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Conceptualization of Gender Variant Inclusive Healthcare Service Delivery

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MSW, Joint Master Program at NCAT and UNCG, 2016

BSW, Winston Salem State University, 2015

Dissertation Submitted in Partial Fulfillment

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Abstract

Gender variant people experience a variety of health concerns for which they seek the assistance of healthcare providers. These concerns may range from chronic health conditions and psychological disorders to gender affirming concerns. Due to living in a heteronormative society, gender variant individuals are more susceptible to experiencing stigmatization, discrimination, and other forms of unfair treatment while accessing healthcare services, which contributes to poor health outcomes. This treatment may be attributed to the lack of knowledge, competency, and training of healthcare providers as it relates to trans-inclusive care. Grounded in minority stress theory and intersectionality theory, the purpose of this study was to explore how gender variant individuals conceptualize trans-inclusive service delivery. A generic qualitative research design was used to explore how nine gender variant individuals defined trans-inclusive service delivery as well as to determine how inclusivity may be present within the healthcare setting. The findings from this research suggested that gender variant individuals defined inclusive service delivery by the presence of the following: representation, validation of identity, language and behavior, medical knowledge, and accessibility of resources. The results from this study may contribute to promoting the need for policy changes to remove systemic barriers and other forms of discriminatory practices within healthcare that impacts gender variant populations and their overall healthcare experiences as well as to provide information to assist in advocacy and encourage training-specific courses that may help improve the standard of care for gender variant populations.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

In this generic qualitative research study, I explored how gender-variant individuals defined trans-inclusive service delivery. According to the 2011 National Transgender Discrimination Survey, 50% of the 6,450 respondents expressed dissatisfaction with the healthcare services they received (see Safer et al., 2016). This and several other similar studies support the need to improve service delivery for this population (Baldwin et al., 2018; Chisolm-Straker et al., 2018; Christian et al., 2018; Garcia & Crosby, 2020). This study produced knowledge that can improve healthcare standards provided to gender-variant people by defining inclusivity and providing effective service delivery implications (Williams et al., 2016). In this chapter, I provide a brief background related to the scope of this study, identify, and discuss the problem statement, explain the purpose of the study, provide information on the conceptual frameworks that guided the study, discuss the nature of the study, provide definitions, clarify assumptions, and discuss study limitations as well as the significance of the present study.

Background

Gender-variant communities are comprised of people who differ from cisgender majorities. According to a study conducted in 2016 by the Williams Institute, it was estimated that 1.4 million individuals identify as gender-variant (Flores et al., 2021). Gender-variant individuals express themselves in a way that does not conform to gender norms (Donatone & Rachlin, 2013; Kattari et al., 2016). *Gender-variant* is an umbrella term to describe a multitude of gender identities, such as transgender, transexual, genderqueer, gender nonconforming, nonbinary, or gender fluid (Donatone & Rachlin, 2013; Kattari et al., 2016). Individuals belonging to this group often experience more significant forms of discrimination and oppression than individuals who identify as cisgender (Kattari et al., 2020). This discrimination may contribute to accessing employment, housing, and other survival needs (James et al., 2016). As a result, this population faces health disparities at a greater rate and is more susceptible to higher mental health and substance use rates (James et al., 2016). Health disparities are population-specific differences in access to health care, quality and utilization of health care, and health outcomes (Kachen & Pharr, 2020). In addition to the existence of health disparities, this population may lack the necessary access to healthcare that is needed to address these disparities, such as mental health, primary care, and other forms of healthcare (Garcia & Crosby, 2020).

Kachen and Pharr (2020) suggested that gender-variant populations often learn to demonstrate resiliency due to navigating stigma, minority stress, and microaggressions. These experiences may manifest in various environments or situations, and research has shown that they frequently occur in healthcare settings (Garcia & Crosby, 2020; Kachen & Pharr, 2020; Kattari et al., 2016). The Institute of Medicine discovered that the significant barriers denying gender variant individuals' access to health resources included inadequate medical insurance, stigmatization, and a knowledge gap by healthcare providers (as cited in Rice, 2019). As a result, Cruz (2014) explained that gender-variant communities often postpone seeking care at higher rates out of fear of these negative experiences. Although there is extensive literature that supports the need for improvement in healthcare settings and amongst healthcare providers, the current study is needed to provide information and context on the importance of inclusive care and what it should look like from the perceptions of those who will be receiving it.

Problem Statement

This research addressed the social problem related to the significant amount of transphobia, discrimination, and stigmatization experienced by transgender and other gender-variant individuals when accessing healthcare. This type of adverse treatment further exacerbates the negative health outcomes of this population. According to Kattari et al., 2020, gender-variant individuals experience high levels of health disparities and are more likely to experience denials of health care than their cisgender counterparts. The literature revealed a need for better healthcare providers' training to be inclusive and reduce their gender-variant patients' denial rates (Kamen et al., 2019). Safer et al. (2016) supported this conclusion by explaining that the most significant barrier to health care reported by gender-variant individuals is lack of access due to lack of providers who are sufficiently knowledgeable on the topic. The following barriers were also discussed: financial barriers, discrimination, lack of cultural competence by providers, health systems barriers, and socioeconomic barriers (Safer et al., 2016). A growing body of literature has justified this by explaining that discrimination exists from both an interpersonal and institutional level (Baldwin et al., 2018; Christian et al., 2018; Gridley et al., 2016). This is exemplified amongst healthcare providers who lack the experience, competency, and empathy around gender diversity. In addition, from an institutional level, healthcare settings cater to cisnormative and heteronormative processes and polices that create a barrier to care for gender variant populations (Nadal et al., 2014).

To address the barriers to gender-variant care, several recommendations have been discussed within the literature. First, creating a welcoming and gender-affirming environment is essential for ensuring equality for access to healthcare for all populations (Rowe et al., 2019). Next, researchers have implied that health care providers need to be prepared to respond to specific needs of the gender-variant community (Deutsch, 2017; Kamen et al., 2019; Kattari et al., 2016). In addition, studies have confirmed that healthcare settings must be inclusive, as evidenced by gender-neutral bathrooms and the use of neutral terminology (Deutsch, 2017; Quinn et al., 2015). Lastly, it is suggested that policymakers promote equality by creating and implementing nondiscriminatory policies (McBride, 2018). Each of these recommendations has been discussed to overcome the barriers to care for gender-variant people; however, no researcher has asked what gender-variant people need to overcome these barriers. Previous research has focused on the deficits in healthcare, the negative experiences of gender-variant people in healthcare, and the negative health outcomes that are a direct result of adverse treatment when accessing healthcare services (Baldwin et al., 2018; Chisolm-Straker et al., 2018; Christian et al., 2018; Garcia & Crosby, 2020). This research will address the problem of not hearing from the population that is impacted the most. I explored what inclusivity looks like based on their perceptions.

Gender-variant people experience a significant amount of prejudicial treatment from providers based on their identity when accessing healthcare (Kattari et al., 2016;

Safer et al., 2016). This treatment contributes to high mental illness rates, increased suicide rates, increased substance use, negative treatment retention, and poor health outcomes (Broussard & Warner, 2019; James et al., 2016). While researchers have pointed to the importance of trans-inclusive service delivery, no researcher has studied how gender-variant individuals conceptualize what this service would look like. This information is essential because it can help improve the treatment provided to these individuals to improve health outcomes, encourage treatment retention, and reduce the negative stigma associated with accessing healthcare services. The specific research problem addressed through this study was a lack of understanding of how gender-variant individuals conceptualize inclusive service delivery when accessing healthcare services.

Purpose of the Study

The purpose of this generic qualitative study was to explore how gender-variant individuals conceptualize trans-inclusive service delivery. In addition, the study contributed to the empirical research concerning this population. With the knowledge obtained from this research, my hope is that it may aid in developing training, competencies, and other evidence-based modalities to encourage inclusivity within a variety of healthcare settings for gender-variant populations. Lastly, this study provided a platform for gender-variant individuals to discuss their perception of healthcare inclusivity and encourage understanding amongst healthcare providers.

Research Questions

The guiding research questions used to examine the problem in this study were as follows:

Research Question (RQ)1: How do gender-variant individuals conceptualize trans-inclusive healthcare service delivery?

Research Question (RQ)2: How do gender-variant individuals define inclusivity within the healthcare setting?

Conceptual Framework

This study was grounded and framed on the constructs of minority stress theory and intersectionality theory (see Crenshaw, 1991; Meyer, 2003b). Minority stress theory developed by Meyer posited that stress experienced by men who identify as gay arose from both external and internal sources. Since then, researchers have been able to use this theory to study and understand the experiences of other minority groups (Carbado & Harris, 2019; Garcia & Crosby, 2020; Ramirez & Paz Galupo, 2019; Staples et al., 2018). More specifically, it has been used to study gender-variant groups and explore the distal (e.g., cultural and societal) and proximal (psychological) stressors that contribute to the negative experiences of this population. Meyer categorized the types of stressors minority populations may face as the following: general stress, distal minority stress, and proximal minority stress (as cited in Gridley et al., 2016). Meyer's (2003b) theory proposes that experiences such as identity-based discrimination, prejudices, and stigmatization contribute to poor mental and physical health. While incidents of minority stress negatively impact their overall wellness, few studies have specifically addressed how these stressors can be reduced based on defining inclusivity and exploring how it would look concerning service delivery for this stigmatized population.

Crenshaw's (1991) intersectionality theory captures how identities intersect and how oppressions are experienced simultaneously. Several researchers have used intersectionality theory to understand the overlapping levels of stigma and privilege associated with gender identities among gender-variant communities (Bauer, 2014; Etengoff, 2020; Mizock & Hopwood, 2016; Wesp et al., 2019). Puckett et al. (2018) supported the use of this theory by defining intersectionality as the multiple sociocultural identities within an individual that contribute to unique experiences of power and privilege. It is a disservice to explore gender-variant populations' perceptions without considering how the additional aspects of their identity influence their perception.

Minority stress theory and intersectionality theory guided this study because they both examine the existence of power and privilege within systems when examining health disparities. Both supported the current study by considering how intersecting identities of minority groups may impact the power dynamics that contribute to their stressors. Wesp et al. (2019) explained that gender-variant people globally experience intersecting forms of social marginalization and are disproportionately affected by health inequities. Lefevor et al. (2019) suggested that these “health inequities are best understood as the result of persistent discrimination that contributes to increased hypervigilance and other internalized negative self-perceptions" (p. 36).

Nature of the Study

To address the research questions in this generic qualitative study, the specific research design included facilitating in-depth interviews with adults who self-identified as gender-variant. A semistructured in-depth interview was used to capture the perspectives of these individuals. The data were collected and analyzed to determine the perceptions of gender-variant populations and their definition of inclusivity in healthcare through thematic analysis. A more detailed analysis of the nature of the study is explained in Chapter 3.

Definitions

The following definitions provide a framework for this research study.

Cisgender: Cisgender is used to describe individuals who identify with the sex and associated gender they were assigned at birth (Kachen & Pharr, 2020).

Gender: The attitudes, feelings, and behaviors a society expects a particular gender to possess. Characteristics that are consistent with such cultural expectations are classified as gender-normative. In contrast, those who contradict such norms are referenced as gender nonconforming (Kachen & Pharr, 2020).

Gender affirming treatment: Specific care designated for individuals who identify as gender-variant. It may consist of medically supervised transition or the administration and monitoring of hormones (Salas-Humara et al., 2019).

Gender expression: A gender identity that manifests through dress, demeanor, and language (Brotheim, 2013). An individual may identify as a gender and express that gender in various ways through physical characteristics, such as specific genitalia, breast, and body hair (Brotheim, 2013).

Gender identity: A person's internally felt sense of his or her own gender (sex) without physical traits present at birth (World Professional Association for Transgender Health, 2012).

Gender-inclusive treatment: Healthcare that provides services inclusive to all people of all gender identities (De Vries et al., 2020; Kattari et al., 2016).

Gender nonconforming: Those whose feelings, thoughts, behaviors, and appearance contradict the cultural and social expectations regarding gender (Kachen & Pharr, 2020; Lefevor et al., 2019).

Genderqueer: A gender expression that is not male or female but on the gender continuum.

Gender-variant: The term used to describe individuals who dress, behave, or express themselves in a way that does not conform to gender norms. For this research, gender-variant acted as the umbrella term to describe all gender identities that fall on the gender continuum (see Donatone & Rachlin, 2013; Kattari et al., 2016).

Healthcare services: A business entity that provides treatment that addresses a diagnosis. For this research, this included primary care, mental health care, or gender-affirming interventions (e.g., hormones or gender-affirming surgeries).

*Healthcare settin*g: The locations in which gender-variant individuals receive healthcare services by a medical provider.

Sexual orientation: Direction of sexual thoughts, feelings, and behaviors towards members of the opposite sex, the same sex, or both (World Professional Association for Transgender Healthcare, 2012).

Transgender: Transgender is an umbrella term to describe individuals who do not identify with the sex and associated gender they were assigned at birth (De Vries et al., 2020; Jaclyn & Sari, 2016; Kattari et al., 2016; Mayer et al., 2008; Turban et al., 2019).

Trans-inclusive healthcare: Healthcare composed of providers educated on the array of gender-related issues and health concerns. This type of care reflects providers who treat all clients with compassion, mutual respect, and appropriate sensitivity, regardless of their gender identity (Deutsch, 2017; Kattari et al., 2016).

Transprejudice or transphobia: Discriminatory attitudes toward individuals who are transgender or identify as gender-variant (Anderson, 2020).

Assumptions

Assumptions are beliefs in research required to conduct the research, but they cannot be proven. One assumption that I made in this study was that participants have had previous or current healthcare involvement to adequately answer the interview questions. I assumed that they had prior knowledge and experience navigating the healthcare system by assessing primary care, mental health care, or gender-affirming care. Due to lack of health insurance or other resources, participants may not have received healthcare. In addition, I used previous research and assumed that there was a high probability that participants have had negative experiences in healthcare. Furthermore, I used intersectionality theory and assumed that participants' intersecting identities influenced and shaped their unique experiences. Lastly, I assumed that participants desired inclusive health care. Although the literature demonstrates this to be a significant concern within gender-variant communities, I assumed that all gender-variant people want their healthcare provider and healthcare setting to be sensitive toward their identity.

Scope and Delimitations

This study was intended to gain an understanding of how gender-variant individuals conceptualize inclusive healthcare. Participants were individuals who were adults, age 18 and over, and self-identified as gender-variant. Individuals who were under the age of 18 or identified as cisgender were excluded from the study. There were no exclusions based on race or ethnicity or residence. Due to resources, such as time and money, recruitment took place via social media. This presented a limitation due to the sampling pool being biased towards those who did not have access to social media platforms. In addition, I used snowball sampling to obtain more participants who were difficult to locate. This was a limitation because it involved a limited selection and contributed to erroneous conclusions. Another limitation involved the sample size and required resources such as time. With this in mind, I recruited and analyzed data for nine participants. Lastly, this research was not to be generalized as I could not provide evidence that the findings will apply to other populations.

