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Relationship Between Non-Affirmation of Gender Identity, Healthcare Stereotype Threat, and Perceived Employment Inequities

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
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Abstract

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

The transgender and gender-diverse (TGD) population faces barriers when seeking healthcare and perceived employment inequities for simply identifying as their gender identity. This study examined the relationships between non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities for TGD people across the United States. The purpose of this quantitative, retrospective, quasi-experimental study was to determine if there was a relationship between non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities. This study was guided by the sexual citizenship theory devised by T.H. Marshall, which examines three elements of the model: (a) civil society, (b) political society, and (c) the State or social society; healthcare stereotype threat is considered part of the central idea in the model. The research questions examined the relationship between non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities. The research questions were analyzed using simple linear regression. The results indicated that non-affirmation of gender identity is a statistically significant predictor of healthcare stereotype threat ($p < .001$), but not a statistically significant predictor of perceived employment inequities. This study will contribute to positive social change by adding to the current body of research surrounding the relationship between gender affirmation, healthcare stereotype threat, and perceived employment inequities. It will supply healthcare practitioners and Human Resource professionals with increased knowledge of inequities that face the TGD community they serve and employ.

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Dedication

To Gretchen. My person, my biggest cheerleader, my patient partner, and the reason I started the journey to becoming a better person. You're amazing, and no words will ever be enough to describe my feelings for you. Thanks for standing on the sidelines cheering me on and waiting patiently for me to finally complete my long doctoral journey.

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Section 1: Foundation of the Study and Literature Review

Introduction

Transgender and gender diverse (TGD) employees make up 18% (Baboolall et al., 2022) of the staff in healthcare organizations across the globe. There are perceived employment inequities surrounding employee retention rates, lack of diversity in staff, and discrimination including sexual harassment and hostile work environments in the healthcare workplace culture for TGD employees. Non-affirmation or rejection of someone's gender identity is a microaggression seen in the workplace by transgender and non-binary (TGNB) employees (Parr & Howe, 2020). According to Thoroughgood et al. (2020), TGNB employees face many issues at their workplace, including discrimination and harassment leading to devastating emotional consequences. Because some healthcare organizations focus only on the sexual orientation of minorities, there are high turnover rates and low productivity for TGNB employees (Liu et al., 2022). The Equal Employment Opportunity Commission (2021) has seen an uptick in discrimination claims for the broader lesbian, gay, transgender, queer, plus (LGBTQ+) community over the past several years. In FY 2021, EEOC saw over 1,989 complaints by LGBTQ+ workers, compared to only 808 complaints in FY 2013. Employee retention and job satisfaction are low for TGNB employees (Thoroughgood, 2020), hurting the bottom line for healthcare organizations and preventing them from striving for more diversity in their workforce.

Healthcare stereotype threat is pervasive for the TGD community and is increasing as anti-transgender laws affect healthcare progress across the United States.

Transgender individuals face higher rates of healthcare stereotype threat due to high rates of daily stress and the lack of resources in healthcare (Saunders et al., 2023). TGD people are forced to advocate for their needs to obtain affirming healthcare due to the systemic stigma of being trans-masculine and non-binary (Seelman & Poteat, 2020). All of this leans toward the idea that healthcare is not a system built for TGD patients requiring their resilience to obtain resources, culturally competent care, and healthcare needs met.

The specific research problem that was addressed through this study is the high rates of discrimination TGD employees face in their healthcare organizations and interactions with human resources. The other research problem is the healthcare stereotype threat for TGD patients when seeking care throughout the healthcare system. The challenge in healthcare organizations is that even though more diversity, equity, and inclusive (DEI) policies and procedures exist across organizations, environments with microaggressions lead to more barriers to obtaining a more diverse workforce and are reflective of the TGD patients who receive care. This study will increase the knowledge surrounding the relationship between gender affirmation, healthcare stereotype threat, and perceived employment inequities equipping healthcare practitioners and human resource professionals with resources to support TGD employees and patients.

Other components of Section 1 include the background, purpose of the study, research questions and hypotheses, theoretical framework, nature of the study, literature review, definitions, assumptions, scope and delimitations, significance, and a summary and conclusion. The literature review provided in this section is a brief review and synthesis of related articles and studies.

Background

TGD employees face high rates of discrimination in healthcare organizations due to many factors. Non-affirmation of gender identity is one of the microaggressions (Parr & Howe, 2020) that TGD employees face when going to work. Gender-based victimization occurs when employees cannot affirm, or there is non-affirmation of their gender identity with the ability to pass as cisgender leaving TGD employees to feel marginalized or treated differently from their peers. Victimization is a more significant systemic issue surrounding gender and sexual minorities receiving healthcare and employed in healthcare.

LGBTQ+ employees and patients face high rates of harassment dominated by a perceived culture that is heteronormative and cisgender. DiPalma (2021) stated that there is a shift in cultural acceptance for LGBTQ+, but there is a need for more improvement for those living as TGD. While many employees know someone who identifies as lesbian, gay, bisexual, or even queer (Baboolall et al., 2022), many do not understand the lived experience of or know a TGD person, which leads to microaggressions and a lack of understanding (Liu et al., 2022). This gap in lack of understanding leads to low satisfaction, decreased productivity, and high turnover for TGNB employees. TGD patients are on the receiving end of an ethos of lack of understanding surrounding TGD identities coming in for preventive care and treatment affecting their mental and physical health and creating harm (Koch et al., 2020). TDG patients must endure stigma and lack of resources to access medical care.

This study is needed to increase the understanding and awareness of the TGD community for healthcare organizations that provide care and employment. By increasing the knowledge surrounding the relationship between gender affirmation, healthcare stereotype threat, and perceived employment inequities, healthcare administrators, clinicians, and allied health professionals will have more tools and resources to interact successfully with the TGD community. These resources will better equip them to be more empathetic and compassionate while bringing awareness to their internal bias that has caused harm and trauma in their prior interactions with TGD patients and employees.

Problem Statement

The problems to be addressed are employee retention, lack of diversity, and discrimination in the healthcare workplace environment for TGNB employees and patients. Additionally, the results of this healthcare environment encompass the lack of affirming healthcare concerning their gender identity and healthcare stereotype threat. Non-affirmation of gender identity is a microaggression seen in the workplace by TGNB employees (Parr & Howe, 2020) and patients in healthcare. Negative healthcare outcomes in combination with the stress of mental harm create a barrier for TGD patients to find an affirming provider (Kattari et al, 2020).

According to Thoroughgood et al. (2020), TGNB employees face many issues at their workplace, including discrimination and harassment leading to devastating emotional consequences. Because some healthcare organizations focus only on the sexual orientation of minorities, there are high turnover rates and productivity for TGNB employees. During COVID-19, the loss of jobs meant a loss of health insurance for

sexual minorities and ultimately no access to healthcare due to the cost associated with having access to care (Woolton, 2024). Healthcare stereotype threat increases when a TGD person loses their job because they no longer can access a resource like health insurance. They face the choice of food and shelter versus gender-affirming care and medication.

The Equal Employment Opportunity Commission has seen an uptick in discrimination claims for the broader LGBTQ+ community over the past several years. Employee retention and job satisfaction are low for TGNB employees (Thoroughgood et al., 2020), which hurts the bottom line for healthcare organizations and diminishes the healthcare organization from striving for more diversity in its workforce. The lack of a diverse workforce diminishes the ability to understand TGD patient needs and experience when seeking care increasing the likelihood of increased healthcare stereotype threat.

Although researchers have investigated this issue, there is very little or no literature on the roles of non-affirmation of gender identity, employment, and healthcare stereotype threat to TGD individuals. This gap in the literature was the focus of this study.

Purpose of the Study

The purpose of this quantitative, retrospective, quasi-experimental study was to examine the relationships between non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities in U.S. adults. The independent variable was the non-affirmation of gender identity. The dependent variable was healthcare stereotype threat and perceived employment inequities.

Research Questions and Hypotheses

The following research questions and hypotheses guided this study:

RQ1: What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?

$H_0$1: There is no statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

$H_1$1: There is a statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

RQ2: What is the relationship between non-affirmation of gender identity and perceived employment inequities?

$H_0$2: There is no statistically significant relationship between non-affirmation of gender identity and perceived employment inequities.

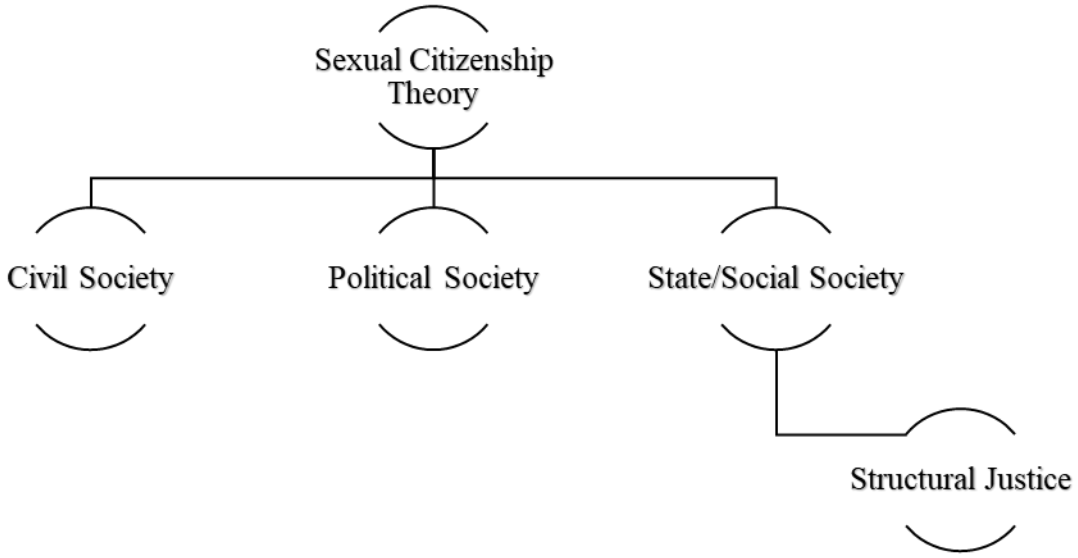
$H_1$2: There is a statistically significant relationship between non-affirmation of gender identity and perceived employment inequities.

Theoretical Framework

The theoretical framework that guided this study is the sexual citizenship theory created by T.H. Marshall (Rosich, 2020). The three elements of the model are (a) civil society, (b) political society, and (c) the State or social society. Theories of structural justice, like sexual citizen theory, are a subset of Marshall's theory of social citizenship (see Figure 1). Sexual citizenship theory focuses on the rights of civil society, such as a person's right to work and seek healthcare for those who identify as TGD**.**

Figure 1

Sexual Citizenship Theory



The logical connections between the framework presented and the nature of the study include theories of structural justice that examine concepts of heteronormativity, homonormativity, and transmisogyny (Rosich, 2020) that affect workplace climate (civil society) for TGD employees and patients obtaining healthcare. TGD employees face a range of discriminatory biases in the workplace resulting in demotion or loss of employment. With the loss of employment, the consequences are the inability to function fully as an adult in the United States, which is the framework of sexual citizenship theory. Additionally, TGD patients confront a healthcare system that has a lack of resources, high levels of bias, and not enough culturally competent providers also in the sexual citizen theory framework.

Nature of the Study

To address the research questions in this quantitative, retrospective, quasi-experimental study, simple linear regression analysis was used to investigate the correlation between non-affirmation of gender identity, healthcare stereotype threat, and employment**.** The quantitative approach was ideal for this study, as it allows the gathering of secondary data, which can be used to analyze the relationships between variables using simple linear regression analysis. The retrospective approach signals the data were done before this study. The study's independent variable was non-affirmation of gender identity. The dependent variables were healthcare stereotype threat and employment. The data included were gathered from the Inter-university Consortium for Political and Social Research (ICPSR) at the University of Michigan. Their secondary data were pre-deidentified to ensure confidentiality. Variables related to non-affirmation of gender identity, healthcare stereotype threat, and employment were exported as an Excel sheet. After export, data analysis was conducted using simple linear regression to assess relationships between the three variables.

Search Strategy

The following databases were accessed to obtain relevant literature: Taylor & Francis, Thoreau, PubMed, EBSCOHost, and The International Journal of Transgender Health. All sources were English-only text to reduce translation bias and peer-reviewed studies that presented empirical data regarding key variables. This review did not include doctoral dissertations and conference proceedings, as peer-reviewed literature was accessible for discussion. Keywords were *healthcare stereotype threat, gender identity,*

minority stress, human resource management, DEI (diversity, equity, and inclusion) policies, training, and *transgender affirming*. The literature review includes peer-reviewed resources published between 2013 and 2024. Key variables of the study frame the literature review.

Literature Review Related to Key Variables and/or Concepts

Nonaffirmation of Gender Identity in Healthcare and Employment

TDG people face discrimination when they show up to work in healthcare organizations when their gender is not affirmed, or it is rejected (Perales et al., 2021). Discrimination is pervasive in healthcare for the LGBTQ+ community (Blackwell et al., 2020), spilling to LGBTQ+ clients receiving care. Discrimination includes not being addressed with the chosen name and pronouns, being harassed about how they express their gender, being passed over for a promotion, having their workload diminished, and being fired from their job. Safety of their employment becomes paramount when compared to job satisfaction.

Safety for the employed TGD population includes the ability to affirm their identity through gender expression (Hughto et al., 2020). Hughto et al. (2020) pulled data from the 2015 US Transgender Stress and Health Study, in which 288 transgender individuals over the age of 18 completed an online survey with 81% identifying as transmasculine and 18.8% as transfeminine with non-binary identities included in both categories with 96% of the participants disclosing their gender identity. The participants were broken up into regions of the United States, with the West at 31%, the South at 26.7%, the Northeast at 26%, and the Midwest at 15.6%. Researchers found a statistically

significant relationship between gender affirmation experiences and several mental health symptoms. The study assessed gender identity as cisgender, male and female, transgender, female to male and male to female, and non-binary identities such as gender non-conforming and non-binary. The question was asked about their medical affirmation and social affirmation regarding their gender identity. The study focused on TDG individuals' discrimination they experienced in seven areas including healthcare and whether they were affirmed by their gender identity when they received care. Researchers scored their anxiety, stress, and depression symptoms with mixed-effects models displaying self-reports of harm and suicidality from before and after ($p<.001$) the start of the gender affirmation process. Researchers found a link between mental health and gender-affirming procedures concerning stress ($p <.001$), anxiety ($p = .01$), and depression ($p =.01$). Hughto et al. found that the ability to affirm and express gender identity decreased depression and suicidality for TGD people. The findings indicate the need for gender affirmation for the TGD population to improve mental health.

