political landscape, familial issues, non-transgender inclusive health systems, negative health provider encounters, and employment retention/loss in a greater or lesser degree were added stressors. The participants' demographical facts were protected by using code names during data collection, data analysis, and documentation. Trustworthiness management in the areas of credibility, confirmability, transferability, and dependability were followed to maintain research integrity. Each research participant was asked to answer one research question and four sub-questions to capture the essence of the transgender person's experience with suicidal thought, suicidal actions, and factors that prompted such ideas and actions.

Research Questions

Each research participant was asked to answer one research question and four sub-questions.

RQ1: How do male-to-female and female-to-male transgender persons perceive their health provider's transgender-specific knowledge deficit and health provider

transgender related discriminatory attitudes as influences contributing to your suicidal thoughts and suicidal attempts during the gender reassignment process?

Sub-question 1. How do male-to-female and female-to-male transgender persons perceive their health quality of their health provider's knowledge about their gender-specific mental and physical health needs before, during, and after the male-to-female sexual reassignment process?

Sub-question 2. How do male-to-female and female-to-male transgender persons perceive the competence with which their health provider(s) met or did not meet their gender-focused mental and physical health needs?

Sub-question 3. What do male-to-female and female-to-male transgender persons perceive as obstacles to accessing gender-appropriate mental and physical health care during all stages of the gender reassignment experience?

Sub-question 4. What are the perceptions that male-to-female and female-to-male gender reassignments patients have about their encounters with health provider transgender discriminatory attitudes that may have led to suicidal thoughts or suicide attempts during the transitional follow-up phase?

Setting

The Contemporary Political Climate in the United States

Hughto et al. (2017) declared that denied access to standard and transitional health care was recorded by 364 online survey participants. The authors used a modified Social-Ecological Model to establish how transgender stigma emerged in health care delivery structurally, interpersonally, and from individual health providers. Structural

stigma blocked access to fundamental human services like employment, housing, and health care. As far back as January 20, 2017, the Donald Trump Administration took a discriminatory stance towards transgender Americans. Trump's administration deleted references to LGBTQ persons from the Department of Labor, the Department of State, and the White House websites, and on January 21, 2017, an anti-transgender judge was appointed to the Supreme Court (National Center for Transgender Equality, 2020).

Thoreson (2019) asserted that just 14 of the 52 states forbade gender-focused health insurance discrimination; 10 states deliberately excluded Medicare-related care for persons in the gender-identity category, whilst Iowa State Legislators secretly rewrote the Iowa State Civil Rights Act and deleted protections that fortified the non-discriminatory healthcare practices that augmented barriers to health care access for trans persons. In 2013 and 2015, right-wing religious conservatives successfully used the Supreme Court to formulate federal and state rulings that legally allowed health care providers and insurance companies to claim *religious freedom* as their constitutional right to refuse health care and insurance coverage to the LGBT persons (Fenway Health, 2020).

Since then, the National Center for Transgender Equality (2020) reported that President Donald Trump intended to modify the Affordable Care Act (ACA) that would undermine the rights of transgender patients to receive health insurance coverage for gender-specific health care. Thus, gender-focused discrimination in health insurance coverage would become legal. Furthermore, the Affordable Care Act modification would issue a denial of federal reimbursement to hospitals and health providers who provided transgender health care. Even though the Health Rights Law is a nation-wide

law, individual states are unrestricted to ascribe state-focused interpretation and implementation directives regarding this nationwide Health Rights law.

Demographics

Only research participants who met the predetermined requirements were eligible to be included in this study. All participants had to:

1. Be within the 21 to 65-year age range
2. Be a United States citizen/ legal United States resident
3. Be able to read, write, speak, and understand English
4. Be a postoperative trans man or trans women patient
5. Have attempted suicide within the past 12-24 months
6. Have entertained suicidal thoughts within the past 12-24 months
7. Experienced transgender-related rejection after gender confirmation surgery.
8. Experienced some form of transgender-related discrimination
9. Have experienced regret following gender confirmation surgery.

Each study participant was assigned a code name: Ms. Rose Petal was a 56-year-old white, non-Hispanic trans woman; Ms. Strawberry was a 57-year-old white, non-Hispanic trans woman; Mr. Blueberry was a 25-year-old white non-Hispanic trans man; and Mr. Lavender was a 36-year-old white, non-Hispanic trans man. Due to the threat of transgender-focused violence and possible job loss, public distributions of the recruitment flyer were unsuccessful from January 20, 2020 to February 29, 2020. So, I pursued the organizational approach. In late February 2020, I met with a trans woman executive at the SunServe Organization and presented a summarized version of my research project to

her. She immediately volunteered to post my recruitment flyer on her social media page so that transgender members of the SunServe organization nation-wide could access my contact information and send an email request to me for study-specific details. Within 24 hours, trans men and trans women from across the United States volunteered to participate in my “Transgender Health Improvement Study.” Some potential participants who did not meet the eligibility requirements were self-eliminated. Of the 10 eligible respondents, more than half changed their minds and withdrew their consent to participate, some with and some without explanations. The four remaining participants were assigned code names to protect their identities.

Explanations of Transgender Terminology

The following explanations of transgender terminology are necessary to understand the trans gender demographical categories in this chapter.

Trans Man: Female-to-Male

A trans man is a woman whose physique was surgically changed from female to male via top surgery, bilateral mastectomies to remove both breasts, and/or bottom surgery to remove the uterus and ovaries (hysterectomy and bilateral salpingo-oophorectomy), with or without creation of a penis from the vaginal area, or who have had a combination of top and bottom surgery to achieve a male full male physiology. Also, in FTM patients, exogenous testosterone treatments suppressed female characteristics and prompted virilization (Nolan, Kuhner & Dy, 2019). Masculinizing hormone treatments facilitated the development of other physical features of a man’s body like facial and chest hair growth.

Trans Woman: Male-to Female

A trans woman for the purposes of this study referred to a gay man who has had genital surgery to convert his penis into a vagina (Jackman, Dolezal, & Bockting, 2018), with or without breast implants also referred to as top surgery. Top surgery may have been with or without amputation of the penis in preparation for a vaginal creation. Treatment with exogenous estrogen, a feminizing hormone and anti-androgen help to develop feminine features (Unger, 2016). Additionally, shaving down the Adam's apple to be less pronounced is a procedure that authenticated the female appearance, also a surgical option for male-to-female trans women.

Gender Identity

Moleriro and Pinto (2015) defined gender identity as the self-perception of being male or female, and for the purpose of this study, transgender. Cisgender refers to any individual who do not identify themselves as transgender lesbian, gay, transgender, or bisexual (Wylie et al., 2016).