Limitations

The limitations that exist included access to the target population. Inclusion criteria stated that individuals must be over 18 years of age and identified as gender-variant. Researchers have demonstrated a lack of access to minority individuals who identified as gender-variant due to anticipated stigma and discrimination among this population (Lee & Kanji, 2017). These individuals are often considered a "hard to reach" population in research. Although I used snowball sampling to recruit participants, I am aware that many voices were not captured due to a lack of access to the participants.

Another limitation that existed that involved the target population was the umbrella term that was used, gender-variant. Gender-variant was used to capture the voices of many identities that fall on the gender spectrum. Although this study is grouping the identities, society must not generalize every identity as being the same. This research did not provide the opportunity to differentiate or distinguish the cultural variances between the subgroups of the gender-variant population (see Donatone & Rachlin, 2013; Kattari et al., 2016).

Significance

This study is significant in that it may assist in defining “inclusivity” and how it may assist providers in affective service delivery. This could help inform culturally competent practice, evidence-based training, and preparation needed to equip medical providers with the appropriate knowledge to serve this population best. Because I considered multiple aspects of this population and exploring how multiple facets of their identity (race, socioeconomic status, education, etc.) may impact their idea of "inclusivity," the knowledge produced could be used to help to broaden the understanding of intersectional issues within the trans-community.

Lastly, the literature has shown that when service providers are perceived to be culturally competent, patients can have increased participation in services, increased satisfaction in services, and overall improved clinical outcomes (Kattari et al., 2020). The study generated knowledge that can enhance healthcare providers' competency by providing the voices of one of the most impacted populations. This research is significant to the social work profession because it can provide social workers and other healthcare providers with the information to advocate and train. In addition, it can help social workers better understand how to assist clients with obtaining inclusive care services. According to The National Association of Social Workers Code of Ethics, social workers have an ethical responsibility to challenge social injustice and engage in social change efforts by promoting awareness of oppression and diversity (Workers, 2008). I hope that my research will promote the need for policy changes to help remove systemic barriers and other forms of discriminatory healthcare practices for gender-variant populations.

Summary

Gender-variant communities experience a significant amount of transphobia, discrimination, and stigmatization when accessing healthcare. Although previous studies have been conducted to capture these experiences, through this research, I attempted to fill the gap in the literature that explains how gender-variant communities want to be treated when accessing healthcare services to reduce these negative outcomes. The purpose of this study was to explore how gender-variant individuals conceptualize trans-inclusive service delivery. Data were collected from adults who identified as gender-variant through semistructured interviews to obtain this information.

In Chapter 2, I will provide an exhaustive literature review on previous studies that support the need for this research. It provides background information on the target population, their experiences in various fields of healthcare, and the need for the current research. This chapter also provides more in-depth information on the chosen conceptual frameworks that guided this research, intersectionality theory and minority stress theory. Lastly, it provided an analysis of the strengths and limitations of the literature.

Chapter 2: Literature Review

Introduction

There is a lack of understanding about how gender-variant individuals conceptualize trans-inclusive service delivery when accessing health care services, which this study addressed. Concepts derived from the minority stress model and intersectionality framed this study and helped define relevant variables and constructed how intersecting identities and minority stress may impact an individual's experiences and background.

A literature review follows, focused on gender-variant populations' experiences within the following health care settings: mental health, primary care, and gender-affirming care. This review provides a foundation of the health care deficits and barriers to care. Next, I introduce the patient-provider relationship's importance to explain the significance of the connection to health outcomes. I then provide information on the importance of health provider education, competencies, and trans-inclusive care deficits. The review then concludes by addressing the strengths and limitations of existing literature and its relation to the research topic and methodology.

Literature Search Strategy

For the literature review, I searched the concepts of transgender health, gender-variant health experiences, minority stress, and intersectionality theory within peer-reviewed journal articles. Using the search concepts listed, I performed exhaustive reviews of salient articles related to my topic, with the majority being published within the last 5 years, in the following databases and journals: MEDLINE, CINAHL, Informit, PsycINFO, ProQuest, SocINDEX, Scopus, *The Counseling Psychologist*, JSTOR, SAGE, Science Direct, Thoreau, Psychology Database, PlosOne, Population Health, Social work in Healthcare, Annals of Emergency Medicine, *American Journal of Preventative Medicine*, Transgender Health, *International Journal of Transgenderism and LGBT Life*. Within the databases, the search terms used individually or in combination were as follows: *nonbinary* or *gender nonconforming* or *genderqueer*; *qualitative* or *experiences* or *perceptions* or *attitudes* or *views*; *transgender, trans-identifying,* or *gender-variant; health care* or *mental health* or *primary care* or *trans-specific care, general healthcare, multiple specialties; patient-provider communication, LGBTQ health disparities, health care experiences, cultural safety, gender affirmation care, discrimination in medical care, health disparities, transgender and minority stress model;* and *intersectionality theory.*

Conceptual Framework

Concepts from Meyer's minority stress theory and intersectionality theory conceptualized this research. Both approaches seek to consider how an individual's identity or identities may impact their experiences. For this research, both concepts helped me explore gender-variant populations' experiences to better understand their exposure to forms of stigmatization, victimization, or discrimination (see Crenshaw, 1991; Meyer, 2003b). Meyer's minority stress theory provides information that can be applied to understand better the excessive stress of highly stigmatized groups (e.g., transgender, nonbinary, genderqueer, gender nonconforming, and other forms of gender identities; Meyer, 2003b; Sun et al., 2020). Intersectionality theory, born from critical theories, encourages understanding how multiple identities may intersect, which is vital when exploring an individual's experiences (Crenshaw, 1991). In this research, I explored how gender-variant individuals conceptualized trans-inclusive service delivery in a health care setting.

Meyer's Minority Stress Theory

Meyer's minority stress model seeks to understand the experiences of minority populations. Meyer suggested that minority stress derives from social and cultural structures that may contribute to stigma, homophobia, and other forms of discrimination and victimization (Meyer, 2003b; Sun et al., 2020). Meyer (2003b) explained that an individual's experiences of adverse social conditions related to their minority status impact the mental health disparities in the gender-variant population and the stressors induced by a cisnormative environment. For instance, cisnormativity assumes that all people are cisgender and encourages opposing ideologies that facilitate discrimination against people who do not conform to society's gender expectations (De Vries et al., 2020). Although this theory was first conceptualized and applied to a study involving men who were in same-sex relationships, it has since been used to explain treatment and stressors among various marginalized populations, including different ethnic groups, cultural studies, women studies, and recently transgender studies (see Meyer, 2003b).

Meyer's minority stress theory posits that the increased health problems are related to both distal and proximal stress (Meyer, 2003b). The external experiences that impact a minority individual, such as harassment, discrimination, or victimization, are known as distal stressors. When individuals internalize their experiences based on a stressful event and adopt it as a part of their self-identity, this is known as proximal stress (Meyer, 2003b). An example of distal stress is the adverse treatment, prejudices, or discrimination that gender-variant individuals receive from health care providers. Proximal stress refers to how gender-variant individuals internalize transphobic behaviors, resulting in avoidance of medical care. Meyer asserted that these stressors significantly impact minority populations.

Individuals who belong to gender minority groups may experience various discriminatory acts ranging from microaggressions to unfair treatment to multiple acts of violence that contribute to their stress level (Reisner et al., 2016). *Microaggressions* are subtle, indirect, or unintentional negative messages about a targeted group (Smith & Turell, 2017). Microaggressions originated within the studies of racism (Nadal et al., 2014) but have since been applied to discrimination against many marginalized groups, including sexual minorities (Anzani et al., 2019; Nadal, 2013). The literature has shown that microaggressions impact an individual's mental health, contribute to lower self-esteem levels, increase the risk of depressive symptoms, lower levels of psychological well-being, and increase binge drinking prevalence (Nadal, 2013). According to Meyer (2003b), this type of treatment is influenced by various factors that may include the following: race, ethnicity, age, and socioeconomic status. Microaggressions are an example of distal stress; however, the individual's internal response is an example of proximal stress (Meyer, 2003b). Microaggression was first introduced in 1970 and later developed into framing contemporary discrimination (Nadal, 2013). Microaggression has similar concepts to minority stress theory in the sense that individuals with identities that differ from societal norms may experience daily stressors, such as subtle forms of discrimination that can impact their psychological well-being (Nadal, 2013).

Minority stress theory seeks to explore the internalized homophobia, stigma, and experiences of discrimination and victimization that emerge as a result of existing in a heterosexist culture (Seelman et al., 2017; Waxman et al., 2020). Heterosexism refers to the system of oppression that marginalizes lesbian, gay, bisexual, queer, and other gender nonconforming people (Kosciw et al., 2010; Norris et al., 2018). Minority stress theory suggests that gender-variant individuals experience adverse outcomes when exposed to heterosexist behaviors and attitudes, regardless of the setting (Meyer, 2003a). In 2016, a qualitative study addressed how transgender or gender nonconforming individuals expected rejection in certain situations and responded to the perceived rejection in various cases (Rood et al., 2016). This study demonstrated that belonging to a gender minority group may cause significant stressors such as expecting rejection, although it may not be present.

Intersectionality Theory

Intersectionality theory has been studied for over 20 years and is deemed applicable in social sciences and politics. It has been used to analyze topics ranging from reproductive rights to religion to immigration to other political issues (Al-Faham et al., 2019; Cho et al., 2013). With this in mind, when researching gender-variant populations, it is essential to consider the various factors that impact marginalization, discrimination, and other inequalities. The concept of intersectionality originated from critical race theory, developed by Crenshaw, to explain how an individual's overlapping characteristics or identities intersect in an attempt to understand prejudice and privilege (Carbado & Harris, 2019; Crenshaw, 1991; Etengoff, 2020).

The concept of intersectionality was initially developed to analyze African American women's experiences (Al-Faham et al., 2019; Cho et al., 2013; Crenshaw, 1991). The primary purpose was to explore how social justice problems, such as racism or sexism, overlap to create multiple social injustice levels. Crenshaw used the term "double discrimination" to explore the simultaneous impact of various forms of identities and how they may intersect to shape a person of a minority's experiences (as cited in Cho et al., 2013). Intersectionality involves exploring how social dynamics come together to create challenges (Crenshaw, 1991). Examples of these social dynamics may include homophobia, transphobia, ableism, xenophobia, racism, or sexism (Al-Faham et al., 2019). It seeks to understand the connectedness of identities instead of isolating each identity. This theory often challenges the traditional assumptions, which examine only the influence of one identity regarding oppression, marginalization, power, and privilege (Cho et al., 2013; Crenshaw, 1991). For instance, racism only considers race; sexism considers sex; ageism is only concerned with age. However, intersectionality encourages one to identify how multiple identities, such as race, sex, and age, may impact one's experience rather than focusing on just one (Cicero et al., 2020).

Intersectionality theory supports the idea that race, ethnicity, gender, social class, and sexual orientation are not separate or isolated variables but rather an interconnected system that shapes a person's experiences with social privilege or oppression (Cicero et al., 2020). In a comparison study between cisgender people and gender-variant people, research showed that people of color and people with disabilities experienced a higher prevalence of suicide attempts and substance use than cisgender people or White, able-bodied gender-variant counterparts (Garcia & Crosby, 2020). This study demonstrated how the intersecting identities of race, disabilities, and gender correlates with suicidality. Intersectionality provides the opportunity to study health outcomes at different intersections of identity, social position, processes of oppression, and policies (Bauer, 2014).

Intersectionality theory asserts that it is essential to consider how individuals' multiple identities intersect to impact their experiences, power, and privilege, specifically within specific systems (Cicero et al., 2020). For instance, Garcia and Crosby (2020) published qualitative research that consisted of a sample size of 25 transgender women in Oregon. Qualitative interviews were conducted to explore the social, economic, cultural, and legal factors that shape health access. Due to all of the women having health insurance, they reported ease with the legal name change, inclusiveness of hormone therapy in the Oregon Health Plan, and availability of informed consent hormone therapy. However, the results demonstrated that economic and social discrimination were barriers to accessing and navigating health services (Garcia & Crosby, 2020).

Gender Variant Populations

Gender is a construct of biological, psychosocial, and cultural factors generally used to classify individuals as male or female (Mayer et al., 2008). The term *gender-variant* is used to describe individuals who express themselves in a way that does not conform to binary gender norms (Donatone & Rachlin, 2013; Kattari et al., 2016). It is often used within the scholarly works of psychology, psychiatry, and gender studies as an umbrella term to describe a multitude of gender identities such as transgender, transexual, genderqueer, gender nonconforming, nonbinary, or gender fluid (Donatone & Rachlin, 2013; Kattari et al., 2016). It is important to note that not all gender-variant individuals identify as transgender. Throughout this research, the term *gender-variant* will refer to individuals who do not identify as cisgender. *Cisgender* is a term used to identify individuals whose gender identity corresponds to their birth sex (De Vries et al., 2020; Parr, 2020).

Previous literature used *transgender* as an umbrella term defined as having a gender identity or expression that differs from one's sex assigned at birth (Jaclyn & Reisner, 2016). This definition includes trans women, trans men, nonbinary people, a-gender individuals, genderfluid or genderqueer people, two-spirit members of indigenous communities, and other evolving identities (Kattari et al., 2019). According to Barsigian et al. and De Vries et al. ,2020, *genderqueer* describes a person who does not subscribe to conventional gender distinctions and may identify with neither, both, or a combination of male and female identities.

There are several terms and concepts used in gender studies to describe the variations of gender identity and how someone represents their identity. Specifically, *gender creative* or *gender-expansive* refers to an individual who rejects expected gender roles or stereotypes (Ehrensaft, 2017). This concept was first introduced by Ehrensaft, a clinical psychologist and author of Gender Born, Gender Made (Ehrensaft, 2017). In this text, she discussed the examination of gender fluidity within children and provided recommendations to professionals and parents on how to adequately affirm children's gender and gender expression (Ehrensaft, 2017). *Gender expression* refers to the external behaviors that someone may choose to represent their identity through masculinity, femininity, or gender-variant presentation (Anderson, 2020).

Gender-variant people experience restricted opportunities, discrimination, and harassment resulting from living in a heterosexist culture in which they often do not easily fit in (Broussard & Warner, 2019; Donatone & Rachlin, 2013; Kattari et al., 2016). For example, a quantitative survey conducted in Colorado addressed current health disparities and their effects on 406 gender-variant people (Christian et al., 2018). The survey demonstrated that 40% of respondents reported delaying medical care due to cost, inadequate insurance, and fear of discrimination. Also, respondents reported significant mental health concerns, with 43% reporting depression, 36% reporting suicidal thoughts, and 10% attempting suicide in the past year. Respondents with a transgender-inclusive provider were more likely to receive wellness exams (76% versus 48%), less likely to delay care due to discrimination (24% versus 42%), less depressed (38% versus 54%), and less likely to attempt suicide (7% versus 15%) than those without (Christian et al., 2018).

The social marginalization of gender-variant individuals has a significant impact on their health and quality of life (Broussard & Warner, 2019; James et al., 2016). For example, the 2015 U.S. Transgender Survey is the most extensive survey examining the experiences of transgender people in the United States, with 27,715 respondents from all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S.

military bases overseas to measure discrimination in various arenas (see James et al., 2016). The 2015 survey report provided a detailed look at the experiences of transgender people across a wide range of categories, including the following: education, employment, family life, health, housing, and interactions with the criminal justice system. The findings revealed patterns of discrimination, harassment, violence, and disparities regarding access to employment, housing, and medical care (James et al., 2016). As it relates to medical care, 62% said that at least one provider they saw knew they were transgender and treated them with respect. On the contrary, 33% of respondents reported having at least one negative experience with a health care provider in the past year related to being transgender, such as verbal harassment and refusal of treatment (James et al., 2016).