Gender expression is the way a person displays their gender through the use of clothing, mannerisms, and their voice through pitch and resonance (Sawyer & Thoroughgood, 2017). Gender expression is perceived by coworkers (Davidson & Halsall, 2016) as either male or female by other staff members due to the societal view of only two genders. The binary perception of gender can create cognitive dissonance for fellow employees and providers who may or may not have ever met a TGD person. A lack of understanding or negative beliefs surrounding TGD people creates an

environment of uncertainty and, quite possibly, a safety concern for the employees and patients.

With the current political landscape, many misconceptions around the TGD community affect the healthcare industry, spilling over into patient care and employee rights (Witt & Medina-Martinez, 2022). TGD people face high rates of unemployment, housing crisis, and poverty due to misconceptions around their gender identity, requiring nurses to empathically understand their needs for appropriate and competent care (Wichinski, 2015). Healthcare professionals, then, must be educated on the additional needs of the TGD population. Education then expands the cultural competence of the environment to support all who work and receive care. However, the personal biases of coworkers and providers can impede relationships, increase hostility in the workplace, and create an environment where patients receive subpar care.

Bias around TGD employees' gender identity creates threats to autonomy. Consistent threats around gender identity and not feeling seen or heard result in hiding gender identity in the workplace (Van Laar et al., 2019). The threat of being "outed" as TGD requires the employee to deny their very existence and struggle with internalized transphobia increasing the need for mental health support to overcome their personal bias (Flynn & Bhambhani, 2021). The TGD employee is left feeling a lack of belonging to the healthcare organization.

Lack of belonging in the workplace leaves TGD employees vulnerable to harm. Healthcare continues to struggle with employees' psychological safety, meaning discrimination runs rampant, where many are bullied, harassed, and belittled (Siad &

Rabi, 2021), opening space for TGD employees and patients to feel less than and not affirmed. The lack of belonging creates a toxic and harmful environment for fellow workers and the patients they serve. The harm cycle continues with stereotype threat, creating an environment that lacks safety and belonging.

Belonging in the workplace means affirming the identities of fellow healthcare colleagues in an organization. A healthcare environment that shows hospitality for belonging and acceptance provides LGBTQ people a space to flourish and be present (Newman et al., 2021). All humans inherit the need for belonging, as seen in Maslow's hierarchy of needs. TGD employees and patients feel valued and respected in a healthcare environment that celebrates belonging.

Gender Identity in Healthcare and Employment

TGD employees and patients enter the healthcare environment with past challenges relating to their gender identity. To fully understand the complexity of the challenges, it is essential to define gender identity. Gender identity describes the relationship between oneself and feelings about how one sees their identity, which can be different from their outward expression of gender (Davidson, 2016). Gender identity is tied to how a person feels about their role in society and is separate from their attraction or sexual orientation to another person. TGD individuals know that entering healthcare means they may only have binary choices on how they identify.

Healthcare is driven by a binary system that has been on a false notion that every patient is female or male. This theory is harmful to the TGD community leading to hurt and harm by the medical community and a feeling of being othered by identities such as

non-binary or genderqueer. In contrast, DNA is not female or male but karyotypes XX, XY, XXY, and more (Vincent, 2019). Pragmatic views of gender are not straightforward and can be used as microaggressions against the TGD community. However, when language is introduced to healthcare professionals that includes a broader view of gender and even sexuality, those they interact with feel a sense of respect and feel valued.

TGD people see gender identity as a spectrum, not a linear line where a human is either female or male. Transgender is an overarching umbrella term split between binary terms like transman or transwoman and nonbinary terms such as non-binary, gender fluid, agender, and more (Green & Mauer, 2015). Transgender means a person does not identify with the sex assigned at birth (Dahlen, 2020). These designations or identities require healthcare providers and employers to examine how the employee and patient's outward appearance may differ and require less gendered notions.

Gendered notions or societal norms of gender focus solely on the belief that a person is either female or male and is based on visualizing genitalia at birth. As researchers have noted, gender and sex are different (Rouse & Hamilton, 2021), with sex being tied to hormones, external sexual organs at birth, and genetic sex. On the other hand, gender speaks to how someone is seen in their culture and society at large. These differences can cause problems in healthcare because healthcare treatment and billing see patients and employees who receive insurance as binary, either female or male (Wagner et al., 2022). The binary constructs of the healthcare society do not match the current culture of industrialized nations, pushing workplace policy changes to support TGD employees and patients.

Western cultures tend to lean towards the binary gender theory (Thorne et al., 2019). However, many indigenous cultures revere and celebrate more than two genders creating conflicts in the healthcare system. Indigenous tribes across the Americas recognize the term “two-spirit.” The term represents gender identity and sexual orientation without assimilating to Western theory (Robinson, 2020) and Indian culture; gender variance identities such as hijra, zenana, koti, kinner, and thirunangai (Ghosh, 2022) describe other genders in a cisgender colonized society. The cultural discrimination with these identities spills over into the healthcare system when employees and patients who identify with any number of TGD identities are not respected and even discriminated against, adding to the challenges that TGD people face when staying employed and receiving adequate care in the healthcare organization.

Challenges TGD People Face in Healthcare

TGD employees bring to work the burden of health disparities while taking care of patients and working to stay present. They carry the burdens of homelessness, discrimination, isolation, lack of healthcare access, substance abuse, and mental health concerns into the workplace. TGD employees face high unemployment rates and tend to work in low-paid positions (Leppel, 2021), resulting in community-based trauma concerning their employment. Furthermore, workplace environments have become a social determinant of health (Sherman et al., 2021). For TGD people, walking into their daily job brings constant fear and dread surrounding their employment status and benefits of health insurance, and ultimately staying safely housed. Furthermore, health insurance does not ensure TGD safety in the healthcare environment.

A problem the TGD community faces is that health insurance is inherently binary, forcing TGD people to fit into either the female or male identity leaving no space for non-binary identities. Research has identified discrimination around insurance coverage of gender-affirming care (Lerner et al., 2021) and non-binary individuals are less likely to have affirmation of their gender in healthcare spaces (Reisner & Hughto, 2019), resulting in employees and patients being unable to self-identify with their insurance and then identified instead with their gender assigned at birth. The secondary data analysis of the 2015 Transgender Trans Survey (Lerner et al., 2021) pointed towards discrimination by healthcare providers as the reason for barriers to healthcare utilization by the TGD population in the United States, with 96% of the 21,930 TGD participants identified as US-born citizens. The study found 22% of survey participants did not utilize healthcare at all. Researchers looked at the relationship between avoiding healthcare and cost, invasive provider questions ($p<.001$), refusal to provide affirming care ($p<.001$), verbal abuse ($p<.001$), and provider's lack of education to provide care ($p<.001$). The result is fewer wellness visits and care by medical providers, adding more health crises' and a lack of mental health care. Health insurance for the TGD community must include coverage of primary healthcare, including needs such as gender-affirming hormone therapy. Lerner et al. (2021) pointed out the need for better education for providers to provide better care to the TGD community. For many TGD individuals, living as their true selves and safely in society means needing to pass as binary, leaving non-binary individuals less likely to fit into the binary culture.

To pass means to be undetectable to others as anything other than cisgender female or male (Doyle, 2022) or in a heterosexual relationship (Dixon & Dougherty, 2014). Passing helps some TGD employees navigate the workplace environment by not bringing unwanted attention to their existence. By showing up as a binary gender, which is socially accepted, TGD employees face less paranoia at work (Thoroughgood et al., 2017). With these cultural norms, gender non-binary employees are then expected to show up or express their gender as either masculine or feminine by cisgender colleagues. TGD patients are seen as abnormal whether they pass or not due to the psychopathology of their identity (To et al., 2020). The requirement to pass leaves TGD individuals with more trauma and feeling less likely to belong to a team or even an organization providing care.

Trauma for TGD people can include past trauma in healthcare, social situations, workplace discrimination, and violence. Health and well-being are associated with a lack of affirmation around gender identity (Doyle et al., 2021) and perceived discrimination in the healthcare environment resulting in fear of safety, unemployment, and substance abuse of TGD employees (Owens et al., 2022). Trauma, combined with repeated daily work stressors, requires TGD people to be able to be present and reliable in their work duties with or without additional resources to support their success. The emotional and mental toll can result in unemployment and possible suicidal ideations for TGD individuals.

Gender dysphoria is common for many TGD persons as a social determinant of health, resulting in depression, anxiety, and self-harm (King & Gamarel, 2021).

Employees suffering from gender dysphoria or gender incongruence create minority stress due to misconceptions and persecution of TGD individuals, where more support and acceptance are needed (Piegza & Główczyński, 2022). While not all TGD people suffer from gender dysphoria, challenges happen for those who do and are not supported by their healthcare organization. As negative attitudes toward TGD people increase, higher rates of anxiety and depression are soon to follow, adding to healthcare costs and missed time from work.

Attitudes Around the TGD Population

Studies have shown a history of bias across health organizations and academic medical institutions concerning the transgender community. With this, healthcare professionals can help to advocate for their fellow TGNB colleagues and the patients they serve. Liu et al. (2022) reported that doctors could use their clout along with their upstream power and privilege to ensure policy change to support TGNB individuals working and seeking care in their healthcare facility. Furthermore, privileges that include the broader healthcare field have protection against HR policies that are not inclusive. Enders et al. (2021) challenged leaders to address microaggressions when they happen, not only during a performance evaluation. Policy advocacy and gentle nudges are some ways that physicians and healthcare professionals can speak up against harm seen by those TGD employees they work beside daily. Because doctors are held in such high esteem, they can effect change on local and national levels within their professional membership.

Many healthcare professionals fear saying anything (Canvin et al., 2023) because of the lack of understanding of the TGD community, leaving TGD employees and patients vulnerable to microaggressions. Canvin et al. (2023) analyzed qualitative data from healthcare professionals who worked with the TGD community in London. Providers felt they had inadequate training, fears of getting things wrong, lack of experience or understanding, and the need for more training. The research showed that conducting training in a non-judgmental space equipped healthcare professionals with the tools and language to support the TGD community and overcome bias.

Healthcare professionals come with their belief systems and biases, which translate into strained work relationships, including the inability to communicate and work (Kanamori & Cornelius-White, 2016) with TGD employees. Having a hostile working environment where microaggressions are present can create a feeling of not belonging to the department or the organization, adding to the stress of TGD colleagues. Along with biases, religious beliefs can also be pervasive throughout healthcare organizations.

In 2016, it was estimated that about 14.5% of Catholic for-profit and non-profit healthcare organizations in the United States (Khaikin & Uttley, 2016) shy away from supporting or caring for TGD patients in their communities. Lawsuits by transgender employees in religious healthcare organizations have popped up across the country (Meyer, 2016), giving those employers religious freedom over Section 1557 of the Affordable Care Act. The rulings allow faith-based organizations the freedom to take away gender-affirming healthcare treatment coverage by insurance leaving TGD

employees and patients unable to have care covered and leaving them vulnerable to not fitting in or feeling like they are welcome and supported.

Secular-based healthcare organizations can create hostile work environments for TGD employees, as well. In the southeastern United States, transphobia and racism are increased by conservative and evangelical environments resulting in high unemployment rates, poor healthcare, and fewer social resources for TGD people (Johnson et al., 2020). Religious-based healthcare organizations create more unsafe psychological space for TGD due to past trauma and harm by established conservative religions (Scott et al., 2021). Healthcare TGD employees end up in a position of constant harm or face unemployment along with a lack of feeling of belonging because of their gender identity, and patients feel unsafe to receive treatment.

Fitting in or feeling like the belong requires a binary gender expression for TGD employees in healthcare. TGD employees will often attempt to change their gender expression to fit in with their coworkers (Van Laar et al., 2019). TGD people do this by presenting more binary or more masculine/feminine, like their cisgender cohort. Appearing as female or male can harm the emotional and mental well-being of those who identify as TGD. Furthermore, it perpetuates the stereotype of the binary system in the healthcare environment adding more triggers to the employees just trying to do their job and patients needing access to healthcare.

Transphobia in Healthcare and Employment

In the healthcare environment, transphobia is the best predictor of harm in the TGD community. Transphobia, or the biases of transgender identities, can keep

healthcare professionals from being willing to learn and support TGD people (Stroumsa et al., 2019). Those biases or transmisia keep TGD employees and patients from feeling respected and accepted by the healthcare organization. Furthermore, it fosters a healthcare environment where only cisgender employees and patients are supported. Biases around the TGD community continue the progression of harm in healthcare.

Biases in healthcare create high rates of discrimination against minority healthcare students. TGD medical students' fear of affirming or disclosing their identity creates a hostile environment in teaching hospitals (Giffort & Underman, 2016), furthering the cycle of harm in healthcare. In an environment where all students are coming to learn, TGD students hide their identity to fit into the cisgender culture. Healthcare misses out on opportunities to learn from those whose lived experiences add to patient experience and help to move past binary notions.

Healthcare is intrinsically binary-focused, founded on the notion that people are either female or male. The binary notion is problematic for all identities because TGD and intersex people find themselves in a situation where belonging to a team or department becomes complicated. The binary theory is deeply entrenched in our society (Thoroughgood et al., 2020) and the healthcare institution. Because healthcare treatment is solely focused on female and male anatomy TGD people feel less than or abnormal because of their physical anatomy. In turn, bias around bodies that do not fit in the box of females or males leaves healthcare providers stuck between their fears and biases while attempting to treat patients with dignity and respect.

Healthcare leaders in organizations often lack education on how to provide appropriate care for the TGD community, resulting in ongoing microaggressions fueled by unconscious biases. Unconscious bias is a stronger indicator than the education of healthcare providers around the TGD community (Stroumsa et al., 2019), leading to more harm to TGD employees and patients. Two hundred twenty-three clinicians, with 50.6% being internists, 22.4% being family physicians, and 26.9% being ob-gyn practitioners in the Midwestern United States, were surveyed with a 59% response rate. While most of them treated at least one TGD patient (n=111, 49.7%), they did not have additional education, and if they did it did not always address biases around TGD patients. Researchers focused on health education ($p=.292$), transphobia ($p<.001$), and experience with TGD patients ($p=.259$). Researchers found statistical significance that education did not equate to knowledge, transphobia predicted knowledge. Microaggressions such as not affirming identities, the use of chosen names and pronouns, and the assumption that every employee is cisgender create an environment that is not supportive of employees and patients who are TGD, and those microaggressions can be on top of widespread systemic biases. Education can help address health disparities, however, bias around gender identity does not always dissipate (Stroumsa et al., 2019). To prevent the harm caused by these microaggressions, it is crucial to establish specific organizational policies that prioritize inclusivity and address unconscious biases. This study enforced the need for more education and self-reflection on conscious and unconscious biases when working with the TGD population.