Misgendered

According to Ladenheim and Wormser (2019), the term misgendered is when the trans man was not addressed as Mr., sir, him, his, or e, or the transgender woman was not addressed as Mrs., ma'am, Ms., her, or she).

Gender Dysphoria

Gender dysphoria is an internal psychological struggle between the person's birth gender and the person's accepted gender identity (Davy & Toze, 2018).

Data Collection

Many adult transgender persons from across the nation between the ages of 21 and 65 responded to the social media invitation to participate in this study under the caption “Transgender Health Improvement Research Project.” Many did not meet the eligibility requirements and self-eliminated. Fourteen of the eligible respondents were randomly selected to participate in this study. Each selected participant was notified by his or her chosen email. Four people changed their minds without explanation, three became uncomfortable and declined to move forward, two became unresponsive after receiving consent forms, and one withdrew on the day of the interview. The remaining four participants who signed and returned their consent forms were scheduled for in-person or telephone interviews. I used written field note documentation along with audio-recordings to chronicle the interviews. Any respondent who chose not to be audio recorded was able to read my field notes for accuracy before completing the interview sessions. These voluntary research participants were assigned code names so that their personal data could not be traced. Non-disclosure of address and state location further ensured that participants would remain unidentified. All participant data were securely stored in a locked cabinet in located in a locked office. Electronic records are stored in a password protected file only assessable by me the researcher. The following are the stories of the four research participants who were interviewed.

Participant One: Mr. Lavender Interviewed by Telephone

Mr. Lavender was a 36-year-old White non-Hispanic trans man who hid his feelings of gender dysphoria from his family since his youth. Mr. Lavender admitted that

the stress of living in the wrong gender category drove him to severe depression and suicidal thoughts. Mr. Lavender was married to a cis gender man and was the mother of three children when he revealed his gender dilemma to his husband. The outcome for Mr. Lavender was divorce, post-traumatic stress syndrome, feelings of worthlessness, and deepening depression. In 2017, Mr. Lavender decided to share his new gender identity with his boss to alert the employer to his soon to be finalized legal name change. To his surprise, the employer accepted his new gender and ensured Mr. Lavender that his employment was secure. Finally, the time arrived for Mr. Lavender to “come out” to his father. Unfortunately, Mr. Lavender’s father was not as cordial as his boss. Mr. Lavender’s father response to him was, “I only understand that I have just lost a daughter. You should have waited to come out after I died!” Despite rejection from his spouse and father, Mr. Lavender proceeded with his gender reassignment plan. He had top surgery in November 2018. The bottom surgery plan was almost derailed because there were no surgeons in his home state who were transgender-competent enough to perform the bottom surgery, so he travelled to Detroit to have the bottom surgery.

Mr. Lavender stated that his primary care physician (PCP) was transgender health care competent and treated him with compassion and respect. Unfortunately, the insurance agents and other health care professionals he was referred to for specialty care treatments were not so cordial towards him in his new gender role. Even though Mr. Lavender was preapproved for insurance coverage preoperatively, the insurance capriciously denied his claim postoperatively. Mr. Lavender also mentioned another dilemma. Trans men who only had top surgery had difficulty accessing routine

obstetrical/gynecological (OB/GYN) care. He recalled being embarrassed in an OB/GYN waiting room because he was “a male who was not accompanied by a female.” Mr. Lavender told me that he saw the looks of disgust on the faces of the people in the waiting room, the staff, and the physician. Mr. Lavender perceived that the people felt he had no business being seen by a gynecologist because he appeared to them to be a queer man. Mr. Lavender realized that he was not in a safe space and never returned to that office again. Another disturbing experience occurred at another doctor’s office where he was discriminated against in his role as a trans man and deliberately misgendered by the front desk nurse.

The only regret Mr. Lavender expressed was not coming out sooner. Mr. Lavender stated that he lived with the reality of the risk of being the victim of a hate crime. He stated, “If I am a victim of a hate crime, I hope someone recorded it!” Beyond the transgender resources from his primary physician, Mr. Lavender surfed the internet in search of safe, transgender inclusive health care and safe social event resources. Based on his shared experiences, I asked Mr. Lavender for two recommendations he felt would improve the health care delivery for transgender clients:

Questions and Recommendations. Question 1: How would you improve access to transgender-congruent, respectful, and compassionate medical, surgical, and mental health care for transgender clients?

Recommendation One: Eliminate the red tape and shorten the bureaucratic process that created the barriers responsible for the slowed or blocked access to timely health care. The provision of internet could links to credible, transgender safe health care

professionals and medical health providers; identify safe social events; teach health providers and transgender clients about gender reassignment surgical options, information about mental health, transgender support groups, and transgender friendly insurance agencies. The internet inks should also direct transgender clients to evidence-based transgender-specific sources, and to transgender health care proficient professionals who provided education about the pros, cons, benefits, side effects, and the dangers associated with feminizing and masculinizing hormone treatments.

Question 2: Which strategies would you implement to augment health provider knowledge in the safe, competent, need-based care of the trans man and trans woman?

Recommendation Two: Require education about the essential needs of trans men and trans women with respect to physical health care and mental health care for all health care providers, and share the projected desired health care outcomes before and after the gender reassignment surgical procedure(s) with each patient. Also, health providers should create safe spaces in their waiting rooms to protect the dignity and privacy of the trans men who still need gynecological and post mastectomy care and for trans women who still need prostate care. Mr. Lavender also recommended the Cincinnati Medical Center transgender focused health care entity as an invaluable resource for proficiency training in transgender health care for all health care providers (Cincinnati Children's Hospital, 2020).

Participant Two: Ms. Strawberry: An In-Person Interview

Ms. Strawberry was a white, non-Hispanic 57-year-old male who began transitioning with hormones to become a trans female. In 2012 she had top surgery

(breast implants) to become a trans woman. In 2014, Ms. Strawberry stated that she was not contemplating bottom surgery (penile amputation and vagina creation) because in her experience, the results were less than optimal. Prior to transitioning, Ms. Strawberry was a six-figure earning executive in a Fortune 500 company, while in her birth-gender-role as a male. After her transition from male-to-female, she lost her employment and her economic status deteriorated. As a result, she lost her house, her love relationships, and her discrimination court case for wrongful termination. She was forced to move back home to live with her father. Despite her misfortune, Ms. Strawberry expressed no regrets about her MTF transition decision. Ms. Strawberry admitted that she realized in her early youth that she was different because she was attracted to other boys and was repelled at the thought of interaction with girls. Nevertheless, she kept her conflicting gender identity feelings to herself, for years. The torture of her internal gender identity crises led to chronic depression, anger, a high degree of anxiety, and suicidal thoughts. When Ms. Strawberry reached out to a medical professional for help, she was categorized as mentally ill secondary to drug addiction. At 17 years old Ms. Strawberry attempted suicide several times. To cope with her internal struggles, she binged drank for several months. When the excessive alcohol consumption proved to be an unsuccessful suicide plan, Ms. strawberry deliberately caused a jet ski accident, but survived. The third suicide attempt was a self-inflicted motorcycle accident. Though critically injured, she survived. Consequently, Ms. Strawberry made the decision to embark upon a spiritual journey to help herself and others like herself to rise above the gender dysphoria, depression, and the associated suicidal thoughts and anguish.