The literature showed that gender-variant populations have elevated mental health rates, specifically depression, anxiety, and suicidality (Broussard & Warner, 2019; James et al., 2016; Kattri et al., 2019). Staples et al. (2018) used the minority stress model and the psychological mediation framework to investigate the role of internalized trans-negativity in the relationships of distal trans stress to suicidal ideation and nonsuicidal self-injury. A sample size of 237 gender-variant adults was studied, and structural equation modeling was used to compare models with mediation and moderation effects. The study results indicated that the internalization of negative societal attitudes about one's trans identity (i.e., proximal stressor) is both a mediator and moderator to the connection between distal trans stress and suicidal ideation (Staples et al., 2018). This study defined the moderation effect when individuals develop varying levels of internalized trans-negativity due to generalized stigma contributing to the high levels of suicide or nonsuicidal self-injury (Staples et al., 2018). On the contrary, mediator implies that individuals who experience a great deal of discrimination contribute to internalized trans-negativity. The study suggested that mediators contribute to higher rates of suicide and non-suicidal self-injury (Staples et al., 2018).

The literature suggested that gender-variant people experience high victimization rates in healthcare settings (De Vries et al., 2020; Heng et al., 2018; Kattari et al., 2020; Kcomt, 2018). These experiences include distal stressors such as misgendering, verbal abuse, and denial of service due to gender presentation or identification (De Vries et al., 2020; Hendrickson et al., 2020). *Misgendering* refers to inappropriate language when describing a gender-variant person that does not correctly reflect the gender they identify (De Vries et al., 2020; Hendrickson et al., 2020). A typical example of misgendering within the healthcare setting is the misuse of proper pronouns when providing care to gender-variant individuals. A *gender pronoun* is a kind of pronoun used to refer to a person or people and may have a gender associated with it or may be gender-neutral (Hendrickson et al., 2020). In the 2015 U.S. Transgender Survey, a respondent shared their experience with misgendering, "I was consistently misnamed and misgendered throughout my hospital stay. I passed a kidney stone during that visit. On the standard 1–10 pain scale, that's somewhere around a 9. But not having my identity respected, that hurt far more” (James et al., 2016, p. 96).

Health Experiences of Gender-Variant Populations

Healthcare environments are the most common setting in which transgender individuals experienced discrimination compared with other settings such as housing and employment (De Vries et al., 2020; Kcomt, 2018; Romanelli & Lindsey, 2020). For example, the 2015 USTS showed that 1 in 4 respondents experienced a problem with their insurance in the past year related to being transgender, such as being denied coverage for care related to gender transition. Also, one-third of respondents reported having at least one negative experience with a health care provider in the past year related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive appropriate care (James et al., 2016). In addition, a study conducted by Lee and Kanji (2017) revealed that many respondents felt that coming out to their healthcare providers would change the quality of care they received due to discrimination. The study showed that participants reported two types of discrimination: actual and anticipated. Actual discrimination, a distal stressor, is when participants experience judgmental or homophobic remarks from healthcare providers. Anticipated discrimination, a proximal stressor, was the expectation of being discriminated against due to social stigma or prior negative experiences with healthcare providers (Lee & Kanji, 2017).

A systematic review of journal articles published between January 1, 2010, to June 15, 2018, examined the prevalence of gender-variant stigma and discrimination within healthcare (Kcomt, 2018). The review showed that gender-variant individuals experience healthcare discrimination at higher rates than cisgender sexual minority groups. The study analyzed healthcare's various environments that ranged from mental health, residential settings, hospital settings, and therapeutic settings (Kcomt, 2018). Although many gender-variant individuals may choose to avoid healthcare settings to prevent this type of treatment, there are some instances in which accessing healthcare cannot be avoided. Like all populations, this population can have complex health needs related to both trans-specific care and non-trans-specific healthcare (Kattari et al., 2016; Seelman et al., 2017).

Lobster and McLuskey (2020) suggested that healthcare needs can be complicated for gender-variant or trans-people, with higher levels of depression and a prevalence of mental health among individuals compared to the general population. The literature suggests that healthcare needs are not being met promptly due to a lack of awareness regarding healthcare professionals and negative health encounters that can delay treatment (Lee & Kanji, 2017). According to Lee and Kanji (2017), three barriers prevent gender-variant individuals from accessing health care: discrimination, ignorance related to gender-variant- specific health issues, and assumptions of the patient’s gender identity. Lee and Kanji (2017) further explains the following barriers associated with adverse health consequences: delayed or discontinued care increased negative health behaviors, non-disclosure of gender identity and sexual orientation, and feelings of internalized stigma (Lee & Kanji, 2017). To date, these experiences are most commonly researched in the following healthcare environments: mental health care, primary care, and gender-affirming medical interventions (Cicero et al., 2020).

Mental Health

Mental health is a broad topic that refers to a state of wellness in which an individual can cope with life stressors. It includes the emotional, psychological, and social well-being (National Institute of Mental Health, 2013). Previous research grounded in Minority Theory suggested that gender-variant populations experience a great deal of minority stress due to being a marginalized group, which puts them at greater risk for poor mental health outcomes (Meyer, 2003b; Staples et al., 2018).

Staples et al. (2018) indicated that many mental health concerns develop in response to living in a transphobic world. A *transphobic world* encompasses the fear of, discrimination against, or hatred of trans or gender-variant people, the community, or gender ambiguity. Kattari et al. (2016) and Sue et al., 2009, suggested that depression is significantly correlated to exposure to transphobia, lack of societal acceptance, and lack of support. Eliason et al. (2011) examined the prevalence of transphobic attitudes by medical professionals found that 34% of participants witnessed discrimination of gender-variant individuals in health care settings and 65% reported hearing derogatory, anti-transgender comments made by medical staff (Eliason et al., 2011).

Gender-variant individuals are more susceptible to suicidal ideations, suicide attempts, and other self-harming behaviors (Staples et al., 2018). For example, in a national sample of 6500 gender-variant respondents, more than 50% of respondents reported suicidal ideation (i.e., having thoughts about suicide) in the past year. More than 40% reported having attempted suicide at some point in their lives. Also, gender-variant populations report self-harming behaviors, such as cutting and burning, at higher rates than the general U.S. population (Staples et al., 2018; Tebbe & Moradi, 2016). McLean et al., (2011) discovered the most prevalent types of anxiety amongst gender-variant individuals are specific phobias, social anxiety, obsessive-compulsive disorder, and panic disorder. Kattari et al. (2016) referenced a study conducted in 2013 in which 44.0% of respondents reported depression, 33.2% reported anxiety, 27.5% reported somatization, and 40.1% experienced overall psychological distress in comparison to the general population who reported 16.6% for depression and 28.8% for anxiety.

Primary Care

Gender-variant individuals are disproportionately more likely to experience homelessness, poverty, underemployment, and lack of health insurance, each of which are barriers to accessing primary care (Baldwin et al., 2018). As a result, this community represents one of the most marginalized and underserved populations in primary health care (De Vries et al., 2020). Gender-variant health care issues are highly comparable to those of the general population; however, this population often experiences distinct barriers to accessing and obtaining this care (Kattari et al., 2016).

The National Institutes of Health/National Institute for Minority Health and Health Disparities designated LGBTQ people as a health disparity population (Rice, 2019). Health disparity populations are target groups that have an increased prevalence of disease, premature death, or higher death rates in conditions (Rice, 2019). They may also experience a more significant disease burden (e.g., low quality of life, reduced disability-adjusted life years) or worse daily functioning (Rice, 2019). According to Mayer et al., 2008, they experience health disparities and social inequalities associated with their intersecting identities (age, race/ethnicity, sexual orientation, and marital status) and socioeconomic position (educational attainment, employment status, income, and health insurance). Quality of care in gender-variant healthcare experiences is a vital social issue for reducing health disparities among sexual and gender minority populations (Mayer et al., 2008).

A significant amount of literature showed that physical health has most often been analyzed concerning HIV/AIDS within trans-specific research. For example, a systematic review reported an odds ratio of 48.8 for HIV infection in gender-variant individuals compared with adults of reproductive age across 15 countries (De Vries et al., 2020). Aside from HIV/AIDS, this population is susceptible to other chronic conditions as well. Furthermore, Braun et al. (2017) highlight that transgender patients may have increased cardiovascular risks, increased blood clots, and certain types of cancer due to excessive hormone use (Braun et al., 2017). Even so, the lack of access to healthcare is a significant barrier. Korpaisarn and Safer (2018) informed that approximately 20–30% of transgender persons do not have primary care providers. The lack of access to care or quality of care contributes to unfavorable risk factors, disproportionate levels of discrimination in healthcare settings, and worse health outcomes than cisgender peers (Cicero et al., 2020).

Gender-Affirming Care

Gender-affirming care differs from primary care in the sense that it is designed to address the unique health care needs of gender-variant individuals (Salas-Humara et al., 2019). Gender-affirming care is the specific care designated for individuals who identify as gender-variant. It may consist of medically supervised transition or the administration and monitoring of hormones. Individuals who identify as gender-variant may choose to receive gender-affirming care; however, it is not required. It provides the opportunity to address gender incongruence and reduce the prevalence of mood disorders that may result from a lack of gender acceptance (Gridley et al., 2016; Salas-Humara et al., 2019).

Gender-affirming health care has been described as “health care that holistically attends to transgender people’s physical, mental, and social health needs and well-being while respectfully affirming their gender identity (Reisner et al., 2016)”. Although it is more than just transition-related care, the most common gender-affirming care methods are hormone-replacement therapy and gender-affirming medical interventions. More specifically, interventions may include feminizing vaginoplasty, masculinizing phalloplasty, metaoidioplasty, top surgery, facial feminizing procedures, reduction, voice surgery, augmentation, hysterectomy, vaginectomy, and a mirage of other interventions designed to assist with achieving secondary sex characteristics that are more aligned with an individual’s gender identity. These may help these individuals reduce the incongruity between their sex assigned at birth and their gender identity (Jaclyn & Sari, 2016). De Vries et al. (2020) explains that gender-affirming care models adopt an approach of de-pathologizing gender diversity instead of pathologizing it as a disorder that needs to be treated. According to The World Professional Association for Transgender Health's Standards of Care, it is recommended that individuals who undergo these interventions can alleviate gender-related stress (Jaclyn & Sari, 2016).

The World Professional Association for Transgender Health's Standards of Care (WPATH), Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, UCSF Center for Transgender Excellence, Primary Care Protocol for Transgender Patient Care, and the Endocrine Society are organizations that provide clinical guidelines for the treatment of gender-variant individuals, specifically, transgender (Salas-Humara et al., 2019). They provide recommendations and eligibility requirements that should be followed to ensure adequate gender-affirming treatment (Salas-Humara et al., 2019). Aside from hormone therapy, there are various surgeries that transgender individuals may desire to affirm their gender identity (Salas- Humara et al., 2019).

Several studies have been published that illustrate a high prevalence of depression, anxiety, and suicidal ideation among transgender individuals relative to the general population due to their identity (Jaclyn & Sari, 2016; Kattari et al., 2016; Reisner et al., 2016). According to Sun et al., (2020) those diagnosed with Gender Dysphoria were six times as likely to have a health care visit due to a mood or anxiety disorder. More than three times as likely to have received prescriptions for antidepressant and anxiolytic medication and more than six times as likely to have been hospitalized after a suicide attempt (Sun et al., 2020).

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 2013, (DSMV), the term *gender dysphoria* is defined as extreme distress when an individual's assigned sex at birth assumed gender does not correlate with their identity. Gender dysphoria is a proximal stressor concerned with the internal disconnect between the individual's biological construct and identity. Individuals who wish to undergo any gender-affirming treatment must receive a diagnosis of gender dysphoria, a distal stressor placed on by medical professionals (Sun et al., 2020). The research developed by Sun et al., (2020) exemplifies how an individual's unaddressed gender incongruence or gender dysphoria may contribute to a tremendous amount of physical, emotional, and mental stress that must be addressed by a competent healthcare professional.

Gender-affirming care is designed to improve the quality of life for individuals who may desire this type of treatment. In a longitudinal evaluation of gender-affirming treatment for improving psychological well-being and decreasing suicidality amongst 47 gender-variant youth, there was a significant increase in general well-being levels and a substantial decrease in levels of suicidality following gender-affirming treatment (Allen et al., 2019). It is important to note that gender-affirming care goes beyond altering one's physical appearance. It may be utilized for gender exploration, coming out, addressing a lack of support related to gender, or obtaining information regarding a future as a different identity, all of which must be addressed by a healthcare provider (Puckett et al., 2018).

Trans-Inclusive Care

Wylie et al. (2016) stated that primary care settings should be equipped to provide direct care to gender-diverse patients, no different than providing care to cisgender patients. Their physical, psychological, and sexual needs are considered gender health that affects their well-being (Wylie et al., 2016). It is essential for service delivery to reflect and encourage trans-inclusive care to gender-variant populations. Trans-inclusive care refers to healthcare that provides services inclusive to all people of all gender identities (De Vries et al., 2020; Kattari et al., 2016). In an exploratory, a sequential multimethod study conducted in Texas to explore healthcare experiences, 14 gender-variant participants completed an online survey and audio-recorded in-depth interviews (Hendrickson et al., 2020). The findings suggested that 89% had to educate their providers, 75% had to correct staff on correct pronoun use, and 50% had to tolerate the incorrect pronoun usage from staff (Hendrickson et al., 2020). This study demonstrates the prevalence of incompetent care that exists and further supports the need for trans-inclusive care.

Suggested guidelines were established to aid in the development of trans-inclusive care. Quinn et al. (2015) suggested that one way to ensure trans-inclusive care is to make sure that medical forms required by the patient and bathrooms are gender-neutral, meaning it does not force patients to choose between two binaries, "male" or "female." Another way to ensure trans-inclusivity is by differentiating between a patient's legal name versus their preferred name (Deutsch, 2017; Quinn et al., 2015). The patient's legal name is known as their "dead name." It can cause significant distress if they no longer identify with this name and associated identity (Deutsch, 2017). Lastly, ensuring that proper pronouns are identified during the first interaction and used throughout each healthcare interaction. Healthcare providers mustn't make assumptions based on individuals' physical appearance but ask the "preferred pronouns" from the patient themselves. These guidelines, influenced by a medical advisory board, aim to address health disparities by equipping healthcare providers and health systems with the tools and knowledge to meet gender-variant populations' health care needs. While the limited amount of literature provides a necessary foundation of trans-inclusive care, it does not consider the gender-variant population's perspective and lacks their voice and influence.