Numerous healthcare organizations have acknowledged their deficiency in policies to tackle systemic biases and are now urgently striving to implement measures that support their marginalized employees, including those who identify as TGD. The lack of policies across healthcare organizations intensifies harm because TDG employees report the lack of guidelines and enforcement of Title VII of the Civil Rights Act of 1964 that protects gender identity (Kleintop, 2019). Being TGD includes medical, social, or legal transition, and the lack of policies leaves these employees without protecting their identity (Westbrook & Schilt, 2014). The lack of policies leaves organizations without the means to have a culturally competent systemic environment protecting anyone who is not white, male, cisgender, or heterosexual.

Affirmation of Gender Identity

Cultural Competency in Healthcare and Employment

Cultural competency, although widely discussed in systemic environments like healthcare, extends beyond a one-time effort or a mere notion. Cultural competency requires consistent learning and updating views. For an organization to be inclusive, it must have a diverse pool of employees and additional competency through creativity and innovation (Hossain et al., 2020). Because higher levels of management in healthcare are centered on cisgender white identities, the priority has been less than desirable, leaving TGD employees stuck in less-than-affirming working environments. Cultural competency necessitates going beyond simply educating staff about gender identity, racism, sexual orientation, and issues faced by other underrepresented communities.

To effectively adapt to evolving language and new concepts, cultural competency must be continuously updated and sustained. Due to the rapid pace and constant demands of healthcare environments, health professionals face challenges in both delivering patient care and ensuring equity among their staff and patients (Willging et al., 2019). Unfortunately, education often neglects the inclusion of gender identity and sexual orientation (Galupo & Resnik, 2016). The stress of working in healthcare can block well-intentioned staff from alleviating their personal biases requiring cultural competency to be more than an hour, once-a-year education. Allowing more staff practice and reflection helps to understand the need for self-affirmation of identities for those employed and seeking treatment at a healthcare organization.

Policy in Healthcare and Employment

Implementing gender-affirming policies for TGD employees is essential to foster inclusive employee practices and ensure comprehensive insurance coverage for the healthcare needs of all employees. While there has been a growth of DEI initiatives across organizations, workplace buy-in is a requirement for success (McGregor et al., 2019). Healthcare culture mirrors U.S. culture regarding bias around racism, homophobia, and transphobia (Enders et al., 2021) and requires organizations to have a strategic plan for more inclusion and affirmation.

Enders et al. (2021) researched Mayo Clinic's DEI plan with a qualitative approach to gather data around a DEI framework within the organization. One hundred sixty-two participants encompassed their Health Services Research department. The staff worked out of three of the Mayo Clinics located in Rochester, MN, Phoenix, AZ, and

Jacksonville, FL. The study participants shared ideas and feedback on the plan which includes a two-step approach of increasing the belonging of underrepresented employees and increasing staff diversity (Enders et al., 2021). Workplace environment focused on training be the most important (p=.04) and review nudges (p=.01). The plan had two goals, increase an overall sense of belonging and overall diversity throughout the Mayo Clinic ($p \leq .05$). While this approach may seem too simplistic, it is a start to deeper conversation and curiosity on how to get more input from staff and leaders in a healthcare organization. Reviewing policies and procedures is only sometimes the first step in building a more affirming and inclusive organization.

While Title VII of the Civil Rights Act of 1964 serves as a foundational starting point for reviewing employee policies, it falls short of adequately protecting TGD employees within healthcare organizations. Title VII broadly covers discrimination based on gender identity but does not include policies or steps the administration must take to protect TGD employees (Elias, 2017). Leaders and HR managers are then left to devise policies to protect TGD employees and all other employees from discrimination. If the organization needs TGD employees in leadership or diversity in the workplace, TGD people are included in the conversation where input is essential. Moreover, cisgender leaders lose the ability to have the lived experience needed to comprehend TGD employee experiences fully. Having a solid workplace culture around all identities can help support those underrepresented.

While Title VII offers certain protections for TGD employees, the Americans with Disabilities Act (ADA) provides a more comprehensive level of security. The ADA

offers shelter in public accommodations and entities like bathroom protection, gender expression, and time off for medical needs surrounding gender dysphoria and gender-affirming care (Szemanski, 2020). ADA compliance in healthcare facilities is a federal act supplying broader protections for TGD employees. Having the ability to support TGD employees with federal policies helps in the creation of a workplace policy that affirms all identities.

Healthcare policy for TGD patients helps to ensure they receive the best holistic care. The ability to receive affirming holistic care requires the need for policies that protect TGD patients including policies that address discrimination, health insurance coverage, gender-affirming hormones and treatment, mental health care, and access to changing legal documents (Goldenberg et al., 2020, Perone, 2020). Additionally, the need for a review of structural policies, staff education, and continued access to care needs to be considered in holistic care (Goszkowicz & Davis, 2023). These require hospital administration to draft and execute a safety plan for TGD patients entering their healthcare facility. Starting with federal discrimination policies in the Affordable Care Act (ACA), such as Section 1557, gives healthcare organizations a starting foundation for enacting policies that support the TGD community. Section 1557 of the ACA prohibits discrimination in healthcare based on sex including gender identity supporting the TGD communities' need for protection while the ADA offers protection for receiving gender-affirming care in healthcare organizations.

Religious exemptions cause harm to the TGD community when seeking healthcare at faith-based health organizations. The Religious Freedom Restoration Act

(RFRA) prioritizes religious preferences over discrimination around federal laws such as Title VII or Section 1557 of the ACA (Blazucki, 2023). RFRA opens the door for religious healthcare organizations to deny healthcare and deny employees jobs or promotions to TGD people. Ultimately resulting in harm and additional health disparities for those who identify as TGD.

Self-Affirmation

The capacity to validate one's own identity, such as gender, serves as a valuable asset for an employee and patient entering a healthcare organization. Being able to show up as one's true authentic self is the key to self-affirmation (King & Gamarel, 2021; Doyle, 2022, Rood et al., 2017). The capacity to express one's gender identity is a unique journey to a consistent determinant of health. The ability to express that gender can factor in bias, racism, and discrimination resulting in trauma for TGD people (Sevelius, 2013; Reisner et al., 2016). Employees, patients of color, and those TGD who present non-binary can find themselves at the end of microaggressions and biases by those who do not understand or accept identities outside of the binary genders. The potency of self-affirmation diminishes when the ability to express it is restricted or denied for TGD individuals.

By endorsing the ability to self-identify, people demonstrate support and celebration of the diverse identities present in healthcare. Transitioning is a process of living as one's true self (a) legally: changing a person's legal name; (b) medically: surgical, or through gender-affirming hormone therapy and care; and (c) socially: by expression of clothing, voice, and mannerisms (Thoroughgood et al., 2020). Supportive

healthcare cultures accept and celebrate TGD transitions through policy and approval of procedures by the employee's health insurance (Huffman et al., 2021). Ensuring people have a voice and a seat at the table guarantees that they are both heard and valued.

ERGs

Despite the organization's overall need for greater representation, Employee Resource Groups (ERGs) should strive for increased diversity, specifically by including more individuals from the TGD community. ERGs, which include TGD voices, have been used in organizations to improve DEI procedures and culture to improve the inclusivity of their staff (McNulty et al., 2018). Furthermore, one of the metrics in the *Human Rights Campaign* Healthcare Index (2022) scores the organization on whether or not the company has an LGBTQ+ ERG and a community council. The community council and ERGs influence the healthcare organization for both employee culture and patient care for those they serve. At the same time, allies advocate and support their peers.

Healthcare Stereotype Threat

The theories of minority stress and stereotype threat center around the detrimental impact of bias in healthcare. Minority stress is pervasive in healthcare leading to health disparities (Burgess et al., 2010) and is the framework that appears with incongruency between sexual minorities and dominant culture. Healthcare stereotype threat judging a patient based on perceived unhealthy lifestyles and inferior intelligence (Abdou et al., 2016). Healthcare stereotype threat others those who identify as a sexual minority like the LGBTQ+ community, creating a space of judgment and bias for TGD individuals. The

presence of healthcare stereotype threat has a profound impact on both patients and employees within the healthcare environment.

The persistence of healthcare stereotype threat in the workplace goes unnoticed and concealed by hospitals and healthcare administration, permeating throughout organizations. Research shows that healthcare professionals have overt and covert biases toward the TDG community (Nadal et al., 2016). The biases the authors identified included explicit and implicit, which are not always apparent to the person committing the microaggression. The unconscious behavior causes harm to the TGD person, and the aggressor's behavior may not be held accountable due to the fear and isolation TGD people feel because of the injury. The race and income of the TGD community can further intensify the healthcare stereotype threat.

Given the intersectionality of TGD individuals' identities, race assumes a prominent role in shaping the healthcare stereotype threat. Researchers have identified a correlation between race, gender, and sexual orientation in communities of color (Thorpe et al., 2022). Thorpe examined secondary data specific to sexual identity and minority stress in healthcare. One hundred forty-two Black and biracial cisgender females living in the United States were asked about gender conformity and sexual identity concerning exposing their identities to healthcare providers. Out of the participants, 45.6% identified as bisexual, and 40.8% identified as lesbian/gay. While this study did not specifically focus on gender identity, researchers found a significant correlation between Black cisgender women who presented more neutral or masculine and healthcare stereotype threat ($p=.04$). Results showed those whose gender identity is gender non-conforming

have higher levels of stigma in accessing healthcare (p=.03). A missing data point in this study was the absence of Black TGD voices. Being TGD and BIPOC poses an even more significant threat of bias and discrimination due to historical stereotyping and victimization in a healthcare environment. Numerous DEI initiatives within healthcare organizations are presently addressing racism and income disparities through the lens of healthcare stereotype threat.

In healthcare settings, unconscious bias often occurs, leading to detrimental effects on both employees and ultimately impacting patients. Microaggressions and the suppression of gender identity and sexual orientation increase triggers of TGD across an organization **(**Thorpe et al., 2022). Employees are then forced to deal or cope with the stereotypes and stigma of being TGD every time they enter their workplace and TGD patients fear accessing care. This burden affects the person as well as the organization with absenteeism, mental and medical crises, and eventually loss of job or demotion in work. Healthcare organizations incur hidden costs related to the recruitment of additional staff, educational efforts, reputation deficits in terms of diversity, and the presence of a hostile work environment.

Race

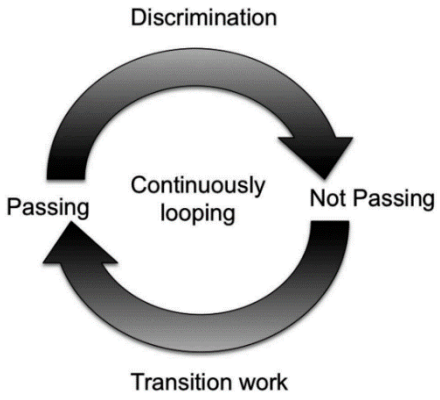
Healthcare stereotype threat is a comprehensive theory that examines biases and stereotypes, yet it becomes problematic with the intersections of identities of race and gender. Diving deeper into microaggression theory, a reader notices that personal interactions filled with one-off comments or microaggressions converge (Arayasirikul & Wilson, 2019) on the TGD community during their time at work or access to healthcare,

creating a dangerous environment for their health and well-being. According to the research of Arayasirikul and Wilson (2019), 38 transwomen 16-24 years of age in Chicago and Los Angeles shared their introductory work experiences and how their identities were perceived in the workplace. The mean age of participants is 20.95 with 34.2% identifying as Black, 13.2% identifying as White, 15.8% identifying as Asian American/Pacific Islander/Native American, and 23.7% identifying as Latino. The qualitative study found a significant intersection of transmisogyny as a structure of oppression by forcing TGD to pass which requires a medical transition. Workers who could pass as cisgender had better workplace experiences versus those who were early in their transition and faced transmisogyny and microaggressions for staff and clients.

The term transmisogyny, coined by Julia Serano in the mid-2000s, defines the intersectionality of the biases of "transphobia, misogyny, and racism" (Whipple, 2021) and has become a way to highlight the stereotypes and struggles of black TGD identities. Researchers (Arayasirikul & Wilson, 2019) identified the passing of the complex (Figure 2), which is a continuous loop of transition work of passing, and the discrimination that comes from not passing. TGD people not only have to overcome stressors around transphobia but systemic racism is seen across the healthcare organization, once again requiring TGD individuals to bear the burden of being resilient. TGD resilience comes with high levels of mental health challenges, with substance abuse leading to unemployment within the TGD community.

Figure 2

The Passing Complex (Arayasirikul & Wilson, 2019)



Trans women of color are less likely to be hired, creating housing and mental health encounters leading to unemployment and housing instability. In the social hierarchy of TGD identities, BIPOC women and feminine transgender individuals face more violence and homicide due to systemic racism and transphobia, leading to fewer employment opportunities, abuse, and housing insecurities (Wesp et al., 2019). The cycle of black and brown sexual objectification creates more harm and less ability for employment or access to healthcare. The TGD person's healthcare then suffers from the lack of lived experiences of BIPOC TGD employees and the inability to support patients in that demographic. The lack of employment opportunities, housing, and access creates income insecurities for BIPOC TGD individuals.

Self-affirmation of race supports black and brown TGD employees and patients. Positive encounters in healthcare settings, such as self-affirming race and gender, lower stereotype threats for BIPOC individuals (Taber et al., 2016). Furthermore, TGD employees in rural areas and southern communities are less likely to support Black

employees (Smart et al., 2020). Healthcare organizations, where race is celebrated versus environments where racism is present have better job satisfaction and fewer mental health crises. In cases where stereotype threat becomes deeply ingrained in healthcare culture, it inevitably results in unemployment which leads to income loss.

Perceived Employment Inequities

TGD live in fear that they will lose their job due to their gender identity or expression of their gender. Discrimination is a concern for gender minorities because of their gender identity creating an unsafe environment to self-identify on resumes and job applications (Cabacungan et al., 2019). Moreover, disabled, gender minority employees fear isolation and stress due to exposing their gender identity at work (Dispenza et al., 2019). The perception of how their gender identity will be embraced or rejected adds another layer of concern surrounding their employment opportunities or status at their current organization creating perceived employment inequities. How the TGD employee is perceived by their co-workers is a daily stress carried throughout their employment journey.