Eventually, Ms. Strawberry decided to become her own personal help advocate. The first personal-help phase was self-medicating with feminizing hormones without a physician's prescription or supervision. After some research, Ms. Strawberry said she found a pharmaceutical company in Europe willing to ship the hormones directly to her home. Meanwhile, she began searching for a surgeon to perform her breast implant surgery. Ms. Strawberry praised her cis gender female primary care physician (PCP), whom she met sometime after self-initiating her hormone treatments. This physician graciously took care her general health care concerns as well as her trans male-focused health care needs. On one routine Dr.'s visit, the PCP scheduled Ms. Strawberry for a diagnostic colonoscopy at a religiously affiliated hospital. Even though Ms. Strawberry had clearly documented her present gender and her new name on the patient information chart, the office nurse deliberately misgendered her. When the physician was ready to see Ms. Strawberry, the receptionist called for Mr. Brown (not the real birth name) several times to come in to see the doctor. Ms. Strawberry stated that she refused to respond to her birth name. Finally, the physician entered the waiting room and said, "hello Ms. Strawberry, I am pleased meet you. Come in." Ms. Strawberry expressed her profound embarrassment and anger for the misgendered discrimination and the disrespect from the nurse at the physician's office. She swore that she would never return to that office for any follow-up care.

Not long after the Dr. office incident, Ms. Strawberry's PCP told her about an anonymous benefactor who wanted to donate money to defray the cost for one transgender person's gender reassignment surgery. The Dr. encouraged Ms. Strawberry

to apply. To her surprise, Ms. Strawberry was selected and had her top surgery free of charge. Even though the surgery was paid in full, the three-day recuperation period in a private room at a hotel and the employment of a private nurse expense was the patient's responsibility. Appreciatively, a gay nurse volunteered to donate his services to care for Ms. Strawberry and care for her free of charge during the three-day postoperative recovery process. I asked Ms. Strawberry to make two recommendations for transgender health care improvement and health care provider education.

Questions and Recommendations. Question 1: How would you improve access to transgender-congruent, respectful, and compassionate medical, surgical, and mental health care for transgender clients?

Recommendation One: Transgender Health Care Improvement

Ms. Strawberry recommended the creation of a website to function as a safe-space where transgender men and transgender women could voice personal and community concerns, get information about need based help, get counselling from transgender-friendly physicians and transgender competent mental health professionals, find information about transgender-safe dating, social groups activities and workshops, economical help, and employment opportunities.

Question 2: Which strategies would you implement to augment health provider knowledge in the safe, competent, need-based care of the trans man and trans woman?

Recommendation Two: Health Provider Education

Ms. Strawberry suggested that physicians and nurses be educated about correct health care practices for trans men and trans women. Secondly, provide health providers

how to instruct transgender patients about what to expect during the pre-surgical, post-surgical, and pre-hormonal treatment initiation stages and understand the risks, benefits, and possible undesirable outcomes connected with the various treatment choices.

Participant Three: Ms. Rose Petal, Interviewed in Person

Ms. Rose Petal was a 56-year-old Caucasian trans woman who had top surgery for breast implants. Ms. Rose Petal chose not to share the date of her breast implant surgery. Three reasons prevented Ms. Rose Petal from moving forward with bottom surgery (penile amputation and vagina creation): (1) to avoid health insurance coverage issues; (2) to please her cis gender female partner who enjoyed having intimate relations with her as a male, and (3) to keep the option to naturally impregnate her partner if they decided in the future to have children of their own. The ability to conceive naturally eliminated the expense connected with invitro fertilization and artificial insemination. Ms. Rose Petal stated that she loved her partner enough to sacrifice her desire to surgically change the bottom half of her physique from male characteristics into female characteristics as her partner had requested.

Health Care Provider Transgender-Specific Knowledge Evaluation

Ms. Rose Petal evaluated her health care provider's transgender-specific health knowledge as very little, with a discriminatory attitude, and was non-transgender-inclusive. The health insurance company refused to cover her transition surgical care costs. Ms. Rose stated that she had to guide her primary care physician (PCP) through the postoperative breast implant care phase. Ms. Rose Petal conveyed that her health care providers who were uninformed about the correct transgender health care protocols

created the most formidable obstacles to timely, competent transgender health care. She stated that she was in a stable, secure, monogamous, and loving relationship with her partner and happily reported that she entertained no suicidal thoughts and made no suicide attempts after her breast surgery. Even though Ms. Rose Petal did not personally experience any postsurgical regret, she did, however, admit to being rejected by some family members, in social circles, by friends, and by employers who urged her to dress like a man while on the job. Ms. Rose Petal specified that she had to be knowledgeable about how to identify safe spaces within multiple environments as a trans woman. I allowed Ms. Rose Petal to choose the transgender friendly location where I conducted her in-person interview because she had experienced threatening encounters in the past at non-transgender inclusive eating establishments. This location even had transgender-appropriate restrooms. I asked Ms. Rose Petal to share two recommendations for improving transgender health care.

Questions and Recommendations. Question 1: How would you improve access to transgender-congruent, respectful, and compassionate medical, surgical, and mental health care for transgender clients?

Recommendation One: Improve Transgender Health Care Access

Ms. Rose Petal stated that she would educate multidisciplinary health provider groups in the correct procedures for rendering respectful, compassionate, culturally competent transgender-appropriate care; create funding assistance resources for hormone treatment initiation and management, and for mental health treatment and counselling; mandate that safe spaces be created in hospital, clinics, and in physician office waiting

rooms so that transgender patients would not be fearful to seek help at health facilities and from health providers; require primary care health providers take the time to meet one-on-one with their transgender patients to identify their individual health care needs. Health care institutions and health care providers should standardize protocols to guide collaborative interactions among primary care physicians, mental health physicians, endocrinologists, surgeons, anesthesiologists, Advanced Registered Nurse Practitioners, Registered Nurses, Nurse Educators, home health providers, and discharge planning representatives to formulate a holistic, customized plan of health delivery actions for transgender clients.