There are several organizations designed to optimize transgender-inclusive care (McBride, 2018). The Fenway Institute published recommendations for relevant questions that should be asked in clinical settings. For example, in efforts to create a safe and affirming space, one suggestion included providers asking gender-variant individuals what words they feel most comfortable using to describe their body (McBride, 2018). It suggested using different languages, anatomical models, or other visuals to ensure that patients feel comfortable discussing body parts. The UCSF Center of Excellence for Transgender Health is an educational website designed for medical professions to inform them of the best standards of care, best practices, and other learning materials to increase cultural competency (McBride, 2018). It offers various information regarding masculinizing and feminizing hormone therapy, different types of gender-affirming surgeries, and health insurance coverage. Lastly, to increase the quality of care, The National LGBT Health Education Center provides consultations to multiple organizations to provide adequate healthcare (McBride, 2018).

It is highlighted that the existence of having a transgender-inclusive provider is vital. For instance, Kattari et al., 2016, studied the association between having a transgender-inclusive provider and mental health outcomes. The study proved that competency is linked to better treatment outcomes and reduces suicidality prevalence amongst this population. Kamen et al. (2019) provided the following guidance in caring for gender-variant patients, "Provide safe clinical encounters, inquire about and respond professionally to patients’ identities and identifiers, include chosen support people, provide care relevant to patients' gender identities, and address treatments' effects on sexuality (p.2525).” Transgender-inclusive care is composed of providers educated on the array of gender-related issues and health concerns. This type of care reflects providers who treat all clients with compassion, mutual respect, and appropriate sensitivity, regardless of their gender identity (Deutsch, 2017; Kattari et al., 2016).

Patient-Provider Relationship

The patient-provider relationship is vital to improved health care outcomes (Rossi & Lopez, 2017). The ability to build rapport and maintain healthy interactions are essential to patient care. Furthermore, Kattari et al., 2016, p. 638, suggested that "cultural competence is a critical skill when working with patients in the health care settings." According to The National Center for Cultural Competence, several definitions explain cultural competency according to the discipline of study. This research will utilize the following description of cultural competency as "consisting of some degree of self-awareness concerning beliefs and biases, knowledge regarding the interplay between the provider's culture and the culture of the other group, and the possession of skills for both assessment and intervention" (Sue et al., 2009, p. 4).

Cultural competency is not always present in healthcare settings, specifically regarding the experiences of gender-variant people. In a quantitative study analyzing the experiences of gender- variant patients navigating health services, gender- variant people reported experiencing four forms of victimization by their healthcare provider: the use of harsh and abusive language; the provider was physically rough or abusive; the patient was verbally harassed in the healthcare setting, and the patient experienced unwanted sexual contact in the health care setting (Kattari et al., 2020). These are clear indications of victimization, stigma, and other forms of discrimination that may impact their ability to feel comfortable, safe, or secure within the healthcare setting.

Accessing services, specifically related to healthcare, is a vulnerable experience. It requires trust, acceptance, and a sense of security. Gender-variant populations are not always afforded this fundamental right. In a mixed-method study that captured undergraduate gender-variant individuals' experiences and perceptions, this population reported experiences and fears related to discrimination and violence, rejection, and non-support from their healthcare providers (Goldberg et al., 2019). They report many instances of having their problems invalidated due to the provider's competency level (Goldberg et al., 2019). For example, 85% of participants reported mental health challenges and reported fear of violence and non-support as stressors (Goldberg et al., 2019).

Health Provider Education, Competency, and Deficits Regarding Trans-Inclusive Care

One of the most significant problems experienced by gender-variant populations is the lack of culturally competent healthcare providers (Seelman et al., 2017; Smith & Turell, 2017). For instance, a quantitative survey of 182 transgender people revealed that 30% of transgender females reported a lack of access to culturally competent providers (Korpaisarn & Safer, 2018). When providers lack competency, they lack the knowledge base to provide adequate services to address the presenting problem. On the contrary, when a provider is competent, one can assume that services can be identified and implemented to ensure that treatment outcomes are met (Seelman et al., 2017; Smith & Turell, 2017). For example, individuals who identify as transgender and decide to receive trans-specific care will require a comprehensive, multidisciplinary approach. That approach may include primary care providers, mental health providers, endocrinologists, plastic surgeons, urogenital surgeons, gynecologists, and social workers (Korpaisarn & Safer, 2018). All of which will be expected to have adequate knowledge to ensure effective care. Kattari et al. (2020) suggests that when service providers are perceived to be culturally competent, patients can have increased participation in services, increased satisfaction in services, and improved clinical outcomes.

Improving healthcare experiences for gender-variant people requires improving the healthcare encounter's essential dynamics at interpersonal and healthcare system levels beginning with the healthcare provider (Smith & Turell, 2017). A national survey was administered to individuals who identify as transgender to measure their discrimination experiences within the healthcare setting (Seelman et al., 2017). Out of 6450 respondents, 28% reported not receiving medical care because of their fear of discrimination,19% reported being refused care due to gender identity, 28% reported harassment, 2% reported physical violence within the medical setting. Over 50% reported having to educate their medical providers on transgender information (Seelman et al., 2017). Over a quarter of participants reported misusing substances to cope with discrimination related to their gender identity or expression (Seelman et al., 2017). To expand upon this, Makadon et al. (2015) reported that the gender-variant population is at a higher risk of obtaining preventable diseases due to neglecting their care due to mistrust and fear of becoming a victim of discrimination when accessing services.

Healthcare providers receive little training and knowledge regarding LGBT-specific healthcare, resulting in a lack of competency (Kattari et al., 2016). In a study published in 2018, providers who work in the Emergency Department were surveyed regarding their interactions with transgender and gender non-conforming patients to improve patient treatment (Chisolm-Straker et al., 2018). The results indicated that 88% of participants reported providing care to transgender and gender non-conforming patients; however, 82.5% reported receiving no formal training to provide care to this population (Chisolm- Straker et al., 2018). Only 26.1% of providers knew the most common gender-affirming surgery for female-to-male patients. While 9.8% knew the most common nonhormone gender-affirming medication that male-to-female patients use, and no providers (<3%) were aware of emergency medicine practitioners' performing inappropriate examinations on transgender and gender-nonconforming patients (Chisolm- Straker et al., 2018).

Strengths and Limitations of Existing Literature

I was able to gain great insight regarding the treatment of individuals who identify as gender-variant. Due to their gender identity, this population experiences many stressors that impact their functioning level within a cisnormative society (Elma de Vries et al., 20). The literature also provided a robust assessment of the stigmatization, discrimination, and prejudice that gender-variant populations experience (Anderson, 2020; Garcia & Crosby, 2020; Meyer, 2003a, 2003b). Many research studies applied intersectionality theory or minority stress theory to examine how intersecting identities and minority stressors impact their well-being (Carbado & Harris, 2019; Garcia & Crosby, 2020; Ramirez & Paz Galupo, 2019; Staples et al., 2018). This supported the researcher's choice in utilizing both theories to frame the current study. The literature found connections between negative healthcare experiences and adverse health outcomes (Lee & Kanji, 2017; Salas et al., 2018; Staples et al., 2018). Lastly, the current research provided an opportunity for the researcher to understand the barriers that contribute to these negative healthcare experiences, such as lack of competent healthcare providers, financial barriers, discrimination, health systems barriers, and socioeconomic barriers (Kattari et al., 2020, 2019, 2016; Kcomt, 2018).

The limitations of the current literature review involve the target population. The gender-variant population is vast and encompasses a variety of identities. Umbrella terms such as this one do not provide an opportunity to focus on the cultural variances between the subgroups of the gender- variant population (Donatone & Rachlin, 2013; Kattari et al., 2016). In addition, gender is fluid and encourages a variety of ways in which someone may identify. Existing literature ceases to provide studies that are targeted to each subgroup belonging to the gender-variant population. Although relevant literature supports the idea that gender-variant individuals experience barriers related to access to healthcare and the lack of competency within healthcare, it did not provide the opportunity to gain an alternative perspective. By studying a marginalized population predisposed to negative experiences, many studies may have subconsciously encouraged participants to respond based on perceived or anticipated experiences rather than their actual experience (Rood et al., 2016). Furthermore, the current literature provided information on the deficits of the experiences of gender- variant healthcare experiences; however, it lacked information on systemic ways in which these barriers may be addressed. The current study will begin to address one significant barrier to gender-variant health care regarding the lack of inclusivity of health care providers and how one might conceptualize this.

Summary and Conclusions

The major themes found in the literature supported the notion that gender-variant populations face a plethora of health disparities and proximal and distal stressors that impact their well-being. It showed the disproportionate rates of mental illness, chronic health conditions, and other health concerns amongst this population. The review also explained how this population experiences a great deal of harassment, discrimination, stigmatization, and rejection within the healthcare setting. The study supported the social problem that gender-variant people are most likely to experience a lack of access to adequate care, unfair treatment while accessing services, and lack of resources to address their medical needs, resulting in adverse health outcomes. Furthermore, the review demonstrated the prevalence of incompetent healthcare providers, the lack of training obtained, and the lack of fundamentals of gender-specific concepts. Lastly, the review revealed the need for competent healthcare providers and illustrated how this population is impacted without them.

The results of this literature review indicate a gap in the way that gender-variant people conceptualize inclusive healthcare. Although several studies have assessed and analyzed the healthcare experiences of gender-variant individuals, the perceptions of healthcare professionals working with this population, and the lack of inclusivity in healthcare regarding gender-variant people, there is limited research explaining how gender- variant individuals conceptualize transgender-inclusive service delivery. This literature review revealed both progress and absence in the research related to gender variance, minority stress, intersectionality, and their outlook on inclusive healthcare. The need for a clear definition of "inclusivity" could improve effective service delivery. It can help inform culturally competent practice, evidence-based training, and the necessary preparation needed to equip healthcare providers with the appropriate knowledge required to serve this population best. The study's unique focus on intersectionality and minority stress will allow for exploring intersecting minority identities that may impact the perception of "inclusivity" to obtain a well-rounded outlook.

In chapter 3, I will provide a thorough description of the research design and rationale. I will explain my role as the researcher by addressing positionality and the presence of any researcher biases. I will provide an in-depth description of the generic qualitative methodology research design and explain data collection procedures that will take place. In addition, the data collection instrumentation will be discussed along with the procedures for recruitment. Following this, a detailed description of the data analysis plan will be provided. Lastly, chapter 3 will conclude with a thorough discussion of how rigor will be established as well as the ethical procedures that will take place.

Chapter 3: Research Method

Introduction

In this generic qualitative research design, I explored how gender variant individuals conceptualize trans-inclusive service delivery. This chapter provides an in-depth overview of the methodology that was used to gather and analyze data for this study. I give a detailed rationale for the research design and explain the research questions that guided the study. Next, I provide information on the role of the researcher, including positionality and identity. I explain the procedures that used to collect data, including participation recruitment, instrumentation, and interviewing techniques. Lastly, I explain the data analysis plan and how it ensured research rigor.

Research Design and Rationale

The research design for this study was a generic qualitative design. This approach was chosen because it allowed me to explore and understand the meaning individuals or groups ascribe to a social problem (see Creswell & Creswell, 2018a; Creswell & Poth, 2018b). This approach allows the researcher to understand what participants experience as reported by their own personal descriptions (Kahlke, 2014). It is important to note that generic qualitative methods can draw on the strengths of one or more qualitative research designs while not claiming complete allegiance to a single established methodology. This allows a researcher to be more flexible in their approach to a phenomenon (Kahlke, 2014).

Before choosing a generic qualitative research design, I considered other qualitative research designs to ensure the best fit to address the research questions;

however, they were rejected for various reasons. First, phenomenology was not an appropriate choice as it suggests that phenomenological research seeks to obtain descriptions of experience through first-person accounts captured through interviews (see Moustakas, 1994). My research was not focused on the lived experiences of gender variant individuals; therefore, it did not require a description of their lived experiences. Next, grounded theory was not appropriate as it was a qualitative research design that used the data gathered from participants to develop a theory (see Glaser & Strauss, 1967; Morse, 2016). In the current study, I used minority stress theory and intersectionality theory as the framework of choice; therefore, grounded theory was declined.

Furthermore, a narrative research design was rejected due to previous research capturing the healthcare experiences of gender variant individuals, but the gap that was addressed is how gender variant individuals conceptualize inclusive healthcare. A narrative research design would not have provided the opportunity to address this social problem. Lastly, ethnography focuses on investigating the network of social groupings, social customs, beliefs, behaviors, and practices that define a specific culture. I did not seek to define gender-variant groups or understand any elements of their culture. As mentioned in, Kahlke, 2014, generic qualitative study was the best choice because it was research that is not guided by an explicit or established set of philosophic assumptions in the form of one of the common qualitative methodologies.

Research Questions

RQ1: How do gender-variant individuals conceptualize trans-inclusive healthcare service delivery?

RQ2: How do gender-variant individuals define inclusivity within the healthcare setting?

Role of the Researcher

Postholm (2019) suggested that the researcher's role depends on the theoretical stance, the aim of the research, and their personality and values. The qualitative research design of this study required specific responsibilities of the researcher. First, my role as the researcher was the primary research instrument because I formulated the questions to ask and facilitated the interviews to collect data. My role as the researcher also included transcribing and analyzing the data. Not only did I conduct the interviews but I also transcribed the interviews. I was responsible for analyzing the data, interpreting the findings, and presenting the data in the most representative manner.

Yeh and Inman (2007) described the concept of "self" as understanding how selves shape, create, and construct evidence, interpretations, analysis, and theory in qualitative analysis. Sutton and Austin (2015) discussed the importance of considering how one's identity and intentions may impact how data is represented. Savin-Baden and Major (2013) identified three primary ways that a researcher may identify and develop their positionality: first, acknowledging how personal positions have the potential to influence the research; second, determining how researchers view themselves and participants; and lastly, recognizing that research will be influenced by self and by the research context.

When applying the concept of “self” and establishing positionality, I acknowledged that I am a cisgender woman. This means that I identify with my assigned gender at birth. Due to my identity, I do not share everyday experiences or meanings as my target population; therefore, I wanted to ensure that I used the appropriate language and rhetoric culturally sensitive to gender-variant people. Thus, I wanted to be aware that I did not unintentionally look for meaning that reflects social and cultural aspects of gender variant individuals without their confirmation that I appropriately captured their perspectives.

In addition, I work as a gender specialist apprentice in which I complete gender-affirming evaluations and provide psychotherapy at an LGBTQ-specific practice. This role requires me to assess individuals who are interested in receiving hormone therapy or gender-affirming surgery. Following the assessment, I provide letters of readiness by implementing the standards of the World Professional Association of Transgender Health. The nature of my job involves providing direct services to gender-variant populations; therefore, I have a history of learning of their experiences and have assisted them with navigating concerns regarding their identity. Due to my connection and involvement in the LGBTQ community, there was a possibility that I could have received a potential client who met inclusion criteria for this study; however, any current clients was excluded from the sample due to possible power concerns. Creswell and Creswell (2018a) suggested that researchers recognize their own background and how it may shape their interpretations and position themselves to acknowledge how their personal experiences may impact their understanding. I completed field notes, created an external audit trail, and facilitated member-checking during the transcription and analysis process to reduce bias. I explain these concepts and how they were applied in greater detail later in this chapter.

Methodology

Crotty (1998) suggested that methodology is defined as the broad research strategy, and methods are the particular "techniques or procedures used to gather and analyze data" (p. 3). In this section, I explain the methodology for this research, including the participant selection process, the data collection instrument, interview protocol, recruitment process, and data analysis process.