Healthcare environments may be culturally competent and still have room for improvement with TGD employees. TGD employees reported perceptions around their visibility and ability to be out as themselves brought concern and worry about their equity in the healthcare workplace which aligned with concerns by their cisgender co-workers about TGD employees (Katz-Wise et al., 2022). Updated policies and continuing education must continue to address improvements around employment inequities. Growth

areas in healthcare are felt by all employees in the arena of diversity, equity, inclusion, and justice.

The rise in hostile work environments, the enactment of anti-transgender legislation, and past instances of discrimination all contribute to the challenges faced by TGD people in coping with the stigma associated with their identity. Resilience among those in the TGD community is consistently noted in research (Van Laar et al., 2017). However, it does not remove the constant discrimination the TGD employee faces when entering a work environment and patients needing and receiving care. TGD individuals face daily misunderstandings about their gender identity and expression of gender. They must justify names, pronouns, and how they dress, walk and talk. TGD folks of color are forced to combat elevated levels of discrimination because of stereotypes and biases rooted in racism within healthcare organizations.

Income

In addition to facing unemployment, TGD people encounter additional challenges such as lower wages and mental health crises. Workers who identify as TDG have lower wages than their cisgender and lesbian, gay, and bisexual counterparts, leading to poor mental health (Owens et al., 2022). Minority stress puts TGD employees in a position of feeling unstable in their low-paying job, further exacerbating the worker's mental health. Additionally, TGD individuals have seen higher rates of discrimination in the healthcare environment (Reisner et al., 2015). Healthcare stereotype threat overshadows the TGD population's employment experience while attempting to do their low-paying job. The bias and employment inequity overshadowing creates stress that negatively impacts the

mental health of workers, perpetuating a cycle that increases the risk of job loss, substance abuse, and various social determinants of health.

Having a high level of education does not necessarily translate into increased employment opportunities, in so doing impacting the income of TGD employees. TGD people in states where there are transgender rights have a better chance at having a job, and TGD employees tend to have more education than their cisgender counterparts, but laws drive employers when hiring and wages (Leppel, 2016). Researchers note that laws propel employment and wages higher or lower for the TGD community regardless of degrees and education, even though they have more. Additionally, income is wielded both as a tool for and against TGD employees, further aggravating income instability across the board.

Summary of Literature Review

TGD people face discrimination in healthcare which often spills over into their employment in healthcare organizations (Perales et al., 2021; Witt & Medina-Martinez; 2022). Gender identity plays a large role due to the ability to affirm gender identity (Davidson, 2016; Doyle et al., 2021; Hughto et al., 2020; Sawyer & Thoroughgood, 2017) through expression, names, & pronouns at work. Bias in healthcare also plays a role in the discrimination of TGD people (Flynn & Bhambhani, 2021; Stroumsa et al., 2019; Van Laar et al., 2019). All this leaves TGD employees with feelings about their safety (Siad & Rabi, 2021) and belonging (Newman et al., 2021). For TGD employees, the healthcare workplace can wind up being an unhealthy environment to thrive (Doyle et al., 2021; King & Gamarel, 2021, Lerner et al., 2021; Sherman et al., 2021) due to the

cultural norm of being cisgender (Doyle, 2022; Thoroughgood et al., 2017, 2020; Van Laar et al., 2019). Healthcare leaders and professionals can improve the healthcare environment through education (Enders et al., 2021; McGregor et al., 2019), addressing microaggressions (Arayasirikul & Wilson, 2019; Canvin et al., 2023; Stroumsa et al., 2019, Thorpe et al., 2022), and policy changes (Elias, 2017; Kleintop, 2019; Liu et al., 2022; Szemanski, 2020). Overall, discrimination and bias around gender identity require further consideration and research as a means of addressing and improving the needs of the TGD community in healthcare.

Definitions

Non-affirmation of gender identity is the inability to affirm someone's gender identity using a chosen name, pronouns, and recognition of gender (Reisner et al., 2020).

Healthcare stereotype threat is a framework that describes negative stereotypes around healthcare evaluation, treatment, and diagnosis by clinicians based on one's social group (Saunders et al., 2023).

Perceived employment inequities is a term that refers to the feelings employees have based on their employment status based on the biases of their social group resulting in demotion and termination or inability to be hired (Thoroughgood et al., 2017).

Cisgender is a term that refers to people whose gender identity aligns with their sex assigned at birth (Goldbach et al., 2021).

Gender diverse is a term for a person whose gender identity or gender expression does not conform to society's definition of binary male or female gender norms (Rusow et al., 2022).

Heteronormative is a system and a viewpoint that heterosexuality and binary sex are the only sexuality and gender identity held as the cultural norm for all family dynamics (Goldbach et al., 2021).

Homonormativity is adding the privilege, like same-sex marriage, of heterosexual ideas and norms onto the LGBTQI+ community (Stewart, 2020).

Transgender is a term that refers to people with a gender identity that does not align with their sex assigned at birth (Goldbach et al., 2021) and serves as an umbrella term for the broader community (Green & Maurer, 2015).

Transmisogyny targets the transgender community of color with the intersectional view of transphobia and misogyny (Boe et al., 2020), focusing on sexualizing and fetishizing those whose gender identity is female or feminine expressing (Serano, 2021).

Assumptions

The assumptions in the study were that TGD employees in healthcare described the workplace environment as their experience, the ability to affirm their gender identity, and significant components surrounding workplace culture without the fear of retribution. Additional assumptions include correct data collection and input by researchers without bias and employees sharing their experience without the fear of workplace retaliation. The experiences were necessary to measure the relationship between healthcare stereotype threat and non-affirmation of the TGD lived experience within healthcare organizations.

Scope and Delimitations

The scope of the study was limited to generalizations across healthcare organizations. Each healthcare organization may have different experiences and workplace cultures. Healthcare stereotype threat validity may vary based on the response rate of staff and the TGD community regarding the feeling of safety to disclose their gender identity, received bias, and harm. Perceived employment inequities can be felt at any organization, for any TGD employee, based on their specific workplace environment. Furthermore, the data set focused on the TGD community and does not represent all TGD people and their lived experiences.

Limitations

Limitations include references from multiple healthcare environments such as hospitals, clinics, pharmacies, and healthcare billing offices but the data did not provide specific job titles or categories within healthcare organizations. Other limitations include all TGD identities not specified in the dataset that excludes non-binary identities terminology outside of non-binary and genderqueer, which excludes many more gender identities. The measures used to address the limitations were the generalizations for broader healthcare organizations which included using job titles such as clinicians, healthcare professionals, and administrators for commonality. Employment inequity is also generalized based on responses that were the perceptions of TGD individuals working in the United States not always specific to healthcare. Other measures include using TGD to encompass binary and non-binary transgender individuals.

Significance

The results of this study could potentially contribute to an examination and explanation surrounding the healthcare stereotype threat for the TGD community in the healthcare organization when they disclose their gender identity. Previous studies such as the U.S. transgender survey in 2015 and 2022 focus on whether the TGD employee was fired or demoted from their job (Leppel, 2021) and focus on bias and discrimination the community lived through on a broader scale without affirming their gender identity. The study identified the significant relationship between healthcare stereotype threat in healthcare environments with TGD employees and patients. As such, the study may potentially provide better clarification of the harm TGD individuals face in healthcare and other industries around the affirmation of their gender identity along with the ability to live their true authentic lives. This potential implication of this study will increase understanding and awareness for those in healthcare to be a beacon of support to the TGD community they serve and employ.

Summary and Conclusions

TGD people are continuously discriminated against in the healthcare environment (Casey et al., 2019). They cannot affirm their gender identity due to bias and stereotypes in and out of work (Reisner et al., 2016; Van Laar et al., 2019). The purpose of this quantitative retrospective quasi-experimental study was to examine the relationship between non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities of TGD people in healthcare organizations. This study will fill in the gaps in the current literature to extend knowledge of awareness and provide more

support to the TGD community in healthcare organizations. This section identified the supportive literature review, the purpose of the study, and the research questions. The following section will include the design and methodology that guide this study.

Section 2: Research Design and Data Collection

Introduction

The purpose of this quantitative retrospective quasi-experimental study was to examine whether there is a relationship between the non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities concerning employees in healthcare systems and organizations. The variables are non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities. Non-affirmation focuses on the gender identity of the employee and patient. Healthcare stereotype threat sheds light on the gender and sexual orientation of the employee and patient. Perceived employment inequities center around their status only as an employee.

While TDG people face higher rates of discrimination, this study focused on the culture of healthcare organizations where TGD patients and employees face inequities, verbal abuse, and sexual assault. Conducting this study shed light on employee policy and the treatment environment in healthcare organizations that affect the status of TGD employment and the care TGD patients receive. All variables were gathered from secondary data collection from the TransPop survey. Collected data involved using correlation analysis via Statistical Package for the Social Sciences (SPSS) for Windows Version 29, and descriptive statistics were calculated.

This section includes the research design and rationale for choosing a quantitative method of research, the methodology will be explained, threats to validity will be assessed with the final summary of the findings, and the end of this section will discuss research design and collection.

Research Design and Rationale

This retrospective, quasi-experimental, quantitative study was designed to examine the relationship between the independent variable of non-affirmation of gender identity, and the dependent variables of healthcare stereotype threat and perceived employment inequities. Because the variables in this study are identified and measurable, the quantitative method is applied to the purpose of the study. This retrospective, quasi-experimental was used to establish cause and effect because the data has already been used in previous studies where there has already been intervention (White & Sabarwal, 2014). For the field of study, the retrospective, quasi-experimental quantitative research design was chosen to establish possible relationships between TransPop study variables. The correlational study is the most logical for these specific variables from the dataset, for this study.

This retrospective, quasi-experimental, quantitative study used a secondary dataset collection from a survey from 2016-2018 specific to the TGD community and their perception of their employment and healthcare access. The quasi-experimental design was used in this study, with no time or resource constraints.

The purpose of this study was to examine any relationships with the non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities which are numerically measured for the secondary data source. Data were received from people living in the United States.

Methodology

Population

In the TransPop survey from 2016-2018, the combination of transgender and cisgender created one dataset. The transgender sample was N=274 and the cisgender sample was N=1,162 with a combined total of N=1,436 across the United States. The secondary data were collected from the TransPop survey. In the United States, it's estimated that the TGD population of adults 18 years and older is about 1.3 million people, .5% of the population (Herman et al., 2022). The term transgender is a person who does not identify with the sex they were assigned at birth (Dahlen, 2020). Because the non-binary and genderqueer population data has not always been captured in US census data until recently, this number is an estimate. Using the CDC's Behavior Risk Factor Surveillance System (BRFSS) survey, they report 38.5% (515,200) identify as transgender women, 35.9% (480,000) identify as transgender men, and 25.6% (341,800) identify as nonbinary/gender nonconforming (Herman et al., 2022) across the United States.

Sampling and Sampling Procedures for Data Collection

The focus of the study was on a random sample of TGD employees throughout the United States in 2016-2018 This study examined the variables using statistical tests based on the secondary source of the TransPop Survey focusing specifically on non-affirmation of gender identity, healthcare stereotype threat, and employment. Correlational methods of research are intended to determine the intensity of the connection between variables (Frankfort-Nachmias et al., 2021). The sampling strategy

that was deployed was probability sampling which was random with known non-zero probability. This study aims to add gaps in the literature and expand knowledge about TGD employees in healthcare.

The original study goal was to get a representation of the TGD population in the United States focusing on health outcomes, behaviors, institutional discrimination, and other health-relevant domains based on personal perception. The TransPop was the first national probability sample in the United States. The study is a combined dataset of two data sources with one being TGD-only respondents, and the other being cisgender respondents. The sample weight applied to the cisgender population is 50x the TGD population. Bias surrounding data collection was twofold: a) target characteristic-TGD and b) target community-LGBT. Recruitment and screening were performed by Gallup Inc. using two methods:

1. US Adults using random digit dialing on cell and landline phones were contacted and asked if they identified as lesbian, gay, bisexual, or transgender.
2. Shifted to address-based sampling by mail or online survey where Gallup sent out surveys based on address.

Sampling inclusion included 18 years of age, the minimum of sixth-grade education, and English speaking. The exclusion was Spanish speaking (5% of participants), fifth-grade education and lower, and youth 17 years old and younger based on the inability to consent legally. Each caller was then asked if they identified as LGBT, if yes response, they were asked their sex assigned at birth and gender identity. Respondents who identified as transgender served as the transgender sample. Those who

did not identify as transgender served as the cisgender sample. Participants were placed in regions where they lived. Those regions include New England, Middle Atlantic, East and West North Central, South Atlantic, East, and West South Central, Mountain, and Pacific. Consent was assumed by filling out the survey or responding to questions asked to each participant. Due to the privacy of disclosure, participants were not asked to sign a consent form. In the second phase, respondents received a $25 gift card if they completed the survey online or $25 cash if they mailed the survey back to Gallup.

The TransPop dataset is publicly available on the ICPSR at the University of Michigan website. The study protocol was reviewed and approved by Gallup IRB and UCLA IRB. The study collaborated with Columbia University, the University of Texas at Austin, the University of California at Santa Cruz and San Francisco, the University of Arizona, Surrey University, UK, and the University College of London, UK. These collaborations included academic and professional input and feedback from TGD leaders, researchers, and healthcare professionals.

A G* Power analysis was performed by using G*Power software version 3.1.9.7. Input included a medium effect size of 0.15, an alpha error of probability of 0.05, a power of 0.80, and one predictor. Based on the calculations, the necessary sample size for each separate variable with statistical significance was 55. The available number of participants is 252, which is adequate to achieve statistical significance and detect a false null. With these tests, the minimum sample will support or disprove the statistical significance of the research questions. Statistical significance can also rule out the null hypothesis in this study.

Instrumentation and Operationalization of Constructs

The main data set used in the study is the TransPop survey from 2016-2018, published in 2021 by Ilan Meyer. The goal of the study was to provide researchers with a sample of the transgender population including basic demographics and examine health outcomes and institutional discrimination (Meyer, 2021). Data for this study were obtained publicly through the ICPSR at the University of Michigan website where no permission was needed. The data was extracted from the website into an Excel document. Specific data focused on non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities by use of sexual identity, race, and gender minority. This dataset expanded upon another dataset, the US Trans Survey of 2014, and validated scales of the TransPop survey that measured the identity, stress, and health of the transgender population in the United States.