Question 2: Which strategies would you implement to augment health provider knowledge in the safe, competent, need-based care of the trans man and the trans woman?

Recommendation Two: Improve Health Care Provider Education

A uniform plan of health care delivery paradigms for transgender clients' care should be formulated and added to the current college and university courses to teach the transgender competent procedures for rendering respectful, compassionate, culturally competent transgender-appropriate care as a permanent part of the curriculum in medical schools, nursing schools and schools that educate health care workers at every level and in each specialty of service. There should be panel discussions with multi-specialty health care professionals and transgender patient representatives to identify health needs to inform the construction of correct transgender health intervention and suicide prevention paradigms. Afterwards, decide on proper time for implementation strategies for each

need-based health paradigm. Add quarterly updates about new transgender policies, procedures, and other credible, evidence-based transgender health care information as a mandatory ongoing continuing education process.

Participant Four: Mr. Blueberry Interviewed via Telephone

Mr. Blueberry was a 25-year-old Caucasian trans man who described himself as a White-White man. Mr. Blueberry had *top* (bilateral mastectomies) and *bottom* (hysterectomy without ovary removal) female-to-male gender reassignment surgeries in December 2005. Mr. Blueberry defined his primary care physician (PCP) as nondiscriminatory, whose transgender health care knowledge was proficient, and whose LGBTQ (lesbian, gay, bisexual, transgender, questioning or queer) health care knowledge as transgender compliant. Regrettably, Mr. Blueberry's endocrinologist's transgender health care knowledge was deficient, his staff was blatantly discriminatory and disrespectful, and had arbitrarily fractured his basic human rights, as well as his HIPPA mandated rights to privacy. Mr. Blueberry provided the details of one such incident during a preoperative doctor's visit. Mr. Blueberry had an appointment to see an endocrinologist whose role was to titrate his feminizing hormones and monitor his hormone treatment response. Mr. Blueberry arrived at the doctor's office for his appointment dressed as a man, to reflect his new gender role. The waiting room was full of people. He approached the nurse at the front desk and identified himself as Mr. Blueberry. The nurse directed him to complete and return the patient information form. As was his custom, Mr. Blueberry completed the form to reflect his new name, his new gender identity, provided his driver's license, and his insurance card to the nurse. Even

though Mr. Blueberry's name was legally changed on his identification, he did, however, have to provide his cisgender name for insurance payment purposes on the health information form.

Discriminatory Attitudes

When the doctor was ready to see Mr. Strawberry, the nurse entered the waiting room, ignored his transgender name which was clearly indicated on the chart in her hand and called Mr. Blueberry by his birth name. Mr. Blueberry did not respond, thinking that she had made an honest mistake. After calling his birth name two more times with no response from Mr. Blueberry, the nurse told the physician that Mr. Blueberry was a no-show. The physician declared that he saw Mr. Blueberry in the waiting room a few short seconds before. Again Mr. Blueberry approached the front desk nurse to again identify himself as Mr. Blueberry. But, before he could speak, the nurse looked at him and gave him directions to another department in the medical arts building that was across from where this doctor's office was located. Mr. Blueberry insisted that he was at the right location to see his endocrinologist for hormone treatment and evaluation. "Hormone treatments?" The nurse replied, "you look like you have a disability connected with fetal alcoholism syndrome that is why I referred you to the disability clinic." At that point, the endocrinologist entered the waiting room and said, "there you are Mr. Blueberry, come in." To Mr. Blueberry's surprise, the doctor did not apologize, or make his nurse apologize for her atrocious behavior towards Mr. Blueberry that had embarrassed him in the crowded waiting room. Mr. Blueberry admitted that he had feelings of worthlessness and wanted to die. Mr. blueberry told me that preoperatively, he experienced rejection,

threats of violence, suffered from chronic depression, and regret for feeling trapped in a body that did not match his gender identity. Hence, he had a heightened sense of anxiety and entertained thoughts of suicide. I assured Mr. Blueberry that his input was valuable to this study and gently requested him to recommend two strategies to improve transgender health care access and health provider knowledge in appropriate transgender health care.

Questions and Recommendations. Question 1: How would you improve access to transgender-congruent, respectful, and compassionate medical, surgical, and mental health care for transgender clients?

Recommendation One: Transgender Health Care Access Improvement

Mr. Blueberry stated that with the exception of AIDS and HIV studies, transgender persons are mostly excluded from credible health care research studies about the basic health status protocols and the expected outcomes for cholesterol, blood pressure, diabetes, cancer, renal failure, masculinizing and feminizing hormone, as well as expected treatment outcomes, and dialysis treatment protocols. As a result, there are no health delivery policies and procedures to proficiently treat transgender persons. Therefore, cis gender health protocols are erroneously applied to treat transgender clients that resulted in less than desirable outcomes that were sometimes injurious. Hence, transgender persons have no desire to access health care providers and health care systems that remain discriminatory and incompetent in safe transgender health and health maintenance conveyance.

Question 2: Which strategies would you implement to augment health provider knowledge in the safe, competent, need-based care of the trans man and trans woman?

Recommendation Two: Improve Health Provider Transgender Education

Mr. Blueberry recommended a mandatory health industry-wide education to establish and sustain compassionate, respectful, nondiscriminatory, culturally appropriate, transgender-proficient health care delivery procedures and policies.

Variations in Data Collections

Three companies were to assist in the original data collection and participant recruitment plan: Equality Florida, the Williams Institute, and SurveyMonkey. The first phase of my plan was to collaborate with the Director of Transgender Equality at the Equality Florida organization who had expressed her commitment in the past to assist me with my research project during my dissertation proposal phase. Unfortunately, once my proposal was approved this person was unresponsive to my emails. Likewise, persons with the authority to grant research assistance permission were also nonresponsive. Additionally, in February 2020, a representative from the SurveyMonkey Team informed me via email that my targeted transgender population was less than one percent of the total U.S. population, too small for the SurveyMonkey team to gain access to. Hence, I turned my attention to other viable resources from which to recruit appropriate prospective research participants.

