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The Experience of Transitioning for the Transgender Person: An Appreciative Inquiry Approach to Advance Gender Affirming Care

By

Shelley Evans

A Dissertation
Submitted to the Faculty of Graduate Studies
through the Faculty of Nursing
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy
at the University of Windsor

Windsor, Ontario, Canada

2023

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The Experience of Transitioning for the Transgender Person: An Appreciative Inquiry Approach to Advance Gender Affirming Care

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DECLARATION OF ORIGINALITY

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ABSTRACT

Background. The process of transitioning has a significant impact on improving quality of life among transgender and nonbinary people (Johansson et al., 2010). Transitioning is the act of moving towards a gender identity that feels more aligned with internal identity (Rankin & Beemyn, 2012). However, despite promising research that supports the benefits of medical, social and/or legal transitioning, the understanding of the experience has not been fully explored (Evans et al., 2021), and it is a barrier to advancing the delivery of gender affirming care among nurses, other health care providers, and health care organizations. There is a need to awaken new ways of understanding the transitioning process from the perspective of the non-cisgender person that informs and strengthens supports for the transgender and nonbinary community.

Purpose. The purpose of this study was to gain insight into the experience of the process of transitioning for transgender people from a strength-based perspective.

Method. A qualitative, interpretive descriptive methodology using the Appreciative Inquiry approach was used for this study. Interviews from 14 transgender people who were seeking transition, engaged in transition, or had completed the process were analyzed.

Results. The four main themes revealed were: 1) having responsive gender-affirming health care, 2) social gender affirmation, 3) support, and 4) transitioning on my own terms. There was a pervasive tension between the

positive and negative narratives. Nurses positively influence the experience of transition through demonstrations of understanding and advocacy.

Conclusion. Findings of this study inform positive actions that support a positive process of transitioning for transgender and nonbinary people. To advance gender affirming care, nurses, health care providers, and health care organizations must advocate for and deliver trans competent care that is responsive, supportive, and flexible in meeting the needs of non-cisgender people. This study may contribute more broadly to the beginning of a universal normalization and shift in societal and systemic cis-normative standards towards a world where living the authentic self is healthy and free of the fear of rejection.

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CHAPTER 1

INTRODUCTION

Every health care professional, including nurses, will eventually encounter a transgender or gender non-conforming patient in their practice (Ettner et al., 2006; Stroumsa**,** 2014; Watts et al., 2017). The word *trans, is* an umbrella term for anyone whose gender differs from their sex assigned at birth including transgender, Two-Spirit, nonbinary, or simply male or female (Bonvicini, 2017). The process of transitioning is the act of moving away from the gender identity one is biologically born with towards one that feels more congruent with internal identity (Rankin & Beemyn, 2012). Members of the transgender population may choose to affirm their gender identity through the experience of transition and studies have found health care providers who support the process have the potential to impact an individual's experience in a life-saving way (Dorsen et al., 2022).

The literature reveals that transitioning is beneficial and leads to an improvement in general well-being for the transgender population (Johansson et al., 2010). Health care resources to support transitioning has had positive effects on body satisfaction and body image and has lessened the degree of gender dysphoria, which is defined as the incongruence with the gender identity and sex assigned at birth (Ainsworth & Spiegel, 2010; Van De Grift et al., 2017). Studies have shown that adolescence is a critical developmental period, and if questioning one's gender identity is added to their personal identity development, may become a period of transgender emergence that involves transitioning considerations (Tatum et al., 2020). Through the exploration of transgender youths' experiences of transitioning, the process has been identified as a coping strategy

used by children to deal with growing up within the societal gender order ideology (Travers, 2019). Health care systems are experiencing an increase in child and adolescent referrals to clinics that specialize in transgender competent care (Dodson & Langer, 2019; Steensma & Cohen-Kettenis, 2011; Zurada et al., 2018).

In Canada, approximately 0.33% or 100,000 people, 15 years of age and over, identify as transgender and/or nonbinary (Statistics Canada, 2021). Canada's government recognizes the rights of transgender people through the building of policies and passing of laws that support the understanding that there are many different genders, gender identities and gender expressions (Eidinger, 2021). Canada is a progressive nation that recognizes the dignity of transgender and gender diverse people and their transitioning needs (CPATH, 2020). Canada's position on the recognition of the transgender population is reflected in it's claim as being the first country to collect census data on transgender and nonbinary people using questions that expand sex and gender information (Statistics Canada, 2021). Despite this progress, the westernized, binary idea of only woman and man remain strong where almost 75% of non-cisgender people experience some form of harassment/violence because of transphobic attitudes (Eidinger, 2021; Trans PULSE, 2020). Although there is an increasing presence of literature in medicine/nursing education to increase knowledge around health care of the transgender person in North America (Dubin, et al., 2018; Evans et al., 2021), Canada is currently ineffectively meeting the primary health care needs of the population and barriers to knowledgeable practitioners, medications and surgeries for medical transition exist (Ziegler et al., 2020).