Non-affirmation of gender identity is the independent variable. The dependent variable is healthcare stereotype threat and perceived employment inequities. Survey participants were instructed to choose their level of agreement with statements of the quantitative variables from a 5-point Likert scale, ranging from “strongly disagree” to “strongly agree.” The variables were recoded using a discrete count from zero to the total sum score amount for each variable.

Nonaffirmation of Gender Identity

The variable for non-affirmation of gender identity looks specifically at the question surrounding the perception of gender and gender expression. Gender conformity for TGD people includes perception of gender expression or physical appearance and

non-affirmation of gender identity by others. Participants were given four statements using a 5-point Likert scale in which they had to state whether they "strongly disagreed, disagreed, neither agree nor disagree, agreed, or strongly agreed" to the statements. The original data set used 1 for "strongly disagree," 2 for "disagree," 3 for "neither agree nor disagree," 4 for "agree," and 5 for "strongly agree." Using a recoded sum score for each survey participant between 0-24. Zero denotes the participant has the least affirmation and 24 denotes the participant has a strong affirmation of their gender identity. Strong affirmation means that the TGD person felt affirmed in their gender identity, gender expression, pronouns were respected, could "pass" regarding the gender identity, and whether they felt understood as a person.

Healthcare Stereotype Threat

When the participants sought out healthcare, judgment, bias, and negative diagnosis during their visits were asked by the researchers. Healthcare stereotype threat refers to discrimination against TGD participants based on their sexual identity, and gender minorities including BIPOC. The sexual identities include sexual minorities other than heterosexual, lesbian, gay, bisexual, queer, same gender loving, asexual, and pansexual. Gender identities include trans men, trans women, and trans-GNB (gender non-binary). Participants were given four statements using a 5-point Likert scale in which they had to state whether they "strongly disagreed, disagreed, neither agree nor disagree, agreed, or strongly agreed" to the statements. The original data set used 1 for "strongly disagree," 2 for "disagree," 3 for "neither agree nor disagree," 4 for "agree," and 5 for "strongly agree." This variable of healthcare stereotypes will include healthcare

experiences using a recoded sum score for each survey participant between 0-16. Zero denotes the participant with the least healthcare stereotype threat and 16 means strong healthcare stereotype threat. Strong healthcare stereotype means the TGD patient felt judged negatively, worried about negative health interactions, receives a negative diagnosis when seeing a provider, and is a negative stereotype for the TGD community.

Perceived Employment Inequities

The perceived employment inequities variable spotlights the employment status of the TGD employee on how often the employee was fired from their job, denied a job, denied a promotion, or received a negative evaluation based on their perception. Furthermore, the variable looks at the outcome of employment focusing on being fired, denied a job or promotion, or receiving a negative evaluation for each survey participant. The scale used for these statements is how often the employee was fired, denied a job or promotion, or received a negative evaluation with 1 being "never," 2 being "once," 3 being "twice," and 4 being "three or more times." A recoded sum score between 0-6. Zero denotes the participant had no employment issues and 6 means three or more issues such as termination, being denied a job or promotion, or receiving negative evaluations. The two variables being used to measure negative employment outcomes record the number of times fired, demoted, etc. as 0, 1, 2, or 3 or more. Even though there is no true count for people fired more than three times, these represent a relatively small portion of the sample (around 10%). The survey questions were treated as quantitative variables by simply adding the two questions of how often the employee was denied a job or promotion, negative feedback, or fired to get a rough measure of negative employment

outcomes. This biased the results towards being more conservative since those with more than three firings or demotions were coded as having no more than three.

Data Analysis Plan

The data were exported from Microsoft Excel with the statistical analysis done using SPSS (version 29). Data exploration started by preprocessing the variables and removing all missing data and outliers to have a clear and concise data set and to ensure the validity of the findings. The examination of the data was restricted to specific questions about being fired, terminated, and denied a promotion. Using SPSS, the data set was cleared of any missing data to ensure reliability. Demographics of the sample include adults 18 years and older who identify as transgender or gender non-binary.

The data analysis was completed using a simple linear regression analysis, to answer both research questions. Simple linear regression was appropriate for this study because it establishes if there is a relationship between one independent and one dependent variable. In this case, the independent variable is non-affirmation of gender identity, and the dependent variables are healthcare stereotype threat and perceived employment inequities. These three variables were created for the analyses as follows.

Tables 2, 4, and 6 in Chapter 3 refer to the TransPop survey questions that contain data for the variable of non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities. Participants were given these statements using a 5-point Likert scale in which they had to state whether they “strongly disagreed, disagreed, neither agree nor disagree, agreed, or strongly agreed” to the statements. The original dataset used 1 for “strongly disagree”, 2 for “disagree”, 3 for “neither agree nor

disagree". 4 for "agree" and 5 for "strongly agree". Scores were recoded to range from 0 to 4, then added together for a single index, resulting in a recoded sum score for each survey participant between 0-24 for non-affirmation, 0-12 for healthcare stereotype threat, and 0-6 for perceived employment inequities. Zero denotes the participant strongly disagreed with all statements, and the upper range denotes the participant strongly agreed with all statements.

These linearized index values were then checked to make sure values were not clustered and hence better represented as a binary outcome. Because each index showed a wide distribution of answers, simple linear regression was an appropriate way to determine whether non-affirmation of gender identity was a significant predictor of either outcome because it compares two quantitative variables, as long as their relationship is linear and the deviations between the ordinary least-squares regression line and the actual observed values are homoscedastic and normally distributed.

The research questions and hypotheses guide this study are as follows:

RQ1: What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?

$H_0$1: There is no statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

$H_1$1: There is a statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

RQ2: What is the relationship between non-affirmation of gender identity and perceived employment inequities?

$H_0$2: There is no statistically significant relationship between non-affirmation of gender identity and perceived employment inequities.

$H_1$2: There is a statistically significant relationship between non-affirmation of gender identity and perceived employment inequities.

The results were interpreted using a P value of <.05 to signify statistical significance.

Threats to Validity

Internal threats to validity include a low population of TGD identities present in the study. In the data collection, white cisgender-identified participants are the majority when it comes to race and gender identity. Sampling bias can be seen in the marketing and outreach of the survey to a specific population in two ways. The first way is marketing explicitly to TGD individuals. The second way is marketing to the specific community of LGBTQ+ persons. External threats in this study are the data from the study was used to determine whether or not there are statistically significant results for non-affirmation of gender identity, perceived employment inequities, and healthcare stereotype threat of the TGD population from the TransPop data set. Recoding of variables was needed to explain the sum score of the participants in the analysis of the data set.

Ethical Procedures

Collecting data for populations such as the TGD community assists social science research in improving the lives of TGD people and aiding in additional research collection that helps to respect the autonomy of the TGD community (Castendea &

Smith, 2022). This study uses principles of the Belmont Report which focuses on the ethical ideas of respect for persons, beneficence, and justice (Brothers et al., 2019). While the Belmont Report was drafted to protect research participants, it misses the mark on protecting minority communities and populations that have been harmed in the past by the medical community (Friesen et al., 2017). The TGD community has a history of avoiding medical care due to discrimination and harm creating a culture of violence and a lack of safety for TGD people.

The IRB must review and approve all research by the researchers of the TransPop survey and through the Inter-university ICPSR at the University of Michigan. However, this data set is available publicly with no personal data attached to it. There is no need to request the TransPop data set.

For this study, the threat of harm is low to none due to the analysis of secondary data. To ensure the confidentiality of the participants, no data will be collected, and the data used will remain confidential. The variables include only the sample size and the demographics of gender, sexual orientation, race, and income keeping other identifiers out of the analysis. While the original data collected did not contain personal information, a data breach would not cause harm to those who participated in the study.

Furthermore, to protect from a data breach, all information from this study was protected. Any paper documents will be locked in a secure, fireproof safe. Electronic materials will be encrypted, and password protected, as well as protected by a VPN (Virtual Private Network), in my possession at all times. After 7 years after the

completion of this study, all documents, paper and electronic, will be destroyed by ways of shredding, permanent deletion of files, and reformatting of drives to ensure deletion.

Summary

The purpose of this retrospective, quasi-experimental, quantitative study was to examine the relationships between non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities for TGD people in healthcare organizations. The variables measured in this study using secondary data are obtained from the TransPop Survey from the Inter-university ICPSR at the University of Michigan website. A correlation analysis will be used to analyze data from the TransPop data set using SPSS for Windows Version 29. Section 3 will display the results and findings of the analysis of the TransPop data set.

Section 3: Presentation of the Results and Findings

Introduction

The purpose of this quantitative retrospective quasi-experimental study was to examine whether there is a relationship between the non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities concerning employees in healthcare systems and organizations. This section includes the data collection of the data set, the results from the analysis, and the summary.

The research questions and hypotheses guide this study are as follows:

RQ1: What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?

$H_0$1: There is no statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

$H_1$1: There is a statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

RQ2: What is the relationship between non-affirmation of gender identity and perceived employment inequities?

$H_0$2: There is no statistically significant relationship between non-affirmation of gender identity and perceived employment inequities.

$H_1$2: There is a statistically significant relationship between non-affirmation of gender identity and perceived employment inequities.

Data Collection of Secondary Data Set

The secondary data set was collected from the TransPop study (Meyer, 2021). The data was pulled from the Excel document and SPSS data set from the Inter-university ICPSR at the University of Michigan There were no discrepancies in the use of the secondary data set from the plan presented previously in Section 2.

The focus of the study was on a random sample of TGD employees throughout the US in 2016-2018. Recruitment and screening were performed by Gallup Inc. using two methods. First, US Adults using random digit dialing on cell and landline phones were contacted and asked if they identified as lesbian, gay, bisexual, or transgender. Then, it shifted to address-based sampling by mail or online survey where Gallup sent out surveys based on address. The total survey sample in both cisgender and TGD identities over the age of 18 years old. The baseline descriptive and demographic characteristics of the sample included age, gender identity, sexual orientation, race, and education.

The statistical assessment used to assess the hypotheses for each of the research questions proposed was a simple linear regression of the variables. Simple linear regression was chosen as an appropriate method to assess whether non-affirmation of gender identity significantly predicted either outcome variable while adhering to the statistical assumptions. Because the one outcome and one predictor variable all showed a wide distribution of answers, it compared two quantitative variables, as long as their relationship is linear and the deviations between the ordinary least-squares regression line and the actual observed values are homoscedastic and normally distributed.

The procedures used to account for this analysis were due to the multiple factors influencing healthcare stereotype threat and perceived employment inequities. There was no basic univariate analysis, covariates, or confounding variables. Using SPSS, the analyze option was used to review descriptive statistics and frequencies to create tables in the software.

For gender identity, Tran woman or male-to-female (MTF) made up 43.2 % (115 individuals) with Trans man or female-to-male (FTM) at 28.6 % (76 individuals) and Trans GNB or transgender non-binary at 28.2% (75 individuals; Table 1). The mean age of respondents was 39 years old with the highest numbers identifying as heterosexual (21.7%), bisexual (19.0%), and queer (18.3%; Table 1). In total, 73.2% of respondents identify as White, 9.6% as Hispanic, 8.8% as Black, 4.2% as Asian, and 4.2% as Other (Table 1).

Table 1

TransPop Demographics

Gender	N	Percent
Trans man (FTM)	76	28.6
Trans woman (MTF)	115	43.2
Trans GNB	75	28.2
Total	266	100.00

Age	
N	266
Mean	39.3
Median	34
Std. deviation	16.9
Minimum	18
Maximum	72

Sexual identity	Frequency	Percent
Straight/heterosexual	57	21.7
Lesbian	23	8.7
Gay	22	8.4
Bisexual	50	19.0
Queer	48	18.3
Same gender loving	9	3.4
Other	21	8.0
Asexual spectrum	12	4.6
Pansexual	21	8.0
Total	263	100.00

Race	Frequency	Percent
White	191	73.2
Other	11	4.2
Black	23	8.8
Asian	11	4.2
Hispanic	25	9.6
Total	261	100.0

Note. Demographics of the participants in the *TransPop* study who identified only as transgender and gender diverse.

Results

Descriptive statistics and related data visualizations were reviewed for the variables included in RQ1 and RQ2 using SPSS analysis output. The sample included a total of n=1436 samples; n=1162 were cisgender male and female and n=274 TGD individuals. Of the 274 TGD individuals, 266 were found to be valid (i.e., had complete data) for the data analysis (Table 1). Three new variables were created for the analyses, described as follows.

Table 2 refers to the TransPop survey questions that contain data for the variable of non-affirmation of gender identity. Participants were given six statements using a 5-point Likert scale in which they had to state whether they "strongly disagreed, disagreed, neither agree nor disagree, agreed, or strongly agreed" to the statements. The original dataset used 1 for "strongly disagree," 2 for "disagree," 3 for "neither agree nor disagree," 4 for "agree," and 5 for "strongly agree." Scores were recoded to range from 0 to 4, then added together for a single index, resulting in a recoded sum score for each survey participant between 0-24. Zero denotes the participant has the least affirmation and 24 denotes the participant has a strong affirmation of their gender identity. Strong affirmation means that the TGD person felt affirmed in their gender identity, gender expression, pronouns were respected, could "pass" regarding the gender identity, and whether they felt understood as a person.

Table 2

Nonaffirmation of Gender Identity Statements

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Total
I have to repeatedly explain my gender identity to people or correct the pronoun.	59 (22.2%)	49 (18.4%)	49 (18.4%)	63 (23.7%)	46 (17.3%)	266 (100%)
I have difficulty being perceived as my gender.	68 (25.6%)	40 (15.0%)	43 (16.2%)	61 (22.9%)	54 (20.3%)	266 (100%)
I have to work hard for people to see my gender accurately.	61 (22.9%)	45 (16.9%)	39 (14.7%)	60 (22.6%)	61 (22.9%)	266 (100%)
I have to be overly masculine or overly feminine in order for people to accept my gender.	61 (22.9%)	51 (19.2%)	51 (19.2%)	64 (24.1%)	39 (14.7%)	266 (100%)
People don't respect my gender identity because of my appearance or body.	62 (23.3%)	48 (18.0%)	51 (19.2%)	53 (19.9%)	52 (19.5%)	266 (100%)
People don't understand me because they don't see my gender as I do.	45 (16.9%)	43 (16.2%)	36 (13.5%)	77 (28.9%)	65 (24.4%)	266 (100%)

Note. Questions participants were asked about the affirmation of their gender identity.