Appreciatively, the SunServe organization, an LGBTQ certified entity with the motto, “We Help People” became a valuable recruitment resource. When I contacted SunServe I was transferred to Misty Eyez, a trans woman executive who was the Director

of Transgender Woman's Health and Transgender Proficiency Training. We made an appointment and met the following week in person. When I introduced the goals and intention of my transgender research project to her, was very interested in helping me. She immediately posted my recruitment flyer and contact information to her social media website. In less than 24 hours I received numerous responses from interested transgender persons from across the nation who expressed their interest to become volunteer participants in my transgender research study. Ten participants who met the predetermined eligibility criteria were randomly selected and notified by email with the IRB approved consent form attached. As soon as each participant emailed his or her signed consent form to me, a telephone or in person interview was scheduled according to the participant's preference day and time. A mutually acceptable interview location was selected for the in-person interviews and a mutually acceptable date and time with respect to time zones times (convenient for the participant) to conduct the telephone interview.

Data Analysis

The field notes of each individual's story were the sources for the five original themes, namely, *Theme I: The Perioperative Experience(s)*, *Theme II: The Health Provider's Transgender Health Care Competence*, *Theme III: Perioperative Health Care Barriers*, *Theme IV: Suicidal Ideation*, and *Theme V: Suicidal Attempts*. At the conclusion of the participant interviews, it was clear that I needed to add three emergent themes: *Theme VI: Provider transgender health education*, *Theme VII: Health provider transgender focused discrimination*, and *Theme VIII: Rejection* to the list for a

comprehensive understanding of the total perioperative experience shared by each participant. The original intention for adding sub-codes was to identify where in the perioperative process the afore mentioned themes occurred (before surgery, during the in-patient stay, after discharge, or during the transitional outpatient phase). Since there were no cookie-cutter answers I was able to assign each person's narrative into the appropriate themes.

Discrepant Data Management

As stated in the third Chapter, even though there were five standardized themes and associated codes for this investigation, three new themes emerged during the course of the interviews, namely, **Theme VI: Health Provider Transgender Health Education**, **Theme VII: Health Provider Transgender Focused Discrimination** and **Theme VIII: Rejection**. Two of the participants experienced postoperative rejection, one was rejected by a parent the other was rejected by an employer resulting in job loss. One participant experienced preoperative rejection by a spouse. The new themes and the associated data were added and analyzed. Theme IV: Suicide Ideation and Theme V: Suicide Attempts within the past 12-24 months were questions based on my projected research theory, not based on evidence or reality. The participants narratives provided holistic explanations of the factors that contributed to each person's suicide ideation and suicide attempts that started many years before the 12-24-month eligibility criteria parameters for this study. Thus, this new information became an integral part of this investigation. The 12-24-month timeframe turned out to be an unrealistic notion because all participants transitioned at least five years prior to this

study. The participant who had gender reassignment surgery in January 2020 withdrew from this study without explanation. Hence this study naturally evolved into a summarized historical sketch of the individual trans man's and the individual trans woman's journey from *birth gender dysphoria* to *chosen gender-acceptance*, a valuable and an integral component for this investigation.

Evidence of Trustworthiness

Each Study participant was assigned a code name to protect his or her identity, each eligible person returned a signed informed consent, each eligible person was given the option to change his or her mind or to withdraw from this study at any time with or without explanation, and without actual or implied penalty. All participant data was stored in a locked cabinet, all electronic data remained secured in a password-protected file known to and assessable only by me, the researcher. This information will continue to be locked away and securely protected for the next six years.

Even though 25-35 minutes was the time original allotted for each interview the actual interview time ranged from 90 to 120 minutes. According to Nolan, Kuhner, and Dy (2019) the extended interview time was important for *credibility* achievement because the extra time allowed the interviewee and me to develop mutual trust (prolonged engagement), understand the participant's perspective, facilitated my recognition of relevant information appropriate for organization of themes (persistent observation), and the use of internet, in-person interviews, radio advertising, and community flyer distributions (Data triangulation), and allowing participants to review interview transcripts for accuracy (member check). *Reflexivity* was achieved with self-examination

to identify and remove assumptions and prejudices to prevent any biases in data collection, data analysis, data results, and recommendations. My field notes-diary and my successful completion of a Human Research Participant Training module enabled me to understand how transgender-focused discriminatory practices from health providers and health systems may have prompted suicidal thoughts and suicide attempts in trans men and trans women. These research results are *transferable* because experiences with transgender focused discrimination from health care providers/health care systems, family acceptance/rejection, workplace discrimination and job loss/job preservation are included. Finally, *Confirmability and Dependability* are transparency milestones congruent with directives contained in Walden's IRB application. I was approved to conduct research and gather data on January 17, 2020.

Furthermore, each eligible study participant returned a signed informed consent form, was assigned a code name to protect his / her identity, was given the option to change his / her mind or to withdraw from this study completely, at any time with or without explanation or consequence. All participant data is in a locked cabinet, known to and assessable only by me, the researcher. This information will be locked away for the next six years. Hence, the trustworthiness goals of dependability, confirmability, transferability, transparency, credible, and reflexiveness were achieved with no preconceptions or biases, as recommendation by Korsjens and Moser (2018).

Results

The four trans persons who completed this study from start to finish were: Ms. Strawberry, a 57-year-old trans woman, Mr. Lavender, a 36-year-old trans man, Mr.

Blueberry, a 25-year-old trans man, and Ms. Rose Petal, a 56-year-old trans woman.

These persons were asked to answer one research question and four sub-questions. The individual responses to each research question and sub-questions are below.

Research Questions and Participant Responses

RQ1: How do male-to-female and female-to-male transgender persons perceive their health provider's transgender-specific knowledge deficit and health provider transgender related discriminatory attitudes as influences contributing to your suicidal thoughts and suicidal attempts during the gender reassignment process?

Ms. Strawberry, a 57-Year-Old Trans Woman

According to Ms. Strawberry, prior to her gender reassignment surgery, her health care providers had no transgender health care education, hence, they were ill-equipped to render competent, gender-specific care. As a result, she was misdiagnosed as mentally ill and delusional. Consequently, her experience with health provider's transgender-related maltreatment caused her mental state to deteriorate into anger, chronic depression, persistent anxiety, continual suicidal thinking, and two suicide attempts.

Mr. Lavender, a 36-Year-Old Trans Man

Mr. Lavender stated that he only entertained suicidal thoughts preoperatively because his health care provider's attitude towards him was blatantly disrespectful and discriminatory, continually.

Mr. Blueberry, a 25 -Year-Old Trans Man

Mr. Blueberry reported that his primary health care provider and his referred-to health provider were both proficient in delivering high-quality transgender-congruent

health care, postoperatively. It was during the preoperative transgender reassignment phase that he entertained suicidal thoughts due to health provider and health systems discrimination.

Ms. Rose Petal, a 56-Year-Old Trans Woman

Ms. Rose Petal admitted that she did not experience suicidal thoughts and made no suicidal attempts preoperatively because her current primary care physician was transgender health-care-knowledge-deficient the doctor treated her respectfully.