Research has found nurses are aware of the transitioning process but have limited knowledge and continue to express discomfort when caring for transgender people (Carabez et al., 2016; Samuels et al., 2018). A phenomenon known as *betrayal trauma* can occur if a health care provider is perceived to respond in a judgemental or discriminatory way toward a LGBT patient (Burton et al., 2020). Burton et al. (2020) further explained that if a transgender person seeking support for transitioning encountered a judgemental nurse, access to health care services may be viewed as threatened or at-risk as nurses tend to be the first point of contact in hospitals and clinics.

The World Health Organization considers suicide to be a global concern and attributes this to the high exposure rates of stigmatization, discrimination, and violence towards the transgender population (Thomas et al., 2017; WHO, 2015). According to TransPulse, an Ontario, Canada community-based research group, 43% of the transgender population attempt suicide due to an inability to access health care and because of feelings of isolation (Scheim et al., 2014). More recent statistics in Ontario recognize the problem continues to persist with transgender and nonbinary youth, age 14 to 24, where one in three youths considered suicide and one in 20 attempted suicide (TransPulse, 2020). The highest risk for suicide is when transgender individuals are contemplating transitioning but have not yet begun the process (Bauer et al., 2013; Bourns, 2015; Trans PULSE, 2020).

1.1 Significance

A supportive environment from health care providers regarding the transitioning process has emerged as one of the key preventative factors of suicide (Bailey et al., 2014). Therefore, it is imperative that nurses provide wholistic, non-discriminatory care

to all transgender people. The U.S. National Transgender Discrimination Survey found that those who provide health care lack expertise in transgender health, avoid and/or resist caring for transgender patients (Grant et al., 2011; Ziegler et al., 2021). To begin, gaining insight into the lived experience of the process of transitioning is a start to acquiring knowledge for nurses. Nurses need to recognize the positive influence and key role they may play in facilitating care among transgender clients contemplating a transition. Nurses have the acquired knowledge on screening and identifying risk factors for suicide in patients of various populations (Valente, 2010) but nursing literature is slow in providing health related education specific to the 2SLGBTQQIA community of which transgender people are a part (Dykhuizen et al., 2022). Therefore, a secondary goal of this study was to contribute knowledge that could inform changes within the health care system for promoting safe care that is trans competent by gaining insights from transgender people about their experiences of the transitioning process (Boroughs et al., 2015).

Limitations in facilitating the transitioning process and providing consistent care are blamed on the lack of research and ability to acquire knowledge in the field of transgender health (McRee et al., 2018; Rosendale et al., 2018; Whyatt-Sames, 2017). Nurses have made research efforts to identify attitudes and biases towards the LGBTQ2+ population within their practice, yet in advocating for the unique needs of the transgender population, many in the profession remain silent and confused (Beagan et al., 2012; Bonvicini, 2017). The significance of this research for the profession of nursing and all those who provide health care lies in the need for knowledge on the topic of the transition experience for transgender people. Gaining insight into the experience of transitioning is

a foundational first step towards future development of policies, structural supports, and educational initiatives to support transgender health and transitioning needs. Ultimately, the positive influence may lie in identifying and supporting those who are questioning their gender and seeking to start the transitioning process.

1.2 Study Purpose

The purpose of this research was to gain insight in the lived experience of the process of transitioning for transgender people. This insight may move the profession of nursing forward towards substantiating the need to develop culturally safe care towards trans competency within nursing practice for education and training with gender and sexually diverse people (Rew et al., 2022). Cultural safe care attempts to address power imbalances existing in the health care system towards an environment free of discrimination where people feel safe when receiving care (Browne et al., 2009). A potential to acknowledge and address the discriminatory and unwelcoming health care spaces the systems have created for transgender people seeking to transition may also rise to the forefront as an imperative mandate for nurses.