Verification of the six questions used in the construction of the index variable for non-affirmation of gender identity do not suffer from multicollinearity, as indicated by Variance Inflation Factors (VIFs) less than five. Table 3 shows the results of this test.

Table 3

VIF Table for Nonaffirmation of Gender Identity

Non-affirmation of gender identity	VIF
I have to repeatedly explain my gender identity to people or correct the pronoun	2.09
I have difficulty being perceived as my gender.	4.94
I have to work hard for people to see my gender accurately.	4.11
I have to be overly masculine or overly feminine in order for people to accept my gender.	2.14
People don't respect my gender identity because of my appearance or body.	4.05
People don't understand me because they don't see my gender as I do.	3.03

Note: VIF less than 5

Figure 3 shows that although many respondents reported no incidents of non-affirmation of gender identity, the remainder of the distribution is relatively uniform.

Figure 3

Frequencies of Nonaffirmation of Gender Identity

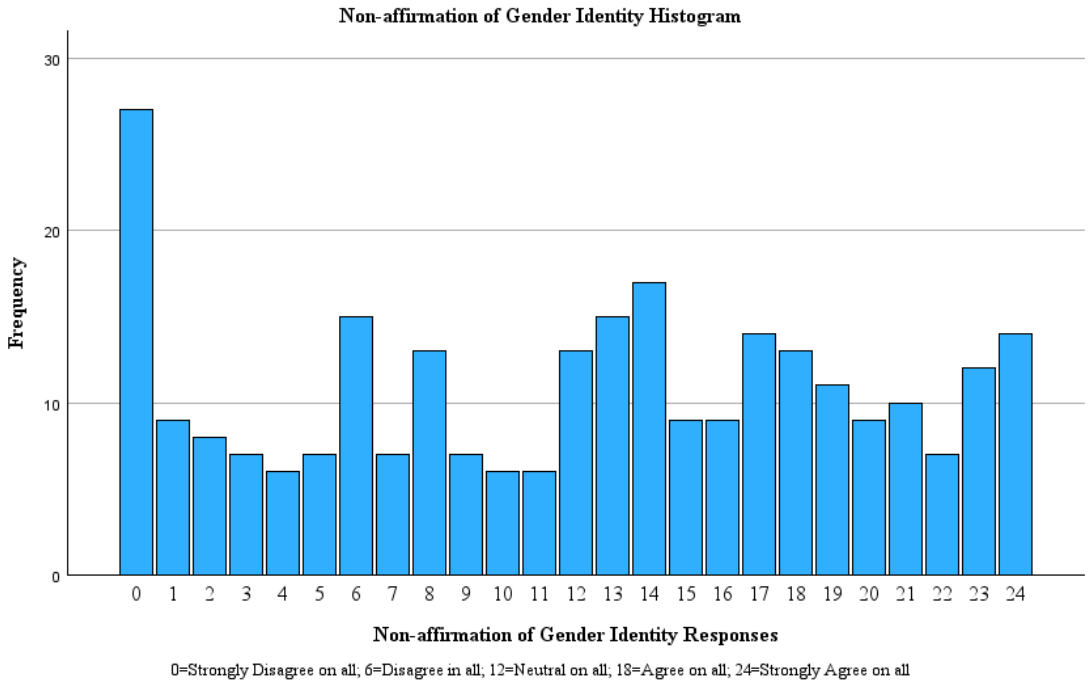


Table 4 refers to the variable of healthcare stereotype threat. Participants were given four statements using a 5-point Likert scale in which they had to state whether they "strongly disagreed, disagreed, neither agree nor disagree, agreed, or strongly agreed" to the statements. The original data set used 1 for "strongly disagree," 2 for "disagree," 3 for "neither agree nor disagree," 4 for "agree," and 5 for "strongly agree." Scores were recoded to range from 0 to 4, then added together for a single index, resulting in a recoded sum score for each survey participant between 0-16. Zero denotes the participant with the least healthcare stereotype threat, and 16 means strong healthcare stereotype threat. Strong healthcare stereotype means the TGD patient felt judged negatively,

worried about negative health interactions, receives a negative diagnosis when seeing a provider, and is a negative stereotype for the TGD community.

Table 4

Healthcare Stereotype Threat Statements

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Total
When seeking healthcare, I worry about being negatively judged because of my gender identity or sexual orientation.	31 (11.7%)	39 (14.7%)	35 (13.2%)	91 (34.2%)	70 (26.3%)	266 (100%)
When seeking healthcare, I worry that evaluations of me may be negatively affected by my gender identity or sexual orientation.	30 (11.3%)	41 (15.4%)	38 (14.3%)	94 (35.3%)	63 (23.7%)	266 (100%)
When seeking healthcare, I worry that diagnoses of me/my health may be negatively affected by my gender identity or sexual orientation.	31 (11.7%)	48 (18.0%)	47 (17.7%)	79 (29.7%)	61 (22.9%)	266 (100%)
When seeking healthcare, I worry that I might confirm negative stereotypes about LGBT people.	62 (23.3%)	60 (22.6%)	43 (16.2%)	60 (22.6%)	41 (15.4%)	266 (100%)

Note. Questions participants were asked about when seeking healthcare.

Figure 4 shows the distribution of healthcare stereotype threat shows a peak around 12, with many people reporting either no threat or maximum threat. The participants in the 0 and 16 categories were those that answered every stereotype threat question the same, with either “Strongly disagree” or “Strongly agree” on all four questions.

Figure 4

Frequencies of Healthcare Stereotype Threat

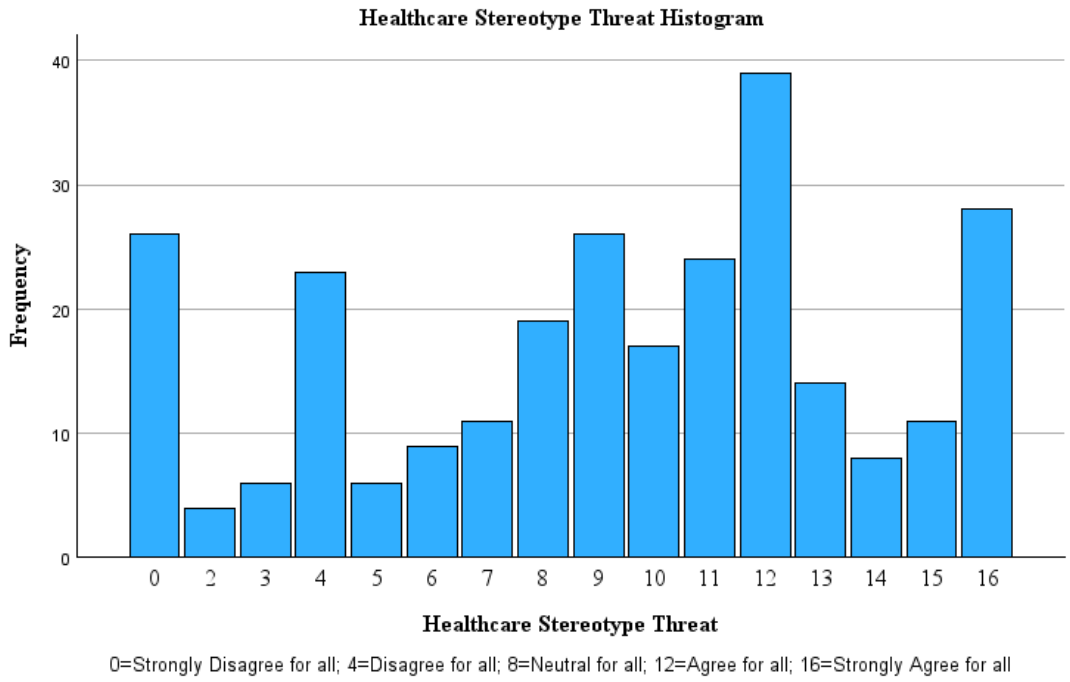


Table 5 refers to the variable of perceived employment inequities. Participants were asked about their employment status on how often the employee was fired from their job, denied a job, denied a promotion, or received a negative evaluation based on

their perception. The scale used for these statements is how often the employee was fired, denied a job or promotion, or received a negative evaluation with 1 being "never," 2 being "once," 3 being "twice," and 4 being "three or more times." Scores were recoded to range from 0 to 4, then added together for a single index, resulting in a recoded sum score between 0-8. Zero denotes the participant had no employment issues, and 6 means three or more issues such as termination, being denied a job or promotion, or receiving negative evaluations. The two variables being used to measure negative employment outcomes record the number of times fired, demoted, etc. as 0, 1, 2, or 3 or more. Even though there is no true count for people fired more than three times, these represent a relatively small portion of the sample (around 10%). The survey questions will be treated as quantitative variables by simply adding the two questions of how often the employee was denied a job or promotion, negative feedback, or fired to get a rough measure of negative employment outcomes.

Table 5

Perceived Employment Inequity Statements

	Never	Once	Twice	Three or more	Total
Since the age of 18, how often were you fired from your job or denied a job?	127 (47.7%)	40 (15.0%)	35 (13.2%)	64 (24.1%)	266 (100%)
Since the age of 18, how often were you denied a promotion or received a negative evaluation?	142 (53.4%)	50 (18.8%)	29 (10.9%)	45 (16.9%)	266 (100%)

Note. Questions participants were asked about their employment.

Figure 5 shows that although many respondents reported no perceived employment inequities, the remainder of the distribution is relatively uniform.

Figure 5

Frequencies of Perceived Employment Inequities

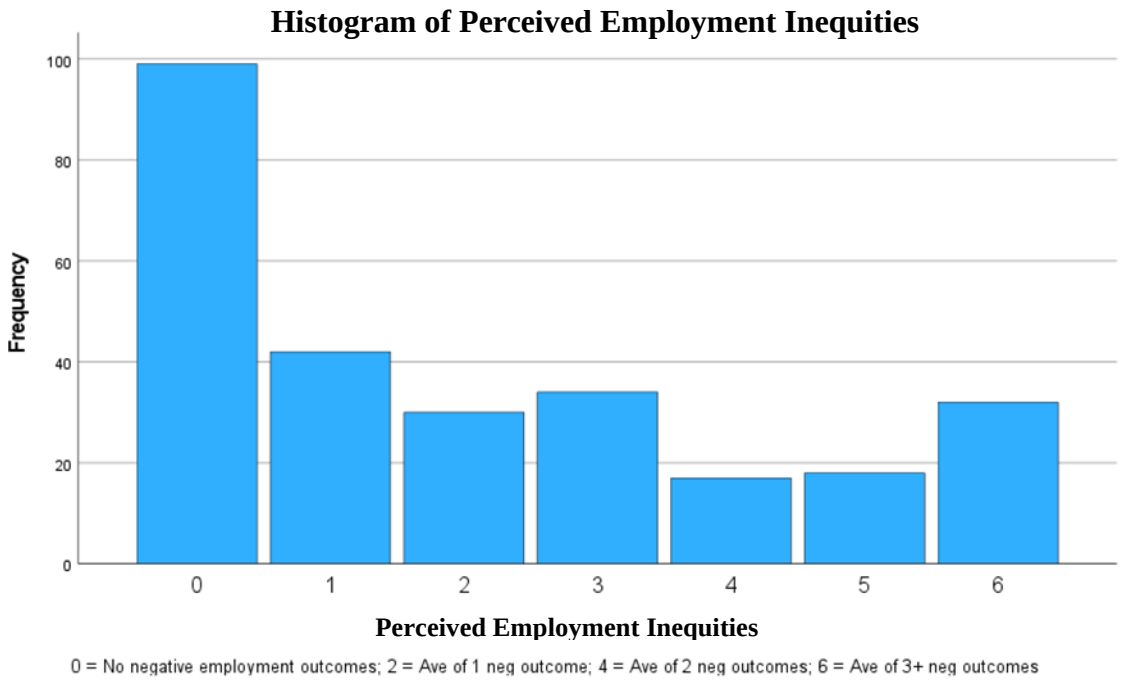


Table 6 shows the sample size for analyses is 266 since all models include non-affirmation of gender identity as the main predictor. The average index for perceived employment inequities is 2, with a median of 1, indicating that values are right skewed. Index values range from 0 to 6. Healthcare stereotype threat and non-affirmation of gender identity have means of 9.1 and 12.1, respectively, on scales from 0 to 16 and 24, respectively. Standard deviations are relatively large given the means, indicating that there is significant variation in participant responses.

Table 6

Average Respondent Experience of Variables

	Non-affirmation of gender identity	Healthcare stereotype threat	Perceived employment inequities
N	266	266	266
Mean	12.1	9.1	2.0
Median	13	10	1
Std. deviation	7.5	4.7	2.1
Minimum	0	0	0
Maximum	24	16	6

Note: Average respondent experiencing one such event of each variable.

Both research questions use simple linear regression analysis. The four assumptions for simple linear regression are (1) a linear relationship between the independent and dependent variables; (2) no non-linear pattern exists in the residuals relative to any independent variable; (3) homoscedasticity through which the residuals have constant variance at every point relative to any independent variable; and (4) the residuals in the model exhibit multivariate normality.

RQ1: What is the Relationship Between Non-Affirmation of Gender Identity and Healthcare Stereotype Threat?