Participant Selection Logic

Creswell and Poth (2018b) suggested that sample size depends on the qualitative design used; however, there is no set number. Based on the qualitative design study, nine participants were used for the study. Bellamy et al. (2016) suggested that generic qualitative research typically aims for a more extensive representation of the population to adequately obtain a range of opinions, ideas, or reflections about the studied phenomenon. Marshall et al. (2013) wrote that the sample size needs to be large enough to provide appropriate diversity that is represented in the population of interest, and the sample size should be small enough to allow for the identification of consistent patterns. Ames et al. (2019) supported this idea by stating that too much data due to a large number of participants can undermine the ability to perform a thorough analysis.

Although I was aiming for 10 to 15 participants, I continued to interview participants until I reached saturation at nine participants. Charmaz (2006) suggested that saturation occurs when the categories or themes are no longer new ideas; instead, the same themes continue to appear throughout the interviews. This is when the research has an adequate sample size. I conducted data analysis at the end of each interview, completed multiple rounds of coding, and kept a record of common themes found in each interview to identify repetition.

Inclusion Criteria

Inclusion criteria for participants were individual who self-identified as

- 18 years and older
- English speaking
- gender variant

Prospective participants who met the above inclusion criteria and agreed to participate were included in the study. Interested participants who met the above criteria were provided informed consent via email that highlighted the study's requirements, level of risk, expectations of the participants, information on member checking, compensation, and confidentiality. The consent form was sent via email and required they respond with “I consent” if they were willing to participate.

Due to the generic qualitative research design, purposive sampling was used to ensure that participants were recruited based upon specific criteria that assisted with answering the guided research questions. Patton (2015) stated that purposeful sampling involves strategically selecting the appropriate participants to encourage rich information. This sampling technique ensured that participant selection aligned with the study's purpose, primary questions, and data being collected. Each participant was selected based on their ability to share their experiences from their identity perspectives.

A snowball sampling method was used, where current participants were asked to recommend other potential participants that may meet the study's inclusion criteria. Patton (2015) described snowball sampling as starting with one or a few relevant interviewees and then asking them for additional contacts who meet the same criteria to aid in recruitment. Essentially, snowball sampling involves creating a chain of interviewers based on people and their pre-established relationships. Previous research has noted that gender-variant individuals are a hard-to-reach population; therefore, snowball sampling was recommended (Fauk et al., 2019; Luvuno et al., 2019; Pulice-Farrow et al., 2019). I provided each participant with a study flyer with contact information and invited them to disseminate the flyer to other individuals within their network who meets inclusion criteria. I continued to recruit participants until I reached data saturation.

Instrumentation

Merriam (2002) suggested that researchers who use a generic qualitative research design seek to understand the people’s perspectives. To achieve this, I conducted semistructured interviews using a self-designed interview guide to collect data (see Appendix A). When developing my semistructured interview guide, I ensured the questions aligned with my social problem, research questions, and research purpose. Creswell and Creswell (2018a) described these as *content questions*. Content questions are the research subquestions developed to learn information central to the phenomenon being studied (Creswell & Creswell, 2018a). The questions were designed using an open-ended format to encourage in-depth responses. I also wanted to make sure that my instrument contained language that was easy for the participants to understand and comprehend. To promote research rigor, I incorporated words like "how" and "what" and "experiences" and "define" and "explain" to align with the basic qualitative research design.

The questions' development were guided by my chosen conceptual frameworks, intersectionality theory and minority stress theory. I developed background questions that established the participant's identity and allowed the participant to reflect on their identity as they navigated the interview. For example, I asked the question, "What identities do you carry with you?" This question was developed to capture the intersecting identities that a client may have and determined how this impacted their perspective. The question, "How would you describe your identity?" allowed for me to establish minority status that supported each participant's perspective during the analysis phase. This question was also used to help confirm inclusion criteria.

The interview protocol consisted of the basic information about the interview, including the date and time of the interview, projected duration of the interview, and the interviewee identifier for documentation purposes. This was used to ensure participant confidentiality and used in place of their preferred name. The protocol also included an introduction that explained the purpose of the study, instructions for participants, informed consent, the structure of the interview, and reviewing the inclusion criteria. I also revisited information on member-checking to ensure that participants understood the concept. I explained that following all interviews, I would send an initial analysis of information obtained from all interviews regarding inclusivity in healthcare to them. I explained that I planned to send this analysis following the completion of all interviews and look for them to provide feedback on whether the analysis adequately captured their ideas and perspectives. The purpose of the introduction was to ensure that participants were as a comfortable as possible and had the opportunity to ask any questions prior to the start. During the introduction, I reminded the participants that responses would be recorded, and hand-written notes would be taken as part of my field notes. The confidentiality practices were explained as well as how participants' identities would be kept confidential by the use of pseudonyms.

Recruitment Participation and Data Collection

I recruited participants via social media, specifically Facebook groups, and LGBTQ-friendly organizations social media within the United States of America. I contacted each community organization to acquire permission to disseminate my research flyer electronically. The flyer included the purpose of the research study, inclusion criteria, and my email address. I also acquired permission to post the same flyer in the following Facebook groups: Transgender Network of the Triad, support group for transgender, nonbinary, gender fluid people, and nonbinary gender pride groups. During the first contact with each group and organization, I explained the study's purpose and how the study's results would be used. The disseminated flyer provided interested participants a method to contact me directly to reduce any possible researcher coercion or selection bias. After the individual contacted me, I sent them a consent form to their email to begin the process.

Interview Process

After obtaining consent, I scheduled a one-on-one private interview with each participant via email. In the email, I explained that I was available to answer any questions prior, during, and after the interview. I met with each participant for their interview via video conferencing using the Zoom virtual platform. During the meeting, I followed the interview guide and asked each participant the same open-ended questions (see Appendix A). Before beginning the interview, participants were informed that I would be taking notes, electronically recording, and transcribing each interview in preparation for data analysis. The time allotted for individual interviews was between 45 to 60 minutes to provide enough time to establish engagement and encourage a collaborative, conversational process to understand their perspectives. The questions were asked in a nonthreatening manner, using a neutral tone to reduce biases. The interviews were concluded by debriefing with an overview of the study and asking participants if there was any additional information they would like to add. Next, I reminded the participants of the follow-up analysis that would be sent following the completion of all interviews within a month or so. Lastly, each participant was reminded of the list of community resources that could be accessed via their consent form if the interview caused any significant distress.

Data Analysis Plan

According to Braun and Clarke (2006), generic qualitative studies often use thematic data analysis, although they are typically less interpretative than other qualitative methods such as phenomenological or ethnographical studies. This type of analysis focuses on coding and the development of themes based on the raw data. For this research, I used a 6-step process of thematic coding established by Braun and Clarke (2006):

1. First, I familiarized myself with the data. I did this by transcribing the data into a word document and rereading the data to become familiar with it. I also listened to the interview audio to ensure that my transcription matched the audio.
2. Next, I began open coding using qualitative data management software, specifically MAXQDA 2020. I decided on open coding so that I did not have to create preset codes and had the flexibility to develop and modify the codes as I navigated the coding process. During this phase, I generated codes representing essential features of the data relevant to the research questions. This involved me creating short-hand labels that described the content. Each participant interview was coded aside from the demographic information of participants. Demographic information is represented in a table and presented in Chapter 4.
3. I then looked over all codes and began to group them to generate initial themes. This required me to identify broader patterns of the meaning of the data collected.
4. Then, I reviewed the initial themes by checking the themes against the dataset to determine if they represented the data correctly. If I read the transcripts and determined that themes were not adequately present at that phase, I decided to alter or discard the themes to ensure accurate interpretation.

5. Then, I took the final list of themes and defined them. Braun and Clarke (2006) suggested that determining themes involves formulating precisely what we mean by each theme and figuring out how it helps us understand the data.
6. Lastly, I wrote up the analysis of the data (Braun & Clarke, 2006). This consisted of naming the themes, describing how often the themes appeared, and what they mean, including examples from the data as evidence. This will be described in chapter 4, in which I will discuss my conclusions and the main takeaways from the collected data.

In addition to the six-step process, I used information from my field notes to aid in the data analysis. Creswell and Creswell (2018a) stated that most qualitative research methods encourage researchers to take field notes to provide context for analysis. Aside from increasing rigor and trustworthiness, I used my field notes to promote reflection and identification of bias. To do this, I made sure that I referred to the field notes from each interview to ensure that I had a basis for interpretation. From the field notes, I referred to my impressions of the interview and essential aspects of my participants that aided with interpretation. To support this, Phillipi & Lauderdale, 2018, stated that field notes provide nonauditory information about the interviews that are useful in understanding participant meaning.

Aside from field notes, I used member checking to assist in data analysis. Following the coding of all transcripts, I sent each participant a copy of my initial interpretation of the interviews by providing a model of inclusive healthcare based on their responses. I asked that participants confirmed that I had adequately interpreted and captured their perspective. I provided an overall summary of the common themes that derived from the responses regarding the conceptualization of inclusivity within healthcare. Not only did this aid in credibility and rigor, but it also assured that the preliminary findings of my research were represented adequately.

Issues of Trustworthiness

Cypress (2017) suggested that trustworthiness is the central concept used to appraise rigor, which is the degree of thoroughness and accuracy of qualitative studies. A research study's trustworthiness is vital to evaluating its worth (Nowell et al., 2017). Trustworthiness is established by the credibility, transferability, confirmability, and dependability of the research and data analysis. Nowell et al. (2017) suggest that research aiming for credibility as generic qualitative research must address the following four key areas: the theoretical positioning of the researcher; the congruence between methodology and methods; the strategies to establish rigor; and the analytic lens through which the data are examined. In this section, I will provide information on how each element of trustworthiness was established within the current study.

Credibility

First, credibility was established by ensuring that each participant met inclusion criterion during the data collection process and member checking was implemented. I ensured that each participant met the inclusion criterion by asking them to confirm their age and identity. As mentioned in the methodology section, the sampling strategy used in this study to recruit participants was purposeful sampling. Patton (2015) stated this is a technique widely used in qualitative research to identify and select information-rich cases for the most effective use of limited resources. The participants in the study were those who could respond to the study's objective. Garg (2016) suggested that good selection criteria will ensure the sample population's homogeneity, reduce confounding, and increase the likelihood of finding a true association between the research questions and final analysis. In addition, member checking is a strategy that was implemented to encourage credibility. Cohen and Crabtree (2006) defined member checking as referring to the data, analytic categories, interpretations, and conclusions being tested or reviewed by individuals from which the data was initially obtained.

Transferability

Amankwaa (2016) suggested that transferability is described as the process of demonstrating that findings are applicable in other contexts. One common strategy of transferability is thick description. Thick description refers to the researcher's task of describing and interpreting observed social action (or behavior) within its particular context (Ponterotto, 2006, p. 543). There are five characteristics that make up a thick description: interpretation, capturing thoughts and emotions, assigning motivations and intentions, rich accounts of details, and detailing the situation's meaningfulness (Ponterotto, 2006). As I interviewed participants, I took notes of their behavioral responses, emotions, facial expressions, and other important elements beyond the surface. Although this technique was initially developed by Ryle, 1949, for ethnography research, I felt that it will help ensure transferability in my basic qualitative research design to assist with interpretation and support my analysis.

Confirmability

Amankwaa (2016) defined confirmability as the degree of neutrality to which the findings are shaped by the participants rather than researcher bias, interest, or motivation. One common strategy for ensuring confirmability is through an audit trail. Lincoln and Guba (1985) described one aspect of an audit trail by creating field notes and providing raw data consisting of all transcripts.

Phillippi and Lauderdale (2018) suggested that field notes are widely recommended in qualitative research as a means of documenting needed contextual information. According to researchers, field notes are essential to ensuring rigorous qualitative research (Creswell & Creswell, 2018a; Patton, 2015; Phillippi & Lauderdale, 2018). The majority of qualitative research methods encourage researchers to take field notes to enhance data and provide a rich context for analysis. Throughout each interview, I took field notes in which I captured various observations of participants throughout the interview, captured their non-verbal and behavior responses to specific questions, and took notes on my critical reaction throughout the interview. Not only did this assist with researcher bias, but it was also useful as a part of my data collection and analysis. When writing up my results in chapter 4, I referred to my field notes to assist with interpretation and to notate any crucial elements from field notes into my results section to add more rigor. The field notes were stored with transcripts and referred to as raw data collection that was analyzed to create the results of the study.

Dependability

Dependability is described as the ability to demonstrate the findings are consistent and can be repeated by other researchers (Amankwaa, 2016). One common technique to establish dependability is external audits. These are conducted by involving a researcher not involved in the research process to examine both the research study's process and product. I established an external audit by keeping track of all raw data, including all interview audio, field notes, transcripts, and final analysis.

Ethical Procedures

I ensured that my research was conducted in an ethical manner. One way was to ensure that guidelines were implemented to protect human participants. The risk to participants in this study were minimal, and provisions were made to reduce harm. The first step involved obtaining prior approval by the Institutional Review Board at Walden University. The IRB approval # is: 06-01-21-0992590. Following approval, I was able to start the recruitment process. One ethical concern that I planned for was potential coercion during the recruitment phase. To reduce the possibility of coercion, I used purposive and snowball sampling to prevent potential intimidation during recruitment. I required that interested participants contact me via email versus me contacting them to ensure that I did not convince the participants and that their participation was voluntary.

Before beginning any interviews with participants, they were provided a consent form that provided an overview of the study, expectations of the participants, the level of risk, how confidentiality would be maintained, and a list of resources that could be accessed if this study caused any distress. In addition, the consent form clearly stated that

I would keep their data for a maximum of five years; however, information would be password protected and stored securely. Additionally, the consent form expressed that each participant's involvement was voluntary, and they could revoke their participation at any moment. The participant's consent was captured by them responding to the email with “I consent”. Participant's confidentiality was maintained by protecting their identity through the use of pseudonyms. For example, each participant was referred to by utilizing alphabetical order such as Participant A, Participant B, etc. The interview questions did not require participants to disclose any of their personal experiences; however, I removed any data that contained identifying information to ensure confidentiality.

When discussing ethics, I considered any ethical concerns regarding data collection, data analysis, and dissemination. All interviews were conducted via zoom. I asked that participants were in a safe and confidential location while speaking to me. In addition, I ensured that I was also in a site alone to protect their privacy and confidentiality. Due to creating an audit trail, I ensured that participant information was not present in any of the documents. I explained to participants that I kept all document files in a password-protected file. Also, I kept all audio recordings and electronic transcriptions in a password-protected file and will for five years following the data collection. After five years, I will destroy the data by shredding any paper documents and deleting any electronic files. I will ensure that both methods are irreversible.

Another potential ethical concern involved the compensation of research participants. Groth (2010) suggested that although payment to participants is encouraged, it should not be a recruitment method as it can coerce participants into the study. In addition, the amount of the compensation was considered. I chose to provide a $20 amazon gift card that was sent electronically to the participants' emails following the completion of the interview. A study conducted by Valera et al., 2014, on participant recruitment and compensation showed that eighty percent of the participants were particularly aware that research participation involved “receiving payment or a reward for their time and effort.” A majority of participants stated that financial compensation increased their willingness to participate in the research study. Previous researchers studying trans-specific populations found it helpful to utilize compensation methods (Asquith et al., 2021; Owen-Smith et al., 2016).