Unfortunately, maltreatment and discrimination from other health care providers during her preoperative and postoperative stages led to thoughts of suicide.

Sub-question 1. How do male-to-female and female-to-male transgender persons perceive their health quality of their health provider's knowledge about their gender-specific mental and physical health needs before, during, and after the male-to-female sexual reassignment process?

Ms. Strawberry declared that even though her primary care physician had above average transgender health care knowledge, the nurses and secondary physicians were transgender health knowledge deficient. Mr. Lavender described his PCP, his secondary physicians, and his nurses as transgender health-knowledge deficient. Mr. Blueberry stated that his primary care physician (PCP) was well versed in all aspects of respectful, compassionate, culturally competent, and medically appropriate transgender health care during every phase of the gender reassignment process. Additionally, Mr. Blueberry's PCP provided transgender health care training for secondary physicians as well.

According to Ms. Rose Petal, her PCP, secondary physicians, and her nurses were all

deficient in safe and appropriate transgender health care knowledge. So, she had to teach her health care providers how to competently care for her gender-specific mental and physical health care requirements.

Sub-question 2. How do male-to-female and female-to-male transgender persons perceive the competence with which their health provider(s) met or did not meet their gender-focused mental and physical health?

The research participants were asked to use a zero to 10 scale (0-4 = Deficient, 5-7 = Fair, 8 = Average, 9 = Above Average, 10 = Proficient) to rate the transgender health care knowledge of their primary physicians, their nurses, and their secondary (referred to) physicians. *Table 1* below illustrated each participant's response.

Table 1: Health Provider Transgender Health Care Competence Rating

(0-4 = Deficient, 5-7=Fair, 8=Average, 9=Above Average, 10 = Proficient).

Code Names	Primary Care Physicians	Nurses	Secondary Physicians
Rose Petal	1	0	0
Strawberry	9	4	2
Lavender	0	0	0
Blueberry	10	0	7

Sub-question 3. What do male-to-female and female-to-male transgender persons perceive as obstacles to accessing gender-appropriate mental and physical health care during all stages of the gender reassignment experience?

Ms. Strawberry

Ms. Strawberry declared that no insurance coverage for transgender-specific health care, health provider transgender knowledge deficits, non-transgender inclusive health systems, non-transgender inclusive medical health, mental health, health programs,

procedures and protocols and non-transgender inclusive postoperative and transitional follow-up care were obstacles to accessing care for trans men and trans women.

Mr. Lavender

Mr. Lavender identified health providers with no transgender health education, insurance agents who used discriminatory practices in transgender health insurance coverage; not able to access routine and preventative prostate care as a trans woman and obstetrical/gynecological as a trans man, and being deliberately misgendered by physicians, nurses, and office or clinic staff as health care access barriers.

Mr. Blueberry

Mr. Blueberry reported that the health care obstructions he encountered were his endocrinologist' and the office staff had discriminatory attitudes towards him in his new gender role, the transgender health knowledge deficit that resulted in the erroneous application of cis gender health paradigms to address transgender mental and physical health needs were health care obstructions.

Ms. Rose Petal

Ms. Rose Petal identified health provider transgender health care knowledge deficits, health provider transgender focused discriminatory attitudes, non-transgender inclusive health care paradigms, insurance companies that refused coverage for transgender-specific care as obstacles to gender-appropriate health care.

Sub-question 4. What are the perceptions that male-to-female and female-to-male gender reassignments patients have about their encounters with health provider

transgender discriminatory attitudes that may have led to suicidal thoughts or suicide attempts during the transitional follow-up phase?

Ms. Strawberry, Mr. Lavender, Mr. Blueberry, and Ms. Rose Petal all agreed that the lack of health provider transgender health education had resulted in transgender-focused discrimination and the associated maltreatment triggered suicidal thoughts and suicide attempts.

Summary

The two trans men and two trans women who completed this study from start to finish were all asked to answer one research question and four related sub-questions that were subdivided into the following eight themes.

In **Theme I: *The Perioperative Experience(s)***, all but one participant admitted to having suicide ideations preoperatively, not postoperatively. In **Theme II: *The Health Provider's Transgender Health Care Competence*** category, all but one declared having to incrementally orient their primary care physicians, and the secondary healthcare provider about how to meet personal gender-specific physical and mental health care needs. With regards to the **Theme III: *Perioperative Health Care Barriers***: only two participants experienced health insurance coverage barriers before and after surgery as well as health care access barriers preoperatively and postoperatively; all cited health provider transgender health knowledge deficits, health provider trans health care competence, and health provider transgender related discriminatory attitudes as additional barriers. For **Theme IV: *Suicide Ideation***, three participants experienced strong feelings of suicide preoperatively. Only one participant reported feeling suicidal during the

postoperative period due to being misgendered, gross discrimination, and being disrespected in his new gender role. One person confirmed **Theme V: *Suicide Attempts*** due to overwhelming feelings of gender dysphoria preoperatively. Three new themes emerged during the data collection process: **Theme VI: *Health Provider Transgender Health Education***, **Theme VII: *Health Provider Transgender Focused Discrimination***, and **Theme VIII: *Rejection***.

All four participants experienced **Theme VI: *Health Provider Transgender Health Education*** and **Theme VII: *Health Provider Transgender Focused Discrimination***. Three out of four participants experienced **Theme VIII: *Rejection***. Mr. Blueberry (trans man) experienced gender rejection by his endocrinologist and his gynecologist. Mr. Lavender (trans man) was rejected by his father, his cis gender male spouse and was subsequently divorced by his cis-gender male spouse. Ms. Strawberry (trans woman) was rejected by her employer and loss her job. The results in this chapter will serve as the foundations for recommendations and social change implications to be discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The nonexistence of transgender-competent health care education in colleges and universities has produced few widely accepted protocols for transgender-appropriate health care. This lack is associated with augmented health disparities for this population (Safer, et al., 2017), including the use of ineffective suicide prevention procedures (Haas, Rodgers, & Herman, 2014) and ineffective suicide interventions (Virupaksha, Muralidhar, & Ramakrishna, 2016). Other health care disparities for transgender individuals involve the stigma associated with being transgender as asserted by Hughto, Rose, Pachankis, & Reisner (2017) and confirmed by Kosenko, Rintamaki, Raney, & Maness (2013), postsurgical regret (Heyer, 2016), and relationship rejection (Klien & Golub, 2016). Contemporary scholars have deemed the higher suicide rates among 1.4 million transgender persons a significant public health problem in the U.S. (Flores, Herman, Gates, & Brown, 2016). The Center for Disease Control and Prevention's National Center for Injury Prevention and Control, (n.d.) has designated suicide prevention to be a major focus in the public health industry using a population method. Hence, the purpose of this hermeneutic phenomenological (Eddles-Hirsch, 2015) qualitative public health research study was to identify and understand which factors within the perioperative phase prompted suicide attempts and suicidal ideation among trans men and trans women.