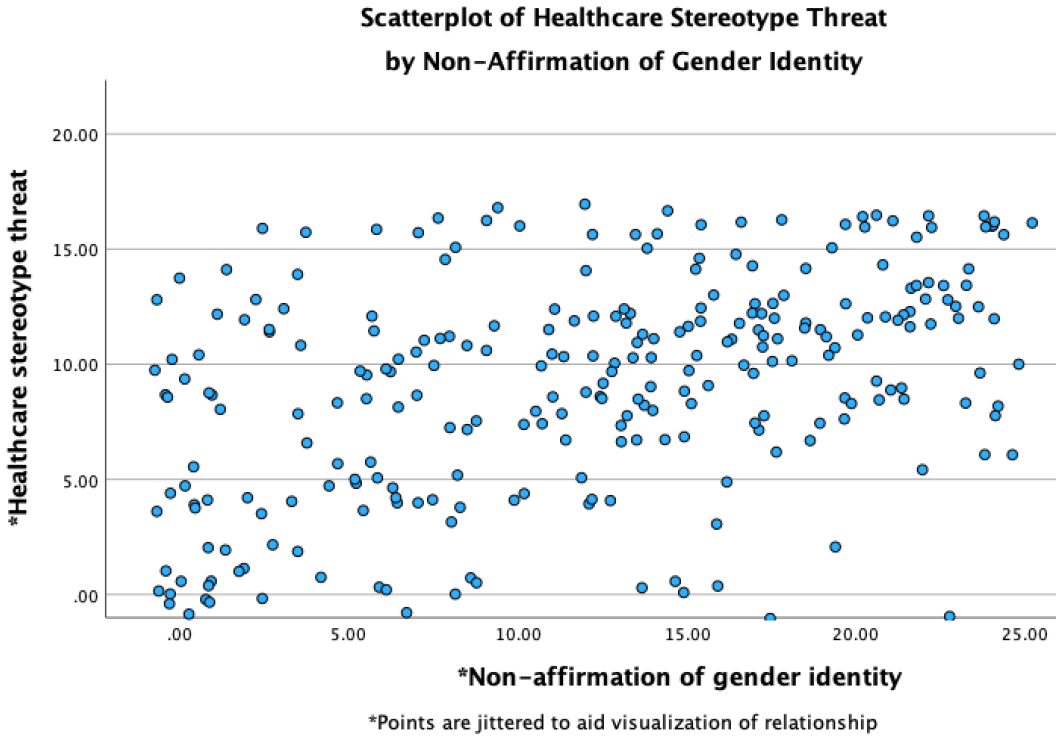
Assumption 1

The first assumption of a simple linear regression is that the relationship between the predictor and the outcome is linear. Therefore, for the first assumption, I needed to check to make sure the relationships between non-affirmation of gender identity and healthcare stereotype threat are best described by a straight rather than curved line.

The scatterplot of healthcare stereotype threat as a function of non-affirmation of gender identity (Figure 6) shows a weak linear relationship that is increasing.

Figure 6

Scatterplot for Nonaffirmation of Gender Identity and Healthcare Stereotype Threat



Assumption 2

The second assumption states that the relationship between the predictor and the errors should not show any curved pattern. Because the mean of the errors is zero by construction, the correlation between the predictors and the residuals will always be zero. But the relationship can still be curved if the model over- or under-estimates the outcome for low values of the predictor but not for high values, or not for medium values.

Assumptions 3

The third assumption states that the relationship between each predictor and the errors should be homoscedastic, meaning the error terms are of similar magnitude regardless of the value of the predictor. Homoscedasticity is visually checked by looking for a funnel shape to residuals, which would suggest that the model does a better job for low values of the predictor than for high values, or vice versa.

Both of these assumptions can also be checked in the scatterplot shown in Figure 6 because the error terms are based on only one predictor. Therefore, if there is no curved relationship between non-affirmation of gender identity and healthcare stereotype threat, there will also be no curved relationship between non-affirmation of gender identity and the error terms. Likewise, there is no funnel shape to the points shown in the scatterplot in Figure 6, which indicates homoskedasticity. Hence, Assumptions 2 and 3 are satisfied.

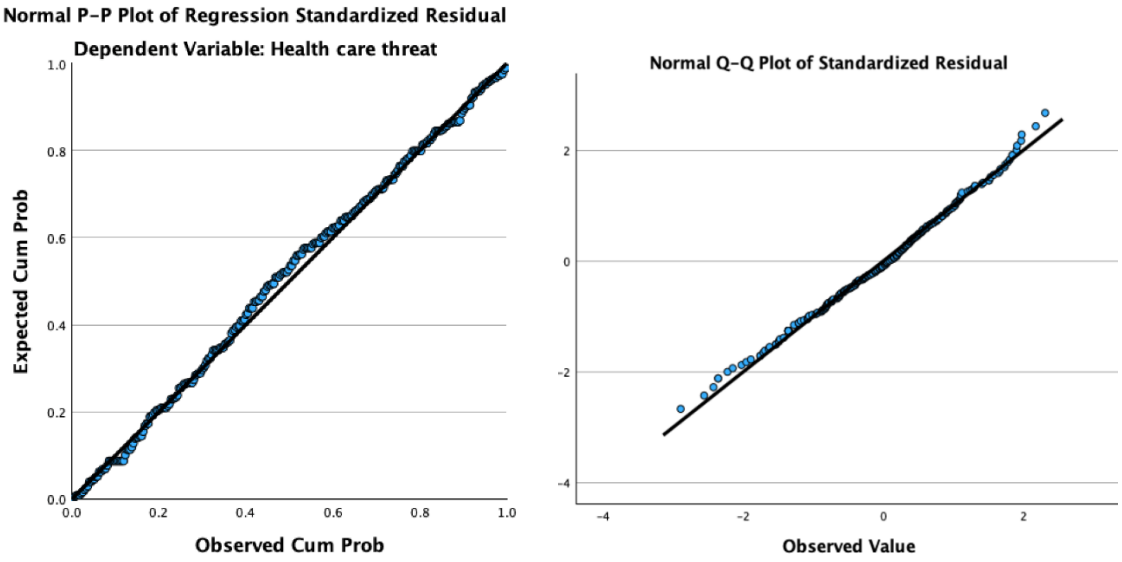
Assumption 4

The fourth assumption is that the residuals show normality. This is shown through a P-P or Q-Q plot, which shows the observed error terms, ordered from most negative to most positive, compared to the expected values of error terms if they are normally distributed. We visually inspect how close the points are to a straight line, which indicates perfect normality. The P-P plot shows cumulative probabilities and is hence more sensitive to deviations from normality in the center of the distribution. The Q-Q plot shows quantiles and is hence more sensitive to deviations in the tails.

Both plots for the model predicting healthcare stereotype threat (Figure 7) indicate that the residuals are normally distributed, shown by the adherence of the expected normal distribution of the residuals to the observed errors.

Figure 7

Normal P-P and Q-Q Plots of Residuals—Healthcare Stereotype Threat



Note: Figures show the straight line for normality of residuals of the independent and dependent variables.

To approach RQ1 (What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?), a simple linear regression analysis was conducted to evaluate the prediction of healthcare stereotype threat from non-affirmation of gender identity. The results of the linear regression analysis (Table 7-9) revealed non-affirmation of gender identity to be a statistically significant predictor of the model ($p <$ .001), shown in Table 9. The regression coefficient [B = .281, 95% C.I. (.213, .349), $p <$ .001] associated with non-affirmation of gender identity suggests that with each

additional point on the 24-point composite scale (Table 2) indicating non-affirmation of gender identity, the healthcare stereotype threat increases by approximately 0.287 units on the composite scale ranging from 0 to 16 units (Table 4).

The R^2 value of .496 (Table 7) associated with this regression model suggests that the non-affirmation of gender identity accounts for 49.9% of the variation in healthcare stereotype threat, which means that 50.1% of the variation cannot be explained by non-affirmation of gender identity alone. Based on these results, the null hypothesis, that there is no association between the degree of non-affirmation of gender identity and healthcare stereotype threat, can be rejected. This is support for the alternative hypothesis that the intensity of non-affirmation of gender identity one experiences increases the likelihood of healthcare stereotype threat.

Table 7

Model Summary for Nonaffirmation of Gender Identity and Healthcare Stereotype Threat

Model Summary[a]

Model	R	R Square	Adjusted R square	Std. error of the estimate
1	.499[a]	.202	.199	4.21281

[a.] Predictors: (Constant); Non-affirmation of gender identity

[b.] Dependent Variable: Healthcare stereotype threat

Table 8 shows that the model proposed predicting healthcare stereotype threat as a function of non-affirmation of gender identity performs statistically significantly better than the null model, which simply estimates healthcare threat as the sample mean ($F = 66.642$, p-value $< .001$).

Table 8

ANOVA Test for Nonaffirmation of Gender Identity and Healthcare Stereotype Threat

ANOVA[a]

Model		Sum of squares	df	Mean square	F	Sig.
1	Regression	1182.750	1	1182.750	66.642	<.001[b]
	Residual	4685.400	264	17.748		
	Total	5868.150	265			

a. Dependent Variable: Healthcare stereotype threat

b. Predictors: (Constant); Non-affirmation of gender identity

Table 9 shows the average index for healthcare stereotype threat is 5.72. All else equal, for each additional point of increase in the non-affirmation of gender identity experienced by trans participants in the survey, health care stereotype threat increases by 0.281 points (t = 8.163, p-value < .001).

Table 9

Coefficients for Nonaffirmation of Gender Identity and Healthcare Stereotype Threat

Coefficients[a]

	Unstandardized B	Coefficients std. error	Standardized coefficients beta	t	Sig.
(Constant)	5.72	.490		11.673	<.001
Non-affirmation of gender identity	.281	.034	.449	8.163	<.001

a. Dependent Variable: Perceived employment inequities

RQ2: What is the Relationship Between Non-Affirmation of Gender Identity and Perceived Employment Inequities?

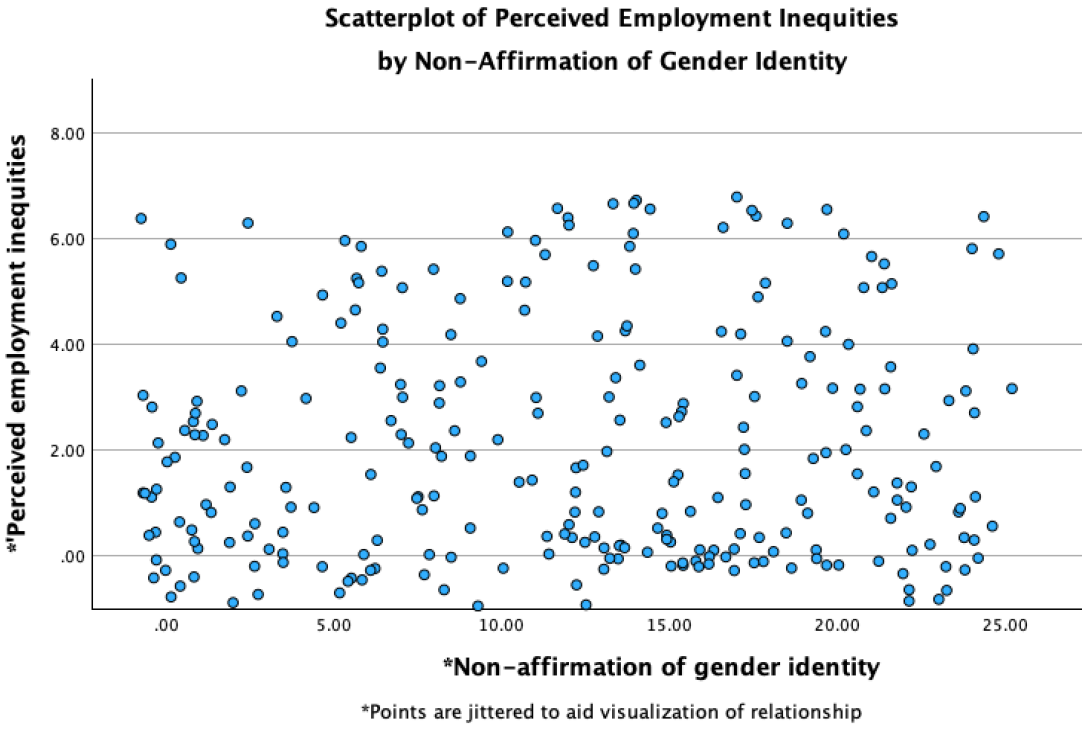
Assumption 1

The first assumption of a simple linear regression is that the relationship between the predictor and the outcome is linear. Therefore, for the first assumption, I needed to check to make sure the relationships between non-affirmation of gender identity and perceived employment inequities are best described by a straight rather than curved line.

The scatterplot of perceived employment inequities as a function of non-affirmation of gender identity shows no relationship, linear or otherwise (Figure 8). The first assumption is satisfied because the relationship is not of a higher order.

Figure 8

Scatterplot of Nonaffirmation of Gender Identity and Perceived Employment Inequities



Assumption 2

The second assumption states that the relationship between the predictor and the errors should not show any curved pattern. Because the mean of the errors is zero by construction, the correlation between the predictors and the residuals will always be zero. But the relationship can still be curved if the model over- or under-estimates the outcome for low values of the predictor but not for high values, or not for medium values.

Assumptions 3

The third assumption states that the relationship between each predictor and the errors should be homoscedastic, meaning the error terms are of similar magnitude regardless of the value of the predictor. Homoscedasticity is visually checked by looking

for a funnel shape to residuals, which would suggest that the model does a better job for low values of the predictor than for high values, or vice versa.

Both assumptions can also be checked in the scatterplot shown in Figure 8 because the error terms are based on only one predictor. Therefore, if there is no curved relationship between non-affirmation of gender identity and perceived employment inequities, there will also be no curved relationship between non-affirmation of gender identity and the error terms. Likewise, there is no funnel shape to the points shown in the scatterplot in Figure 8, which indicates homoskedasticity. Hence, Assumptions 2 and 3 are satisfied.

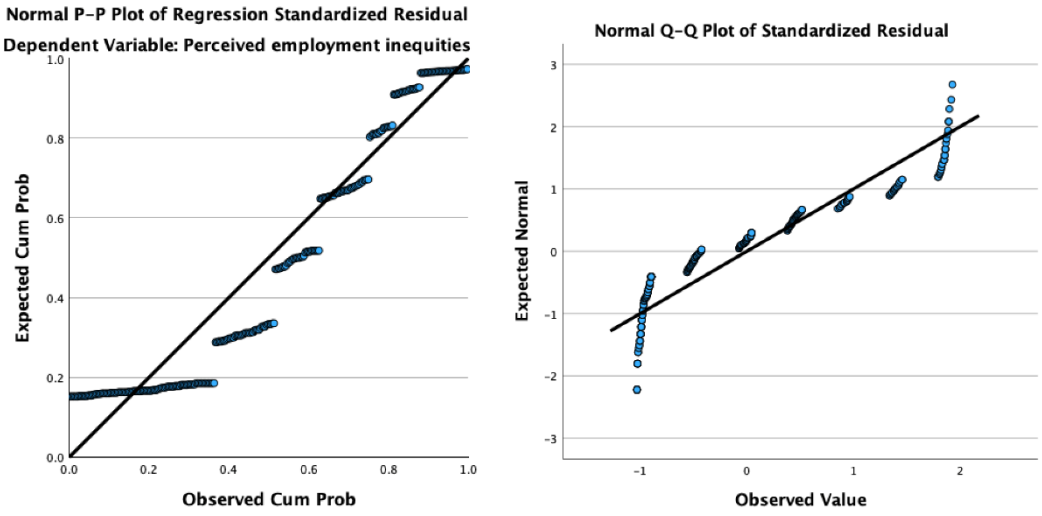
Assumption 4

The fourth assumption is that the residuals show normality. This is shown through a P-P or Q-Q plot, which shows the observed error terms, ordered from most negative to most positive, compared to the expected values of error terms if they are normally distributed. I visually inspected how close the points are to a straight line, which indicates perfect normality. The P-P plot shows cumulative probabilities and is hence more sensitive to deviations from normality in the center of the distribution. The Q-Q plot shows quantiles and is hence more sensitive to deviations in the tails.