Summary

The purpose of this generic qualitative study was to explore how gender variant individuals conceptualize trans-inclusive service delivery. A generic qualitative research design was used to explore and understand the meaning of how this population ascribes to the social problem of lack of gender inclusivity within healthcare settings (Creswell & Creswell, 2018a; Moustakas, 1994). This approach allowed me to understand participants experience and what they look for within healthcare providers and settings by their own personal descriptions (Kahlke, 2014). The data would be collected using semistructured interviews that were facilitated via zoom. I used Microsoft Word to transcribe raw data obtained through interviews and utilized a qualitative data management software to analyze the data utilizing an inductive approach.

Chapter 3 explained how participants would be selected by disseminating a flyer within Facebook groups and the social media of LGBTQ- specific community agencies. I described my sampling procedure following purposive sampling and snowball sampling procedures. I explained the data collection process and analysis process that will be used to obtain answers to my research questions. Lastly, I addressed evidence of trustworthiness and the ethical procedures of the study. I will then transition into Chapter 4, in which I will provide the study's results. I will briefly review the purpose of the study and the research questions that guided the study. I will provide an in-depth discussion about the study's setting, the demographics of the participants, the data collection and analysis processes, evidence of trustworthiness, and the findings based on the collected data.

Chapter 4: Results

Introduction

The purpose of this generic qualitative study was to explore how gender-variant individuals defined inclusive service delivery. This study was grounded and framed on the constructs of minority stress theory and intersectionality theory (Crenshaw, 1991; Meyer, 2003b). The guiding research questions used to examine the problem in this study were as follows:

R1: How do gender-variant individuals conceptualize trans-inclusive healthcare service delivery?

R2: How do gender-variant individuals define inclusivity within the healthcare setting?

A semistructured interview guide consisting of 10 questions was developed and used to facilitate interviews with adults who self-identified as gender-variant (see Appendix A). In this chapter, I provide an in-depth description of the study's setting, demographics of the participants, data collection process, data analysis procedures, evidence of trustworthiness, and the results. Chapter 4 concludes with the summary and transition to Chapter 5.

Setting

The study consisted of nine semistructured interviews with adults who identified as gender-variant. Participants in the study provided their perspectives on the conceptualization of trans-inclusive healthcare and their idea of inclusive healthcare providers and settings. I interviewed each participant via a virtual platform, specifically

Zoom or DoxyMe, based on the participant's preference. Participants resided in various states within the United States. Participants 1, 2, 3, 6, and 7 lived in North Carolina. Participants 8 and 9 lived in South Carolina. Participant 4 lived in Arizona, and Participant 5 resided in Texas. Using two different methods, a handheld recorder and the voice recording application on the Apple iPhone, I captured participants' interviews.

Demographics

I gathered data through interviews with nine participants. Participants were individuals who were 18+ and self-identified as gender variant—participants varied in terms of age, ethnicity, region, and gender identity (see Table 1).

Table 1

Participant Demographics

Participant	Age	Ethnicity	Gender identity	Sex assigned at birth	Location
Participant 1	20	White	Transgender	Male	North Carolina
Participant 2	36	White	Transgender	Female	North Carolina
Participant 3	27	White	Transgender	Female	North Carolina
Participant 4	29	White	Transgender	Female	Arizona
Participant 5	33	White	Non-binary	Female	Texas
Participant 6	18	White	Nonbinary	Female	North Carolina
Participant 7	27	White	Nonbinary	Female	North Carolina
Participant 8	34	White	Transgender	Female	South Carolina
Participant 9	44	African American	Transgender	Male	South Carolina

A description of gender identity, as well as other identities seen by healthcare providers, were obtained by participants. Responding to the question concerning different identities, a couple of participants identified their socioeconomic status, ethnicity, or other cultural identities. For instance, eight of nine participants identified as White and one of nine identified as African American. Participant 9, who identified as African American, also reported the following intersecting identities: African American, experiencing homelessness, no health insurance, and not currently receiving healthcare. Participant 2 identified as a White, transgender individual who worked in human resources and had access to various healthcare systems and passed as a cis-gendered male. Participant 5 identified as a White, nonbinary individual who was a social worker.

Data Collection

Criteria for inclusion included the following: Participants who self-identified as gender-variant and participants over the age of 18. Recruitment took place via Facebook. The following Facebook groups allowed the announcement of the research study: FTM Trans Support, Transgender Alliance Group, LGBTQ+ Community, and The Transgender Alliance of the Triad. Before posting the flyer, I messaged the administration or group moderator to gain permission. Following the posting of the flyer, I received emails from interested participants. Once I received the email, I sent the interested participant the consent form and explained the next steps. After I received the consent form, I sent a welcome email and scheduled an interview time that was most convenient for the participant.

This generic qualitative study consisted of interviewing nine participants with a semistructured interview guide. Interviews took place between June 2021 and September 2021. The interview took place with myself and the participant. Confidentiality was respected by ensuring that each participant was alone during the interview. The duration of the interviews was between 45 and 55 minutes. Each participant was asked 10 questions from the interview guide. One participant requested to receive the interview guide before the interview, and the remaining participants did not. Eight of the interviews took place using a Zoom link sent to the participant once they confirmed an interview time. One of the interviews took place via DoxyMe due to the participant experiencing technical difficulties while accessing Zoom. I took notes during the interviews while also recording the interviews using two different methods: my iPhone and a handheld recorder. I gained permission again before recording each participant. I encouraged each participant to share the flyer with their peers who met the inclusion criteria. Following the interviews, each participant received a $20 amazon gift card to their email. After completing the qualitative interviews and initial analysis of the data, I created and provided a document listing the elements of inclusive healthcare based on analyzing participants' perspectives to each participant via email to confirm that I captured their ideas accurately.

Initially, 10 to 15 participants were the projected sample size; however, at nine participants, I reached data saturation. According to Saunders et al. (2018), data saturation occurs when new data tend to be redundant of the data already collected. Data saturation is present when the researcher repeatedly hears the same comments in interviews; it is then time to stop collecting information and start analyzing collected data. By the eighth interview, no new themes appeared to be emerging; I completed one more interview to confirm that data saturation was complete. When no further information emerged from the final interview, I determined that saturation was met and concluded recruiting.

Data Analysis

I used Braun and Clarke (2006) thematic analysis model, also known as reflexive thematic analysis, to analyze the data. First, I transcribed the data. This consisted of me listening to the interview and using the dictate function in Microsoft Word to transcribe. I relistened to the interview and compared it to the transcript to ensure accuracy. I intentionally confirmed that each transcript was verbatim, including words like "umm, so, etc." I familiarized myself with the raw data by reading, reviewing, and listening to the interview transcripts again. Next, I printed out each transcript and used highlighters to capture any broad keywords and concepts. I analyzed the data through the conceptual frameworks, minority stress model and intersectionality theory, by focusing on any distal and proximal stressors as well as any intersecting identities that may have impacted their perspectives. I also looked for key phrases that related to my research questions. Examples included phrases representing the participant's previous healthcare experiences or any negative and positive encounters with health providers. This allowed me to familiarize myself with the data as well as begin to interpret the data. Next, I used the MAXQDA2020 Data Analysis software to input the transcripts of nine interviews. Then, I began coding my transcripts by reading each line of the text and using color codes to label, in which 57 coded segments emerged. Next, I reviewed each code to determine which codes overlapped. For example, communication with providers and gender-neutral language overlapped. Next, I combined them to determine mutually exclusive categories based on consistent ideas relevant to the research questions. Then, I developed the following categories based on frequency and similarities: competent and knowledgeable providers, multidisciplinary approach, patient-provider interactions, implementation of gender-neutral language, relatability of providers, welcoming behaviors, communication, negative healthcare experiences, and gender-affirming settings. Then, I used the SMART Coding Tool in MAXQDA to view the coded segments to determine more similarities to establish the five final themes.

Following the interviews and analysis, I created and provided a document listing the elements of inclusive healthcare based on analyzing participants' perspectives. This served as an opportunity for participants to clarify if the model adequately represented their perspective of inclusive healthcare. Among the nine participants, six participants responded, stating that the analysis accurately depicted their perspective, and three participants did not respond. Participants received one reminder email following the initial email. Following each interview, I participated in reflexive journaling, in which I was able to make notes about my feelings, challenges, and thoughts related to each interview. I used member checking, reflexive journaling, and interview notes to enhance rigor in the data analysis process.

Results

The following themes emerged within the model: representation, validation of identity, language and behavior, medical knowledge, and accessibility of resources; see Figure 1).

Figure 1

Themes

Figure 1 shows a model of inclusive healthcare that was developed based on participants' responses. The model of inclusive healthcare explains how each domain works together to ensure inclusive service delivery. This model, informed by gender-variant participants, involves the conceptualization of inclusive healthcare. First, inclusive healthcare begins with the "who." While accessing care, participants interact with staff and healthcare providers. Providers who are diverse or identify as gender-variant individuals aid in representing the gender spectrum within the healthcare setting. This assists with fostering a sense of belonging amongst gender-variant populations. Along with navigating services with staff who represent the queer community, specific elements must also be present. First, gender-affirming office décor and signage and gender-neutral bathrooms are present, which validates gender identity. Next, providers are expected to implement and encourage gender-neutral terminology throughout all forms of communication, including verbal, nonverbal, and written communication. Along with language, there is a strong emphasis on the behaviors that impact the patient-provider relationship—the behaviors that aid in cultivating a safe and compassionate environment. Within that environment, the presence of a competent provider elevates the patient-provider relationship. Providers being well-informed and knowledgeable on medical care assists individuals with getting their needs met as well as developing trusting relationships with their providers. Furthermore, providers who are competent and knowledgeable understand the barriers of resources for gender-variant individuals and focus on the significance of providing adequate resources. This involves operating from a multidisciplinary approach to coordinate care, make referrals, or operate within integrated care settings as needed.

Theme 1: Representation

The first theme that emerged from the interviews was representation. Participants discussed the importance of representation being present within healthcare settings. They explained how staff and healthcare providers who represent the queer community are essential and encourages a sense of safety and relatability. For example, Participant 4 stated,

> It would be operated and ran by all trans people. I am talking even the CEO! I would love to come to a place where everyone looks like me. Then, the professionals would be competent and knowledgeable from all sides of the spectrum. Honestly, they don't all have to be trans, but to have some staff that is LGBTQ would be nice. I also would love to see various ethnicities working there to show inclusiveness on all levels.

Participant 9 supported this assertion by stating,

> O, okay. I would want more doctors for us gay folks. You know, like gay doctors. That could understand where we are coming from or understand the type of care that we need and want. I think if they were gay or something, I would trust them more. I would want a provider that looks like me.

In addition, participants explained how diversity amongst staff also creates a feeling of inclusivity. Participant 3 supported this by stating, “I know that if they just have like old White guys or specifically, you know, a White employee base, it’s probably not going to be a lot of diversity or open-minded, to begin with.”

Theme 2: Validation of Identity

The next theme that emerged was validation of identity. Participants believed that it is vital to feeling that their gender identity is affirmed and validated within inclusive healthcare settings. Participants identified the following ways to validate their identity within the healthcare setting: gender-neutral bathrooms, queer-specific office decoration, queer-affirming signage and flags, and gender-neutral language on intake forms.

Gender-Neutral Bathrooms

Participants discussed the presence of gender-neutral bathrooms being present to make them feel more comfortable and accepted. Participant 4 shared their experience by stating,

> The first thing that comes to mind is a gender-neutral bathroom. I remember holding my pee or being so anxious to use the bathroom. For cis people, it's a no-brainer of which bathroom to use. For us, this decision takes strategy. Am I passing enough to use this bathroom? Or what would they think if they see me in that bathroom? A gender-neutral bathroom would eliminate that.

Participant 6 supported this by stating, “I also felt comfortable when I got into the office because she had signs as well as a gender-neutral bathroom.”

Office Decoration

Participants discussed the importance of office decoration to ensure their comfortability and represent inclusivity within the healthcare setting. Participant 4 described an ideal setting by stating,

> I would imagine a place that looks like rainbows threw up everywhere. I would want the aesthetics to represent a safe space for queer people. I think it is important to witness posters, art, or even gender-neutral things in the office. I would love to see art that represents freedom of identity and sexuality.

Participant 1 shared the following: "I think that decoration that is accepting and inclusive is important."

Gender-Affirming Signage

Participants discussed the presence of gender-affirming signage and how it may assist them with feeling more comfortable and welcomed.

Participant 1 reflected on an ideal therapeutic office by stating the following: “The walls had different things on it, showing how much, they support us. It was more like gender-inclusive like signs, letting folks know that you can come in and talk to us.”

Participant 6 reflected on previous signage found in a healthcare setting by sharing the following:

> Well, one in particular that I really like that it says “speak out, listen up and advocate.” It was rainbow in color. She also has one that says “queer AF” so that made me smile…I also think that all providers should have specific signage, not just in their offices, but also in the lobbies or waiting areas.

Gender-Neutral Language on Intake Forms

Participants discussed the significance of gender-affirming language to be implemented within intake forms. Participant 3 explained how this could reduce the psychological impact on gender variant individuals by stating,

> Making sure that the name on their file, not only in the office but on the internet if they use an online portal, is the preferred name and pronouns. This can help alleviate any dysphoria or any discrepancies for people needing care.

Participant 4 shared the positive benefit of gender-affirming language on the intake form by stating, “When I did my intake paperwork, I did like that the paperwork had a section for preferred name and preferred pronouns; I like that.”

Participant 5 shared how intake paperwork can demonstrate inclusivity by stating, “Human-centered intake from the paperwork to the personal connection. I think it would look like um prioritizing clear uh allyship and the ways you demonstrate that you're all-inclusive.”

Theme 3: Language and Behavior

The next theme that emerged was language and behavior. Participants discussed the importance of providers utilizing gender-neutral terminology and using the client’s pronouns when providing care. They also explained how the interactions with their healthcare provider also determine inclusivity within healthcare. Participants identified the importance of their healthcare provider being person-centered, kind, and compassionate.

Pronouns

Many participants used pronouns to identify their gender identity that did not match the pronouns used for the sex they were assigned at birth. Participants in this study reported using pronouns: he/him/his or she/her/hers. While participants who identified as non-binary reported using the pronouns, they/them/theirs. Participants shared how being called their correct pronouns aids in feeling affirmed and validated. Participant 4 shared, “I think it’s important for providers to understand terminology and pronouns and the importance of it.”

Participant 2 reflected on a previous health experience with a provider by sharing that due to his presentation, his provider assumed his pronouns and automatically referred to him as such by stating, “My provider did not ask my pronouns, and that was the worst experience."

Participant 2 further explained,

> I think this education would give a strong foundation to understanding gender identity and the confidence to provide validation and affirm this community. When I started getting called my right pronouns, that's when I realized, okay, so yeah, this is real; how I feel is real. I am the expert of my identity and how others see it.

Participant 7 felt that pronoun usage was so crucial that providers should receive specialized training by stating,

> Have them practice saying the proper pronouns, like a greeting like, hi, I’m this person, or hi I am they, them, you know have someone really make sure they are using the proper pronouns and know how to do that.