The Nature of the Study

The data collection method was telephone and in-person interviews of four postsurgical adult transgender men and transgender women who contacted me, voluntarily agreed to participate in this study, and returned signed IRB approved consent forms. Barr, (2015) declared that the phenomenology research design employed the “lived experience” method of analysis, in this case, the lived health care experiences of transgender men and transgender women during the perioperative phase of the gender reassignment process. The acceptable sample size was 10 or less research participants according to Daniel (2018). It was important for me to understand the prevailing contributing factors that prompted suicidal thoughts and suicidal actions, as well as the individual mental health status from each person’s perspective (Barr, 2015) during the perioperative phase (preoperative, intraoperative, and postoperative transitional phase (Journal of Patient Care, 2018) of the gender reassignment process. I employed Criterion Sampling (Palinkas et al., 2015) for this investigation to recruit male and female transgender participants who met the following eligibility requirements: adult, postsurgical transgender men and postsurgical transgender women 21 to 65 years old, who read, wrote, and understood English, were legal United States residents or US citizens, and who had attempted suicide and/or had entertained suicidal thoughts in the past. Data saturation (Saunders et. al., 2018) for this study was achieved at the three-participant level.

Key Findings

In **Theme I: *The Perioperative Experience(s)***, three participants admitted to suicide ideation preoperatively, not postoperatively. Only one participant reported postoperative suicidal ideas. In **Theme II: *The Health Provider's Transgender Health Care Competence***: the research participants were asked to use a zero to 10 scale (0-4 = Deficient, 5-7 = Fair, 8 = Average, 9 = Above Average, 10 = Proficient) to rate the transgender health care knowledge of their primary physicians, their nurses, and their secondary (referred to) physicians. Ms. Rose Petal gave her primary care physician (PCP) a transgender health knowledge-deficient rating and designated zeros (0) to her nurses and secondary physicians. Ms. Strawberry assigned an eight (8) transgender health care competence rating to her PCP and deficiency ratings (5-7) to the nurses and secondary physicians. Mr. Lavender reported that his physicians and nurses were transgender health care incompetent (0-4). Even though Mr. Blueberry gave his primary physician a transgender health care proficient grade (10) and his secondary physician a fair rating (8), his nurses were rated as transgender health care incompetent (0-4).

For **Theme III: *Perioperative Health Care Barriers***, only two participants, Ms. Strawberry and Mr. Lavender experienced health insurance coverage barriers before and after surgery as well as health care access barriers both preoperatively and postoperatively. All four participants cited health provider transgender health knowledge deficits, and health provider transgender health care incompetence as additional barriers. For **Theme IV: *Suicide Ideation***, three participants experienced strong feelings of suicide preoperatively. Only one participant reported suicidal feeling during the postoperative

period due to being misgendered, gross health provider discrimination, and was disrespected in his new gender role. One person confirmed **Theme V: *Suicide Attempts*** before surgery due to overwhelming feelings of gender dysphoria, stigma, and transgender focused discrimination by medical providers, nurses, and health care systems.

All four participants experienced **Theme VI: *Health Provider Transgender Health Education Deficit*** and **Theme VII: *Health Provider Transgender Focused Discrimination***. Three out of four participants experienced **Theme VIII: *Rejection***. Mr. Blueberry experienced gender rejection by his endocrinologist and his gynecologist. Mr. Lavender was rejected by his father and his cis gender male spouse who subsequently divorced him. Ms. Strawberry was rejected by her employer and lost her job.

Interpretation of Findings

The findings of this study were health insurance coverage issues and deficits in trans men and trans women gender-congruent health care knowledge and practices rendered physicians and nurses incompetent to care for transgender clients. These findings were consistent with the conclusion of Park and Safer (2018) who asserted that doctors and medical students lacked the transgender health education and clinical exposure to transgender patients. According to the participants in this study, most of the primary care physicians, the nurses, and the secondary (referred to) physicians caring for the trans men and trans women had no transgender-specific health education. Nurses and doctors who are educated in a non-transgender inclusive health care learning environment are rendered incompetent and unprepared to deliver safe, need-specific, respectful

transgender-congruent health care (Park & Safer, 2018). Therefore, nurses and physicians should rotate through a series of residency assignments via health service specialties like, surgical, medical, anesthesiology, obstetrics, ophthalmology, intensive care, orthopedics, men's health services, and women's health services.

Limitations of the Study

Even though a sample size of four participants seemed to be a limitation of this study, Daniel (2018) asserted that in the phenomenology research design a group of less than 10 research participants is an appropriate sample size. Another aspect that imposed limitations was the 12-24-month time frame protocol in the questions that automatically disqualified many transgender recruits who were willing to participate in this study. Participants declared that gender dysphoria, suicidal thoughts, and suicidal attempts began during adolescence and incrementally intensified with age.

Recommendations

The participants and I concur with the following recommendations.

Improve Access to Transgender-Congruent Health Care

Eliminate the slow bureaucratic process a road block to timely health care; provide internet links to credible and transgender safe health care professionals and medical health providers; identify safe social events; teach health providers about gender reassignment surgical options information, mental health, transgender support groups; and provide information about transgender friendly insurance agencies. The internet links should also direct transgender clients to transgender-specific resources, and to transgender health care proficient professionals who provided education about the pros,

cons, benefits, side effects, and the dangers associated with feminizing and masculinizing hormone treatments. Provide funding assistance resources for hormone treatment initiation and management, and for mental health treatment and counselling by transgender health proficient providers.

Safe-Space Creation

Mandate safe spaces in hospital, clinics, and in physician office waiting rooms so that transgender patients and families will not be fearful to seek initial and follow-up care from health providers and health entities. Require primary and secondary health care providers to meet one-on-one with each transgender client to identify individual health care needs.

Health Provider Education

Mandate education for health care providers about the unique needs of transgender patients and the procedures for rendering respectful, compassionate, culturally competent transgender-appropriate care; have standardize protocols to guide collaborative interactions among primary care physicians, mental health physicians, endocrinologists, surgeons, anesthesiologists, Advanced Registered Nurse Practitioners, Registered Nurses, Nurse Educators, home health providers, and discharge planning representatives to formulate a holistic, customized plan of health delivery actions for transgender clients, and share the projected desired health care outcomes before and after the gender reassignment surgical procedure(s) with each patient. The Cincinnati Medical Center transgender focused health care entity should be included as an invaluable

resource for proficiency training in transgender health care for all health care providers (Cincinnati Children's Hospital, 2020).