Both plots (Figure 9) for the model predicting perceived employment inequities indicate that the residuals are leptokurtic, meaning that the error terms are more narrowly distributed around zero than would be expected in a normal distribution. Despite this deviation from the expectation, linear regression is fairly robust to violations of the fourth assumption, provided that the first three assumptions hold (Freedman, 2005).

Figure 9

Normal P-P and Q-Q Plots of Residuals—Perceived Employment Inequities



To approach RQ2 (What is the relationship between non-affirmation of gender identity and perceived employment inequities?), a simple linear regression analysis was conducted to evaluate the prediction of perceived employment inequities (Table 5) from non-affirmation of gender identity. The results of the linear regression analysis (Tables 10-12) reveal that non-affirmation of gender identity not to be a statistically significant predictor of the model (p = .50), as shown in Table 12. The regression coefficient [B = .012, 95% C.I. (-.022, .046), p = .495] associated with non-affirmation of gender identity suggests that with each additional point on the 24-point composite scale (Table 2) indicating non-affirmation of gender identity, I cannot say whether perceived employment inequities will increase or decrease.

The R^2 value of [0.042] (Table 12) associated with this regression model suggests that non-affirmation of gender identity accounts for only 4.2% of the variation in healthcare stereotype threat, which means that 95.8% of the variation cannot be explained by non-affirmation of gender identity alone. The confidence interval of (-.022, .046) for non-affirmation of gender identity associated with the regression analysis contains 0, which means the null hypothesis, there is no association between the degree of non-affirmation of gender identity and perceived employment inequities, cannot be rejected.

Table 10

Model Summary for Nonaffirmation of Gender Identity and Perceived Employment Inequities

Model Summary[a]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.042[a]	.002	-.002	2.12867

[a.] Predictors: (Constant); Non-affirmation of gender identity
[b.] Dependent Variable: Perceived employment inequities

Table 11 shows the model proposed predicting negative employment outcomes as a function of non-affirmation of gender identity does not perform statistically significantly better than the null model, which simply estimates negative employment outcomes as the sample mean (F = .467, *p*-value =. 495).

Table 11

ANOVA Nonaffirmation of Gender Identity and Perceived Employment Inequities

ANOVA[a]

Model	Sum of Squares	df	Mean Square	F	Sig.

1	Regression	2.114	1	2.114	.467	.495[b]
	Residual	1196.251	264	4.531		
	Total	1198.365	265			

a. Dependent Variable: Perceived employment inequities
b. Predictors: (Constant); Non-affirmation of gender identity

Table 12 shows the average index for perceived employment inequities is 1.91. Non-affirmation of gender identity does not have a statistically significant impact in this sample. Although the coefficient for non-affirmation of gender identity suggests that for each additional point of increase in the non-affirmation of gender identity experienced by trans participants in the survey, perceived employment inequities increase by 0.012 points (t = .683, p-value = .495). However, because the p-value is quite large, it cannot be determined whether non-affirmation of gender identity has a positive, negative, or no impact on perceived employment inequities.

Table 12

Coefficients for Nonaffirmation of Gender Identity and Perceived Employment Inequities

Coefficients[a]

	Unstandardized B	Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.
(Constant)	1.905	.248		7.694	<.011
Non-affirmation of Gender Identity	.012	.017	.042	.683	.495

a. Dependent Variable: Perceived employment inequities

There were two emerging hypotheses from the data analysis. The results show that more research is needed surrounding the TGD community when looking specifically at perceived employment inequities. The question is not, “Is there discrimination,” but

rather, “What level of discrimination does the TGD community face versus their cisgender coworkers?”

Summary

The purpose of this quantitative retrospective quasi-experimental study was to examine whether there is a relationship between the non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities concerning employees in healthcare systems and organizations. The exploratory data analysis was performed to present the characteristics of the data sets.

The results of RQ1 (What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?) showed that non-affirmation of gender identity is a statistically significant predictor of healthcare stereotype threat. The null hypothesis (there is no relationship between non-affirmation of gender identity and healthcare stereotype threat) was rejected. The alternative hypothesis (a relationship exists between non-affirmation of gender identity and healthcare stereotype threat) was accepted. RQ2 (What is the relationship between non-affirmation of gender identity and perceived employment inequities?) showed that non-affirmation of gender identity is not a statistically significant predictor of perceived employment inequities. The null hypothesis (there is no statistically significant relationship between non-affirmation of gender identity and perceived employment inequities) was retained. The alternative hypothesis (there is a statistically significant relationship between non-affirmation of gender identity and perceived employment inequities) was rejected. Section 4 discusses the conclusions of the study and the possible reasons for the outcomes described in this section.

Limitations of the research and the shortcomings that were encountered during the investigation will also be described. The section then provides a discussion on the recommendations for future research, theory, and practice. The final section is then concluded with a summary of the completed study.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of this quantitative retrospective quasi-experimental study was to examine whether there is a relationship between the non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities concerning employees in healthcare systems and organizations. The nature of this study was to address the research questions to investigate the correlation between non-affirmation of gender identity, healthcare stereotype threat, and employment using secondary data from the TransPop survey. This study is significant in that it fills in the gaps in the current literature to extend knowledge of awareness and provide more support to the TGD community in healthcare organizations, creating positive social change.

Through the secondary data analysis that was conducted, RQ1 (What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?) showed that non-affirmation of gender identity is a statistically significant predictor of healthcare stereotype threat. RQ2 (What is the relationship between non-affirmation of gender identity and perceived employment inequities?) showed that non-affirmation of gender identity is not a statistically significant predictor of perceived employment inequities.

Interpretation of the Findings

The data analysis findings expanded the literature review in Section 1. The major themes found throughout the exhaustive literature review were as follows: TGD discrimination in healthcare environments, gender identity affirmation, bias in healthcare,

cultural norms surrounding cisgenderism, and the need for more education. The current literature identified in the literature review in Section 1 provided an overview of barriers to TGD patients in healthcare organizations; however, there was little to no literature on personal awareness focusing on non-affirmation of a patient and employees' gender identity and ways to prevent harm to TGD patients and employees in healthcare. The results of this study expand the findings from prior studies in which it examined the impact of affirmation of the gender identity of patients and employees in healthcare organizations. The specific aspects have not been addressed in prior research. The focus on healthcare organizations, through the TransPop data set, concerning TGD patients and employees was due to the lack of research done. The conducted analysis adds to the literature by identifying the relationship between the independent and dependent variables in RQ1.

In terms of the theoretical framework, the study's findings align with the Sexual citizenship theory by rights of civil society, such as a person's right to work and seek healthcare for those who identify as TGD. Through this model, healthcare organizations can evaluate their current structure and processes, such as how TGD patients and employees access affirming care and have an affirming workplace. Sexual citizenship theory is applicable and can be used to make sense of the literature review and data analysis. However, there is no statistical significance between the non-affirmation of gender identity and perceived employment inequities, as shown in Figure 9.

The scope of the study allowed for analysis and interpretation of the data provided in the secondary quantitative dataset. The findings showed no statistically significant

relationship between non-affirmation of gender identity and perceived employment inequities; however, there was a statistically significant relationship between non-affirmation of gender identity and healthcare stereotype threat.

Limitations of the Study

The limitations of this study included data, analysis, and the variable chosen such as non-affirmation of gender identity versus gender identity. The TransPop survey was conducted from 2016-2018, in the United States, through Gallop. Disclosure and privacy safety are always a concern in the TGD community. Additionally, many of the data collection surveys rely on self-reported data from the TGD individual and therefore may not always be accurate as there is a possibility for bias by the TGD individual due to prior trauma and past discrimination. RQ2 examined the non-affirmation of gender identity and perceived employment inequities but using this independent variable the results focused strictly on TGD individuals. The use of gender identity as the independent variable in RQ2 would have examined the relationship between cisgender and TGD employees regarding perceived employment inequities with possible statistical significance.

The results of this study may not be representative of all TGD individuals across the United States. The determinants of health may vary from state to state depending on anti-transgender laws and acceptance. The potential for generalizability was considered but well understood that TGD participants are not all treated equally or receive acknowledgment for their gender identity across healthcare organizations, whether the organization is culturally competent and affirming. This is due to conducting an initial assessment to identify the participant's safety in disclosing and sharing experiences as

both a patient and an employee. Data about cisgender individuals were not used in this study even though they were a part of the original survey. The data relationship of the TGD and cisgender community with perceived employment inequities could have expanded understanding of the inequities faced by the TGD community.

Recommendations

In this study, non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities were examined from the TransPop data set. Recommendations for further research include quality of care for the TGD community when their identity is not affirmed, analysis of transwomen and transfeminine individuals around affirmation in healthcare treatment and employment inequities, and ways healthcare administration tackles healthcare stereotype threats concerning the TGD community. There is a lack of research surrounding euphoria in the TGD community when seeking care or employment in healthcare in affirming environments.

This study was hindered by secondary data analysis and constraints of questions asked to the participants. Research can examine how LGTBQI+ organizations and their administrators best serve the TGD using their best practices to springboard better long-term solutions to health disparities, bias, and discrimination. Research using holistic solutions to provide care and social support for the TGD community.

Additional research is needed that focuses on how healthcare organizations tackle bias around the TGD community in the long term. There are plenty of examples of how healthcare organizations are harming the TGD community but fewer that are creating safe and affirming environments for the TGD community. Further research can examine ways

that affirming space has improved the health and well-being of the TGD community through ongoing cultural competency training, policy changes, affirmation by senior leadership staff, and acceptance of gender identity.

Implications for Professional Practice and Social Change

Due to the ongoing anti-transgender legislation that is sweeping across the United States, healthcare professionals struggle to best serve their TGD patients. Some healthcare organizations are faith-based (Khaikin & Uttley, 2016) adding challenges of religious beliefs to overshadow the care needs of the TGD community. Based on the review of literature as mentioned in section one and the literature review, theoretical framework, and analysis developed by this research, the study recommends several changes to professional practice. The following suggestions are aimed at improving the overall healthcare environment for TGD patients and employees in the United States.

First, it is recommended that healthcare administrators and healthcare leaders review policy around cultural competency, how biases are addressed, and how safe and affirming the organization is. Education for all healthcare staff is a resounding theme in the literature. Instruction recommendations are ongoing training on understanding bias and intersectionality of identities, how to affirm the gender identity of all staff cisgender and transgender, and trauma-informed care and support (Boot-Haury, 2023). While these training courses are not intended to be a fix, they can serve as a foundation for social change and provide safer spaces with empathy and compassion for all who receive care and come to work. The training requires that all staff working in healthcare environments receive training that helps them create social and cultural change in the organization.

In addition to these recommended changes, promoting spaces where patients and employees can be their authentic selves and not have to conform to binary rules supports the TGD community. This requires patients and their families, staff, and volunteers to enter the healthcare environment as themselves. This authenticity requires medical records to reflect their gender identity and sexual orientation. Additionally, it opens space to treat the whole patient including their family, homelessness, and lifestyle, not just symptoms. Understanding and support of the patient and staff is more than just their level of status in the organization. It will require every staff member from the CEO down to entry-level staff members to ensure they are asking for and honoring the identities of patients and staff through advocacy for every person.

Finally, healthcare organizations could lead the charge of ensuring equity by speaking up against laws based on misconceptions and myths surrounding the TGD community. Connecting with state and local legislators as a proponent for laws that support and ensure the TGD community. Additionally, being a vocal advocate of the TGD community that they serve can be achieved by scoring high on the Health Equity Index through organizations like the Human Rights Campaign.

Future recommendations for research could include looking at the relationship between gender identity and perceived employment inequities. This study showed that there is a statistically significant relationship between the non-affirmation of gender identity and healthcare stereotype threat showing a correlation of discrimination in healthcare. The difference between being cisgender and transgender can lead to whether a person is hired or fired at their workplace requiring employers to take action to stop harm

in their workplace. Another recommendation for research could include gender identity, age, and perceived employment inequities. As the TGD community continues to age, how will that affect their job status and discrimination?

Conclusions

The review of literature, theoretical framework, and analysis from this study establishes the relationship between non-affirmation of gender identity and healthcare stereotype threat. The purpose of this quantitative retrospective quasi-experimental study was to examine whether there is a relationship between the non-affirmation of gender identity, healthcare stereotype threat, and perceived employment inequities that TGD employees face in healthcare systems and organizations. The questions that were used to address the research problem identified in the purpose of the study were as follows:

RQ1: What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?

RQ2: What is the relationship between non-affirmation of gender identity and perceived employment inequities?

The reason the study was conducted, the key findings, interpretations, limitations of the study, recommendations for future research, applications to professional practice, and implications for social change have been reviewed.

Through the literature review, discrimination and bias around gender identity require additional consideration with ways of addressing and improving the needs of the TGD community in healthcare. The bias and harm from not being affirmed spill over into the employment status of the TGD individuals working in healthcare organizations.

Through the secondary data analysis that was conducted, RQ1 (What is the relationship between non-affirmation of gender identity and healthcare stereotype threat?) showed that non-affirmation of gender identity is a statistically significant predictor of healthcare stereotype threat. RQ2 (What is the relationship between non-affirmation of gender identity and perceived employment inequities?) showed that non-affirmation of gender identity is not a statistically significant predictor of perceived employment inequities. Through the theoretical framework, this study's findings align with the sexual citizenship theory by rights of civil society in which a person's right is to work and seek healthcare for those who identify as TGD. With this model, healthcare organizations must examine the rights of their patients and employees ensuring that they are affirming to everyone who enters their doors.

This study's findings have impacts on positive social change as it relates to the TGD and healthcare organizations. This study is significant in that it can help to identify ways healthcare administrators can ensure the safety of their patients and employees within the organization and reflect those they serve. Recommendations for further research include how healthcare organizations tackle bias around the TGD community long-term. Further research can examine ways that affirming space has improved the health and well-being of the TGD community and the acceptance of gender identity for all people.

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