Provider Interaction

Participants were able to identify how specific behaviors from healthcare providers foster a sense of safety of acceptance. Participants discussed the importance of gender-variant individuals receiving respect, compassion, and kindness in the healthcare setting. In addition, participants expressed the importance of effective communication from their providers and how that impacts their encounters. Participants were able to elaborate on what that would be like for them. For example, Participant 6 stated,

> I would love for them to ask the question, "What can I do to make you more comfortable" You know, let me be the one to tell you what I need if you cannot figure it out…I want them not to be afraid to ask the hard questions, so they can understand me and understand my needs. I want to be treated just like everyone else does with respect. Mutual respect. And without bias. I want them to honor my identity and not assume based on how I may present. I shouldn't have to present a certain way, just to be treated decently.

Participant 1 explained the behavior of an inclusive provider by stating,

> So, this is a really basic answer but kindness. I would just say true genuineness, and if they don't understand something, I have no problem answering questions. I just wish they would be kind and be honest and straightforward, but yeah, kindness above all. Even if they're blindly unaware.

Participant 4 discussed the importance of providers being person-centered by stating,

> I just want to be treated like a human. I don't require much. I just want to be treated with respect and compassion. I want people to be open to me. Now that I pass as a white cis-gendered male with a. beard, I have no problems with this.

Participant 3 shared their expectations of providers by stating,

> Just making eye contact. Not seeming uncomfortable and using their personality to connect with me. I think it requires a sense of vulnerability on their end, too when dealing with this population.

Participant 5 described the importance of providers exhibiting compassion and patience by stating,

> I just want to be treated compassionately, with a level of, the first word that comes to mind is patience. Let's say it's a doctor, and I'm there for a cold, but if they spend at least a minute just checking in with how my dog is doing or just the simple things …it's just a minute of care that goes a long way.

Lastly, Participant 5 discussed the importance of language and behavior when providers are marketing themselves. The participant explained how the use of language could impact the client, even before they access services. Participant 5 explained the following:

> When I'm looking at counselors or therapists, they will have "LGBTQ issues or challenges" listed, when it's not that I'm going to counseling for issues or challenges about me identity…so it always seems weird that's how they list their ally or experience with the LGBTQ population because I feel like they implied there are issues around my identity…so on the website, they shouldn't frame it that way.

Theme 4: Medical Knowledge

The fourth theme that emerged was medical knowledge. Participants discussed the importance of providers understanding the unique needs of gender-variant populations. They explained how the presence of medical knowledge could improve their health outcomes and aid in provider awareness. Participant 4 stated, "I think they also need to be trained on resources. If you are going to see trans people, you should be aware of resources that may be needed for them to thrive."

Participant 4 illustrated a personal account by sharing the following:

> During this time, I had a lot of mood swings and irritability. Her not knowing that T could cause this, she referred me to a psychiatrist stating that I could have a mood disorder. Once I went to the psychiatrist and told them I was on T, they decided against a mood stabilizer and told me to give it time to adjust to my body. That's something that she should've known honestly or not be so quick to medicate me without considering how my transition could be affecting it. Providers also need to have general knowledge of T, doses, and other parts of the transition, so they can help, support and know-how to tell if it is interfering with other parts of the person.

Furthermore, Participant 2 posed the following question: “How am I supposed to trust my health provider when I know more than them from a simple google search?”

Participant 9 described the importance of having a competent healthcare provider, one who is aware of trans-specific concerns, by stating,“ My doctor needs to know how to deal with a ‘special’ woman like me….you know someone who is not normal. I know that I am different, but I need a doctor who knows how to care for me.”

Participant 5 shared the importance of their healthcare provider being knowledgeable on trans-specific concerns by stating, “I just want my therapist to be well versed in it, so I don’t have to teach you during my session.”

Theme 5: Accessibility of Resources

The last theme that emerged was the accessibility of resources. During the interviews, participants expressed the challenges of navigating healthcare services. They discussed access to care and the barriers associated with getting their needs met. The majority of participants presented the idea of having an integrated model of care that consisted of providers from a multitude of disciplines. Participant 6 described an ideal facility with a multi-disciplinary approach by stating,

> It would also be a one-stop-shop. So, it would have all the services that we would need, a dentist, a psychiatrist, a therapist, a general practitioner, everything …so it would be easier if there was like a hub.

Participant 5 explained their ideal healthcare setting based on personal experience by sharing the following:

> The perfect health care setting would be like a one-stop-shop right, were um folks could have access to gender-affirming care across the board, um right now between my counseling, or um psychiatry, or uh hormones or all of the different things in an already taxed system, it's hard to navigate providers, and so I know a lot of people who don't get all of the care that they need because they are too tired of fighting (laughing), and uh it would be nice if it was all together or at least all connected more.

Participant 5 supported their initial statement by sharing how problematic not having access to resources can be by stating the following:

> I still have an issue with a provider not knowing another provider, or not knowing who to refer to, so that seems wild to me that they don’t know for say hormones like who to connect me to is like so weird.

Participant 4 described their idea of an integrated care model by stating,

> I would also love to see a provider that offers T in-house and a therapist. I think that would help keep track of how your transition is impacting your mental and physical…So I think having someone there or having a therapist who could write the letters needed for hormone therapy is helpful. Oh yeah, I think that having a case manager there would be cool. Like what if there was someone who could meet with you to help you navigate or learn more about resources in the community to help connect to trans communities you know.

Participant 8 supported the ideas by stating, "….just a place that addresses all of our needs, all in one place."

Discrepant Cases

Discrepant cases are any information that does not fit with the emerging themes. I completed a negative case analysis to determine cases not consistent with the majority. These cases were coded and utilized in the analysis process. First, while discussing the importance of validation of identity, most participants discussed the presence of gender-affirming office decoration, signage, and a gender-neutral bathroom to validate their identity. Participant 2 was the only participant who shared the need for gender-specific information or pamphlets to be present in the waiting area to demonstrate the importance of gender knowledge and the dissemination of information by stating,

> It would just be nice to see information for trans people while sitting in the lobby. When you go to complete an intake for care, it would be more comfortable to see it.

Another discrepant case that emerged was the need for medical providers to demonstrate humility. While other participants discussed the importance of their providers being knowledgeable and not wanting to teach their providers, Participant 5 shared the following:

> I feel like that’s another thing we all just need to get over, is the humility of like saying, I don’t know, tell me more about it, especially as mental health professionals that sometimes feel like they can’t say that without thinking the clients are going to question them or feel like they're not good enough, or you know, all of those things I'm sure to come up, that would be the only other thing I was think about. Just its humility to ask and to say you don't know.

In addition, the majority of participants focused solely on gender-specific elements when discussing the healthcare setting. Participant 4 shared their idea of an inclusive healthcare setting by discussing the importance of having proper accommodations for individuals with physical and mental disabilities to be considered inclusive by stating,

> You know, having things in the office to help diverse people would be amazing while people are waiting, for people who have a hard time with anxiety. Like fidget spinners or mess with things with their hands that can help them calm down. Or people on the autism spectrum, and streaming helps them, things like that would be helpful for people with neuro divergence can be provided facilities as people who are neurotypical, and then also coming into the office to make sure its disability appropriate accepting. Which is like ramps, accessibility things like boards to assist people getting up and down, tables in the waiting room with nets

> to chairs for people who need extra assistance getting up and down that would be fantastic, not to be able to have people assist you but give the people the tools to help themselves. It would be very important for me in an ideal facility.

Research Questions

Through the initial coding and thematic analysis process outlined above. A total of five themes emerged, with 5 supporting subthemes. The results will be discussed in order of research question. Themes and subthemes will be addressed based on participants' responses.

Research Question 1

The first research question addressed in this study is the following: How do gender-variant individuals conceptualize trans-inclusive healthcare service delivery? RQ1 yielded two themes and four subthemes. The themes include representation and validation of identity. The four subthemes include gender-neutral bathrooms, office decoration, and gender-affirming signage.

Participants were able to conceptualize trans-inclusive healthcare service delivery by discussing the importance of representation within healthcare settings. For instance, they discussed the importance of seeing staff and providers who relate to them directly or providers who represent diversity. They were able to identify how this would make them feel more comfortable and accepted and make it easier to relate to health providers when accessing services.

Participants were also able to conceptualize trans-inclusive healthcare service delivery by discussing the significance of validating identity in healthcare. Participants believed that their gender identity should be validated in a variety of ways when navigating healthcare. They discussed the importance of gender-neutral bathrooms and how their presence affirms their gender and reduces the likelihood of increasing their gender dysphoria. In addition, they explained how gender-affirming office spaces and gender-affirming signage also aligns with inclusive healthcare service delivery. They explained the importance of these elements and how it creates a welcoming and compassionate environment for gender-variant individuals when accessing services.

Research Question 2

The second research question addressed in this study is the following: How gender-variant individuals define inclusivity within the healthcare setting? RQ2 yielded three themes and two subthemes. The themes include language and behavior, medical knowledge, and accessibility of resources. The two subthemes include pronouns and provider interaction.

Participants defined inclusivity within the healthcare setting by having providers who utilize gender-affirming language and exemplify behaviors consistent with compassionate treatment towards gender variant people. Participants felt that if providers use preferred pronouns, preferred names, and other gender-neutral terminology, they will feel more comfortable, confirming that their provider is inclusive. In addition, they discussed the importance of settings that treat gender variant individuals with compassion, respect, kindness, and dignity. According to participants, for settings to be considered inclusive, there must be an essential emphasis on provider interactions with patients that encourage fair and equal treatment.

Participants shared that medical knowledge is imperative when determining inclusivity within healthcare settings. Participants believed that healthcare settings need to consist of competent and knowledgeable providers on gender-variant populations and related health concerns. Participants felt that if they had to educate their providers, then their provider is not inclusive. In addition, they thought that they should be able to trust their provider to have the education and training needed to service them effectively.

Lastly, participants identified the importance of accessibility of resources when deeming a healthcare setting as inclusive. They discussed the idea of having their needs met under one setting. They were able to process challenges and barriers related to navigating various healthcare providers and settings; however, they identified an integrated care setting as an ideal solution to reduce stressors related to accessing services. Participants felt that inclusive healthcare settings look like multiple providers working together to ensure that the 'whole person is treated holistically, rather than addressing only one need.

Evidence of Trustworthiness

Credibility

Credibility refers to confidence in the truth value of the data and interpretations of them. According to Lincoln and Guba, 1985, credibility involves two aspects: conducting the study to enhance the believability of the findings and taking steps to demonstrate credibility to external readers. I established credibility by ensuring that each Participant met inclusion criteria. I did this by asking their age to ensure they were adults and over the age of 18. In addition, I asked them to identify their gender identity to ensure their identity met those categorized as gender-variant. This confirmed that participants had direct experience and would be able to address the research questions. In addition, following the data analysis phase, I developed a write up of inclusive healthcare based on participant's responses in which they could confirm or deny if their responses were captured adequately and expressed in the most representative manner. Cohen and Crabtree (2006) described this as member checking, ensuring that data initially obtained from the participants were presented accurately.

Transferability

According to Amankwaa, 2016, transferability refers to the ability to reapply research findings in another study. The study's results are transferable to Caucasian transgender and non-binary individuals within the age range of 18-35 due to the majority of the study's participants identifying within this demographic. Due to the sampling size, sampling procedures, and participant demographics, the study's findings cannot be transferrable to all subgroups of gender-variant people or people of diverse ethnicities. For example, conclusions do not apply to participants of various ethnic backgrounds due to 8 out of 9 participants identifying as Caucasian. In addition, the majority of participants ranged in ages between 18-35. Conclusions of the study would not be transferrable to individuals who identify as individuals 35 and older or who are minors under the age of 18. Most perspectives were from transgender or non-binary; therefore, there is a need for further research to confirm that findings are transferrable to other subgroups of gender-variant populations. It is important to note for future research; there is a need to study this research from the perspectives of gender-variant individuals from various ethnic backgrounds and other subgroups of gender-variant populations.

Dependability

Another way to ensure trustworthiness is to ensure dependability. All raw data consisting of the interview audio, field notes, transcripts, and final analysis was collected and maintained to establish an external audit trail. In addition, research journals were kept as a means of continuously checking my findings and managing bias. This can also be used for auditing purposes and as a means of replicating the study as near as possible to the original.

Confirmability

To ensure confirmability, I utilized field notes. Phillippi and Lauderdale (2018) encouraged the use of field notes to document conceptual information. During each interview, I took detailed notes on the observations of participants and documented their non-verbal behaviors, essential aspects that transcripts could not capture. Participants' perspectives and responses were the focus; therefore, field notes assisted with keeping my bias restrained. In addition, I used field notes during the analysis process. As I participated in coding, I made notes about themes, patterns, and frequencies of codes. I made notes about how themes related as well as the process of merging themes. In addition, member checking ensured confirmability by ensuring that participants could confirm or deny if their responses were captured adequately and expressed in the most representative manner. The audio recordings, field notes, transcripts, and member checking each make up the audit trail. The audit trail allows other researchers to review data and the analysis process to confirm the findings presented.

Summary

The purpose of this generic qualitative research was to explore how gender-variant individuals define inclusive service delivery. The guiding research questions were as follows:

R1: How do gender-variant individuals conceptualize trans-inclusive healthcare service delivery?

R2: How do gender-variant individuals define inclusivity within the healthcare setting?

I facilitated nine semistructured interviews with participants to address these research questions. Through the use of interview data, field notes, and data analysis, the following themes emerged: representation, validation of identity, accessibility to resources, medical knowledge, and language and behavior. Validation of identity yielded the following subthemes: gender-specific language, gender-neutral bathrooms, office decorations, and gender-affirming signage. In Chapter four, I addressed the research setting, participant demographic variables, data collection, data analysis procedure, evidence of trustworthiness, and an in-depth description of the results. Chapter five will address the study's interpretation of findings, the limitations, the recommendations, and the study's social change implications.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative research was to explore how gender-variant individuals conceptualize inclusive service delivery. The guiding research questions were as follows:

R1: How do gender-variant individuals conceptualize trans-inclusive healthcare service delivery?

R2: How do gender-variant individuals define inclusivity within the healthcare setting?

A total of nine gender-variant individuals participated in this study. The following themes emerged: representation, validation of identity, language and behavior, medical knowledge, and accessibility of resources. The following subthemes were founded: gender neutral bathrooms, office decorations, gender-affirming signage, gender neutral language on intake forms, pronouns, and provider interaction. In this chapter, I review the interpretation of findings. In addition, I review limitations and recommendations for future research. Last, social change implications are reviewed.

Conceptual Frameworks

The major themes related to the research questions are consistent with Meyer's minority stress theory (2003) and intersectionality theory (1989). Meyer's minority stress theory asserts that a person's minority status impacts their experiences. Intersectionality theory asserts that a person's intersecting identities influence their experiences. The participants in this study had various identities that influenced their perspectives that ranged from age, race, sexual orientation, and socioeconomic status.