Transgender Prostate, Gynecological, and Obstetrical Health Care: The Paradox

Public health and non-public health providers should understand that some MTF clients may still need prostate cancer screening and prostate care. On the other hand, some FTM clients may still need post mastectomy care, gynecological care, like pap smears and other female cancer screening services.

Medical School and Nursing School Transgender Health Curricula

A standardized plan of health care delivery paradigms for transgender clients' care should be added to the current college and university courses to teach the correct procedures for rendering respectful, compassionate, culturally competent transgender-appropriate care and become a permanent part of the curriculum in medical schools, nursing schools and schools that educate health care workers at every level and in each health specialty. There should be panel discussions with multi-disciplinary health care professionals and transgender patient representatives to identify health needs to inform the construction of correct transgender health intervention and suicide prevention paradigms. Compulsory quarterly updates about new transgender policies, procedures, and other credible, evidence-based transgender health care information as an ongoing continuing education commitment.

Subsequent Transgender Research Studies

Unfortunately, transgender persons are mostly excluded from credible health care research studies about the basic health status protocols and the expected outcomes for

cholesterol, blood pressure, diabetes, cancer, renal failure, masculinizing and feminizing hormone, as well as the expected treatment outcomes and dialysis treatment protocols. As a result, there are no health delivery policies and procedures to proficiently treat transgender persons. Hence, subsequent transgender health research should focus on constructing transgender-inclusive health care systems that dismantles the present discriminatory, incompetent, and unsafe transgender health and health maintenance conveyance. So, my final recommendation is to establish and maintain a mandatory health industry-wide education culture of compassionate, respectful, nondiscriminatory, culturally appropriate, transgender-proficient health care delivery procedures and policies to upgrade transgender health.

Implications

Contribution to Positive Social Change

The expectation is that this study will contribute to a positive social change paradigm that will dismantle the present traditional, non-transgender-inclusive health care practices by improving the individual, family, and community access to high quality, transgender-appropriate health care. This investigation has confirmed that transgender suicidal thoughts and suicidal attempts were augmented by negative encounters with health care systems and health care providers, as well as within the social, economic, and in personal relationships (Christian, Mellies, Bui, Lee, Kattari, & Gray, 2018). The four participants in this investigation also concurred that the health providers they encountered had no transgender health care education (Safer et al., 2017). Three participants experienced health care discrimination towards them as transgender persons. Thus, the

education of more medical health care providers about the specifics of transgender-compliant medical care could be the catalyst to begin the process of reducing transgender health disparities that: (1) will improve this population's access to competent health care providers who recognize transgender individuals who are at risk for suicidal attempts and suicidal thinking, and (2) will proactively implement suicide prevention standards in a respectful, gender-appropriate, and timely manner.

Public Health Practice Contribution

The hope is that the results of this study could inform existing transgender-specific suicide prevention protocols and transgender suicide prevention legislation poised to help to reduce transgender health care disparities (Christian et al., 2018); to achieve transgender health equity (Noonan et al., 2018), to facilitate collaboration among public health researchers, mainstream health care providers, and representatives from the transgender community to formulate realistic, transgender-specific suicide prevention protocols applicable to multidisciplinary health care settings. The data from this investigation could help improve health provider competence in caring for transgender patients with augmented medical provider transgender health proficiencies (Noonan et al., 2018). Implemented medically appropriate transgender-specific health protocols (Safer et al., 2017) could decrease the higher suicide rates faced by this population. The five-step public health suicide prevention strategy could be used to implement timely, effective interventions; and perform incremental appraisals of the success or failure these interventions (Suicide Prevention Resource Center, 2020).

Contribution to Public Health Knowledge

This investigation confirmed that health professionals have negative preconceptions and negative attitudes towards transgender clients, as shown with pharmacy residents (Leach & Layson-Wolf, 2017) and nursing students (Lim & Hsu, 2016). Hence, the hope is that this study could help to encourage medical schools, nursing schools, and schools training allied health care workers to add transgender-appropriate healthcare paradigms to their existing curricula that could train health providers to achieve transgender health care competence (Kosenko, Rintamaki, Raney, & Maness, 2016).

Conclusion

Existing evidence-based research has confirmed that transgender suicide is a public health problem that affects 1.4 million people in the total United States populace (Flores et al., 2016) who self-identify as transgender. Additionally, deficits in medical health provider transgender-specific health care education was associated with high levels of health disparities for this population (Safer, et al., 2017), that included the use of non-transgender inclusive suicide prevention procedures (Haas, Rodgers, & Herman, 2017) and ineffective suicide interventions (Virupaksha, Muralidhar, & Ramakrishna, 2016). Thus, more physicians and nurses should be educated in the nuances of high-quality transgender-specific male-to-female and female-to-male health needs to deliver high quality transgender-appropriate health care. Competent transgender male-to-female and female-to-male health protocols should include transgender inclusive suicide risk recognition, how to implement timely suicide intervention, and how to create and manage

sustained suicide prevention procedures and promotions. Furthermore, the overall social change impact plan was to utilize the Cramer and Kapusta, (2017) Social- Ecological- Suicide Prevention Model as the foundational framework for creating transgender-specific suicide prevention protocols and suicide intervention paradigms. The Perioperative Medicine Model, according to the Royal College of Anesthetists, (2014) provided the directive for physicians to holistically identify, treat, and provide transgender health care management MTF and FTM patients who had pre-existing physical and mental health disorders during the provision of gender-appropriate perioperative care. The purpose of the Perioperative Patient Focused Model (AORN, 2015) was to certify competencies for the nurses caring for transgender patients during the preoperative intraoperative, and postoperative surgical phases (Malley et al., 2015). Together, these models provide an evidence-based *Triad Model* framework to ensure the achievement of desirable transgender patient outcomes.

According to Park and Safer (2018) there is an acute need for clinical exposure to transgender health care. So, residency field experiences in transgender health care should be mandatory for nursing and medical school students, for practicing health care professionals. Need-specific trans men and trans women care should be an educational instrument to (1) close the transgender health care provider knowledge gap, (2) to improve transgender health care delivery, (3) enable physicians and nurses to recognize transgender patients who may be suicide risks, (4) provide timely transgender-competent suicide interventions, and, (5) augment desirable health outcomes for transgender

patients. Hence, achieving a positive social change milestone that is poised to reduce and eventually eliminate perioperative suicides among transgender persons.

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