Carbado and Harris (2019) suggested that gender-variant individuals may experience health disparities and social inequalities associated with their intersecting identities. I was able to see this through Participant 9 who shared the following intersecting identities: transwoman, African American, and experiencing homelessness. This participant also shared they had no health insurance. The participant explained how this impacted their access to care; therefore, they were currently not receiving any care. The literature supports this participant’s experience by explaining that approximately 20 to 30% of transgender people do not have primary care providers (Korpaisarn & Safer, 2018). In addition, literature has demonstrated that gender variant people of color experience significant barriers to care and increased rates of discrimination when accessing healthcare services compared to their White counterparts (Kattari et al., 2016). On the contrary, Participant 2 identified as the following intersecting identities: transman, human resource professional, and White. This participant shared that he had access to several domains of healthcare, ranging from primary care, therapy, and dental care. He also shared that due to “passing” as a cis-gender male, he received good treatment when accessing care. Both participants had different perspectives and experiences based on their intersecting identities. Tabaac et al. (2018) suggested that various groups within the gender variant community may have differential healthcare experiences based on their identities.

While analyzing the data, I noticed that participants were able to pull from their prior experiences with healthcare providers. Throughout their accounts of their experiences, they identified distal stressors such as noninclusive behaviors, unwelcoming behaviors, and behaviors that caused psychological distress. Participants discussed misgendering, lack of pronoun usage or preferred name, assumptions made from healthcare providers, and having to educate their providers on trans-specific issues. Though this discussion and identification of the minority stressors mentioned, participants identified improvements that could enhance their healthcare experiences. These improvements include provider training, gender-affirming office settings, and overall improvement of the patient-provider relationships, including communication, provider’s attitudes, and effective use of gender-neutral terminology. Reducing these distal stressors may reduce the proximal stressors. For example, one participant, who identified as nonbinary, shared that their healthcare provider referred to their gynecological exam as a “woman’s exam” and they would not attend the appointment out of fear they would be exposed to more microaggressions. The provider’s lack of ability to use gender-neutral terminology increased the participant’s proximal stressors contributing to negative treatment retention. Baldwin et al. (2018) suggested that gender variant patients have reported positive healthcare experiences when their providers have used inclusive language.

Interpretation of Findings

The findings of this research study confirm the knowledge that has been found in previous literature related to gender-variant populations and healthcare. In addition to previous literature, the findings from this research extend to include the perceptions and perspectives of gender-variant individuals. Previous researchers have explained that gender-variant populations experience health disparities and negative healthcare experiences, as well as have higher rates of chronic health conditions (James et al., 2016; Kattari et al., 2016; Whitlock et al., 2019). The findings extend beyond previous research by describing important elements that must be present within inclusive settings to improve the healthcare experiences of gender-variant populations.

Representation

Participants identified the importance of having healthcare providers who represent the queer community or diverse ethnicities and encourage a sense of safety and relatability. Gomez and Bernet (2019) suggested the importance of increasing diversity amongst healthcare staff to improve patient outcomes. Glazer et al. (2018) supported this by stating that increasing diversity amongst healthcare providers is a strategy for reducing racial and ethnic health disparities. While participants felt strongly about this theme, there is limited literature that has supported the need for healthcare providers to identify as a specific ethnicity or gender-variant to be deemed inclusive amongst the gender variant population. This could be addressed in future research.

Validation of Identity

Validation of identity emerged as a theme from participants’ responses. This theme is confirmed within the literature. For example, Quinn et al. (2015) discussed the importance of ensuring that bathrooms are gender-neutral, meaning it does not force patients to choose between two binaries, "male" or "female." Participants identified the importance of their identity being validated by the presence of gender-affirming signage, office décor, and gender-neutral bathrooms. Participants explained how this reduces gender dysphoria and affirms their gender identity. Richard Bränström and Pachankis (2020) supported this conclusion by explaining that gender dysphoria is a proximal stressor concerned with the internal disconnect between the individual's biological construct and identity that can contribute to psychological distress. Researchers have demonstrated that gender dysphoria, a deficit model of wellbeing, has been used to explain the disproportionately high rates of psychopathology in gender-variant individuals when compared to a cis-gender population (Bowman et al., 2021; Brokjøb & Cornelissen, 2021) More specifically, Brokjøb and Cornelissen (2021) conducted a study in which notable links between minority stress, gender dysphoria, and mental health problems in gender variant individuals were found.

Language and Behavior

Language and behavior emerged as a theme from participants' responses. They discussed the importance of health providers incorporating gender neutral terminology. This aligns with the current literature that suggested the importance of incorporating gender-neutral medical forms required by the patient. Deutsch (2017) and Quinn et al. (2015) discussed how health experiences can be improved by simply using a patient's preferred name rather than their name given at birth. Previous researchers have described that the lack of using gender-neutral terminology and the absence of pronouns can lead to misgendering (De Vries et al., 2020; Hendrickson et al., 2020; James et al., 2016). Misgendering is a distal stressor that has the ability to cause internalized psychological effects (James et al., 2016). Furthermore, The Trevor Project, 2021, demonstrated the importance of affirming gender-variant individuals by incorporating gender-neutral language. More specifically, the study's results showed that respecting their pronouns is associated with lower rates of attempting suicide. This finding is also supported by the Centers for Disease Control and Prevention (2020), who recommended that healthcare settings implement a two-step method of collecting gender identity information on intake forms and electronic health records. This consists of collecting their chosen name and pronouns. This recommendation has been incorporated into the "Meaningful Use" guidelines for electronic medical records.

In addition, The National LGBTQIA+ Education Center, 2021, confirmed this research finding by suggesting the following best practices during healthcare visits:

1. Respecting patient preferences by asking their preferred name and pronouns and adhering to them.
2. Asking specifically their sex assigned at birth and gender identity if it is pertinent to the visit.
3. Familiarizing themselves with preferred terminology regarding gender identity.

Several participants stated they would like for their healthcare provider to demonstrate behaviors indicative of compassion. This was supported by a systemic review conducted between 1946 and 2017 analyzing 23 articles in which the perceptions of compassion within healthcare amongst various ethnic groups were examined. The review demonstrated that compassion is a cross-cultural requirement within healthcare, regardless of cultural differences. The findings suggested that various ethnic groups found that compassion could help alleviate health stressors, encourage patient dignity, and improve patient outcomes (Puckett et al., 2018). In addition, a qualitative study conducted with 42 gender variant young adults to identify effective healthcare practices supported the importance of language and behavior by identifying the following: chosen name and pronoun usage, provider knowledge, comfort, and communication (Pampati et al., 2021).

Medical Knowledge

Participants identified having competent and knowledgeable health providers as an important element when conceptualizing inclusive health care. In a study conducted by Hendrickson et al. in 2020, the researchers found that 89% of gender variant participants had to educate their healthcare providers, 75% had to correct staff on correct pronoun use, and 50% had to tolerate the incorrect pronoun usage from staff. This study supported this theme as it demonstrated the prevalence of noncompetent care that exists. In addition, James et al. (2016) identified having to educate healthcare providers as a negative experience, categorized with verbal harassment and refusal of treatment.

As mentioned in Chapter 2, one of the most significant problems experienced by gender-variant populations is the lack of culturally competent healthcare providers (Seelman et al., 2017; Smith & Turell, 2017). A quantitative survey of 182 transgender people revealed that 30% of transgender females reported a lack of access to culturally competent providers (Korpaisarn & Safer, 2018). When providers lack competency, they lack the knowledge base to provide adequate services to address the presenting problem.

On the contrary, when a provider is competent, one can assume that services can be identified and implemented to ensure that treatment outcomes are met (Kattari et al., 2020; Seelman et al., 2017; Smith & Turell, 2017). Participants reflected on previous health experiences in which they received care from incompetent health providers. They explained how this creates distrust and reduces treatment recidivism.

Accessibility of Resources

Wylie et al. (2016) asserted that primary care settings should be equipped to provide direct care to gender-diverse patients, no different than providing care to cisgender patients. The lack of access to care or quality of care contributes to unfavorable risk factors, disproportionate levels of discrimination in healthcare settings, and worse health outcomes than cisgender peers (Cicero et al., 2020). Participants explained the barriers and challenges related to accessing healthcare services as well as reported a lack of resources.

According to literature, there is a need for resources for gender variant populations. Gender-variant individuals are disproportionately more likely to experience homelessness, poverty, underemployment, and lack of health insurance, each of which are barriers to accessing primary care (Baldwin et al., 2018). As a result, this community represents one of the most marginalized and underserved populations in primary health care (De Vries et al., 2020; Kattari et al., 2016).

The majority of participants identified an ideal healthcare setting by discussing a place with a multitude of healthcare services, designed to address various healthcare needs and reduce barriers. There are several states that currently incorporate multidisciplinary services within the healthcare setting. North Carolina has a comprehensive care treatment center, Mosaic Care, that provides primary care, gender-affirming medical treatment, gynecological, and counseling designed specifically for gender-variant populations (Mosiac Comprehensive Care, 2017). In Boston, MA, Fenway offers accessible, patient-centered, gender-affirmative care for transgender individuals philosophically grounded in a model where gender affirmation (e.g., cross-sex hormone therapy) is a routine part of primary care service delivery (The Fenway Institute, 2021). In New York, Callen-lorde is one of the largest outpatient practices in transgender health in the nation, serving over 3,000 transgender and gender nonconforming patients. Callen-Lorde's facilities are designed for transgender sensitivity, including trans-inclusive registration forms, gender-neutral bathrooms and trans-affirmative signage and imagery, and trans-identified staff (Callen-lorde, 2021). In California, The UCSF Gender Affirming Health Program is a multidisciplinary program that incorporates the following disciplines within their facility: primary care, gender affirming medical surgery, hormone therapy, psychiatry, mental health care, and voice and speech therapy (UCSF Gender Affirming Health Program, 2019). Lastly, in Los Angeles, the LGBT Center is one of the few federally qualified health centers with providers who specialize in primary care, sexual health and prevention, mental health, addiction recovery services, as well as pharmaceutical services (Los Angeles LGBT Center, 2021).

The findings from the study confirm preexisting literature on gender-affirmative service delivery. Multidisciplinary team approaches to clinical care and research are an integrated model of service delivery for gender-variant people. Reisner et al. (2016)

suggested the importance of integrated multiple disciplines to help ensure coordination and integration of healthcare to ensure health equity.

Limitations of the Study

The limitations of this study fall within the limitations of qualitative research. In this section, I overview the identified limitations regarding transferability, participant characteristics, and the study's setting.

One limitation of the study involved the study participant population. Individuals who identify as gender-variant are considered a hard-to-reach population. To support this assertion, Asquith et al. (2021) conducted a study in which gender variant populations were interviewed regarding their attitudes towards participation in research studies. The results indicated that participants reported the following barriers: mistrust of researchers, feeling exploited or anticipating exploitation, disdain to research, time constraints, and not wanting to feel like a guinea pig. Due to this, snowball sampling was used to recruit individuals who meet inclusion criteria. This limited diversity and prevented equal representation of diverse variables amongst participants. This may limit transferability of the study's conclusions. For instance, the study's participants involved eight White individuals and one African American individual. Given sample bias towards White, further research is needed to confirm themes transfer to a more racially/ethnically diverse sample. In addition, the majority of the participant sample were ages 18 to 35. Due to intersection of age, the experiences of individuals 35 and older may be different; therefore, I may caution transferability to individuals who identify as individuals 35 and older.

Another limitation of the study involves the study's setting. The majority of participants resided in North Carolina. Some states are more progressive, while others are more conservative; therefore, individual's perceptions and expectations may differ based on their residence. For example, individuals residing in Austin Texas or California, may be more welcoming to LGBTQ populations and have more inclusive health settings, in comparison to Southern states. This could impact their experiences, perceptions, and expectations of health care service delivery.

Recommendations

Through this study, I was able to explore how gender-variant individuals conceptualized inclusive healthcare. As mentioned in Chapter 4, the majority of participants were transgender and non-binary, limiting the perspectives of other gender variant subgroups. Additional research recommendations would include studying subgroups of gender-variant populations such as: pangender, gender outlaw, gender non-conforming and other identities amongst the gender spectra . In addition, this study did not capture the perspective of individuals belonging to various ethnic backgrounds. Future studies should focus on participants from various ethnicities to gain their perspective of inclusiveness. These perspectives can contribute to the knowledge needed to improve the health standards of inclusive health care. In addition, future quantitative research would allow the opportunity for generalization by providing a broader and deeper insight as to the conceptualization of inclusive healthcare amongst a larger sample. Lastly, a further study that includes the perspectives of providers to gain more insight on the barriers related to providing inclusive services could help bridge the gap within trans-service delivery.

Implications for Social Change

The results of this study allows for opportunity to provide several implications for positive social change. First, gender variant populations are a minority group with a plethora of health disparities. While previous research have demonstrated their increased prevalence of mental health concerns, primary health diagnoses and increased risk, no research has explored their perceptions of what is needed to reduce these health disparities. The result from this study provide an idea of the various elements needed to ensure inclusive healthcare. This study allowed this population with place where their voices could be shared regarding their conceptualization of what is needed.

Several studies have shown that effective healthcare can improve health outcomes for this population(Kamen et al., 2019; Kattari et al., 2016; Lobster & McLuskey, 2020; McBride, 2018) .The findings from this study could aid in improving the health standards and evidenced based practices for treating this population. For instance, social workers and healthcare administrators could use the findings to guide inclusiveness efforts within healthcare settings. In addition, policy makers could use the findings to alter intake procedures and associated paperwork to reflect inclusive efforts. The increased awareness of gender-variant perspectives allow for providers to improve the patient-provider relationship by having concrete ways to do so. Based on the findings, providers can have an idea of the preferred language and behaviors that is desired by this population. By understanding what is desired by the gender-variant population, providers have the ability to transform the negative health experiences of this population, validate their challenges and barriers, and affirm their gender identity.

Conclusion

The purpose of this generic qualitative research was to explore how gender-variant individuals conceptualize inclusive service delivery. By engaging and involving gender variant populations in defining healthcare service delivery, communities can ensure that services are gender affirmative and responsive to community health needs. By applying findings from this research, meaningful change in policies and amongst healthcare providers can build the foundation for better practices within the healthcare system. In order to improve care for gender variant populations, understanding the importance of how they conceptualize inclusive service delivery is essential. Research studies such as these, demonstrate the power of providing a marginalized population a voice, suggest policy advocacy, build the foundation for evidence-based practices, and making meaningful social change.

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Appendix A: Interview Guide

Demographic Information:
Pseudonym
Age
Gender Identity
Race/Ethnicity

1. Can you describe your identity?

2. What would you say are the other identities that a healthcare provider sees or assumes when you walk into their office?

3. What type of healthcare are you currently receiving and/or needing to receive that you are currently not receiving?

- If you are not receiving care and need to, what is the barrier?

4. What are the ways that you feel welcome at your provider's office?

5. What specific steps, if any, would you take to make your current provider more inclusive?

6. What are the ways you know if a provider is not inclusive?

7. How do you expect to be treated when you access healthcare services?

8. If you could imagine the perfect healthcare provider for gender variant people, what would you imagine?

9. If you could design the perfect healthcare setting for gender variant people, what would it consist of?

10. What would you say is the most important element for a healthcare setting to have to ensure that you were comfortable , and your identity was respected?

11. If you could facilitate a training for healthcare providers, what would you cover during the training to ensure they were prepared to service gender variant individuals?

12. With this in mind and reflecting on all of your responses, how do you define "gender inclusivity" within healthcare?