1.3 Philosophical and Theoretical Perspectives

In this study, I took the standpoint that the process of how an individual's understanding of themselves through gender exploration is an experience that is defined by the individual's own perceptions of themselves and the social-cultural influences surrounding them. A qualitative approach to collecting data for this study was chosen for its' ability to awaken new ways of understanding, provide more insight for the conscience mind, allow for an understanding of what is an enigma beforehand and find the significance in that understanding (Munhall, 2012). Given the continually evolving

terminology for the transgender population as discussed in the literature review, I believe the English language fails when attempts are made to explain the process of transitioning because conflicting terminology persist despite attempts to define the term transgender, nonbinary or other umbrella terms to explain transitioning (Darwin, 2020). This lack of appreciation for *being trans* reinforces the need to search for the meaning of authentically living one's gender identity from the perspective of the non-cisgendered person who is experiencing this way of being in the world.

1.3.1 Social Constructivism

This study is based in a social constructivist philosophy where society seeks meaning of the world through the development of diverse ideas or constructs (Creswell, 2014). Social constructivists create meaning through multiple realities of lived experiences and social interconnections (Cooperrider et al., 2008). The goal of social constructivism is to understand a situation through reliance on an individual's views foremost and seeks to understand the complexity of these views rather than narrowing things into fewer categories (Creswell, 2014). This goal aligned with the study's stance that the process of transitioning is complex and dynamic, cannot be minimized into smaller parts or steps and deserves to be made sense of by those experiencing it.

1.3.2 Critical Social Theory

Critical social theory, whose purpose is to understand how social practices stemming from ideas or constructs have enabled oppressive social structures for the benefit of dominant groups, illuminated this phenomenon (Chinn & Kramer, 2015). Through the lens of critical social theory, a comprehensive understanding of the experience of the process of transitioning was explored and revealed unfair social

inequities experienced by the transgender population. Nurses have long been viewed as working with marginalized populations and advocating for those who are oppressed (Browne, 2000). Critical social theory addresses how power relations, such as the nurse and patient, can lead to unjust and poorer quality outcomes due to internalized biases despite everyone's best intentions (Allen, 1987).

1.3.3 Appreciative Inquiry

Appreciative Inquiry (AI) was the approach that guided this research. Although in origin, AI has predominantly been used as a process for organizational change (Cooperrider & Srivastva, 1987), there is the beginnings of its use in nursing research (Auxier, et al., 2020; Ebert et al., 2020; Moore & Charvat, 2007). AI is from the family of action research which focuses on generating new knowledge to produce change (Munhall, 2012). Action research has also been recognized with positive change when a participatory element is involved. Participatory action research involves developing partnerships with stakeholders resulting in goals to change society (LoBiondo-Wood et al., 2014). For the purposes of this study, knowledge must first be gained through careful attention to involved members experiences as a foundation to 'building the picture' for future steps that facilitate change. Seeking input from members of the transgender and nonbinary communities was one the first crucial step towards driving future change when all community stakeholders are involved, which is the premise of participatory action research (Cornwell & Jewkes, 1995).

AI's strength lies in its ability to reduce defenses and open discussion. These characteristics are particularly applicable when working with the transgender population considering the global history of victimization and criminalization against anyone who

identifies outside of the cisgender-heterosexual way of being. Another strength of AI lies in its non-reliance on a participant's literacy level or problem-solving ability as these tools were not needed which may exclude members of this population from sharing power to make change (Moore & Charvat, 2007). This study's approach did not require people to read content or interpret and resolve ideas as a requirement to participate. It has been found that the transgender community remain largely excluded from involvement in the research conducted in their communities and therefore, research is often inaccurate, lacks fullness of expression and may even be damaging (Rosenberg & Tilley, 2021). Meaningful involvement and partnerships with transgender people in research not only builds positive rapport within communities but ensures transgender representation in future recommendations. These facts reinforced the empowerment component to AI's methodology as the transgender person should rightfully be the experts to shed light on the perspectives and realities of transitioning (Reason & Bradbury-Huang, 2007).

Another strength of AI's approach and what makes this method different from other branches of action research lies in its ability to work with what is already known using positive narratives, then generating ideas for new change (Munhall, 2012). Because the transgender population has experienced a long history of oppression and marginalization, this research method allowed for people to discuss what is currently being experienced regarding their transitioning process then moving forward to future change in affirming forces or practices they would like to see. The transgender population is burdened with educating others in their health care needs with an imbalance of power created between those who dispense care and those who receive care (Faught, 2016; Redfern & Sinclair, 2014). AI attempts to address the power imbalance, by ensuring

gender affirming views are included when future change occurs. This emancipatory element AI possesses allowed the revealing of potential conditions and possibilities to improve on systemic inequities experienced by the transgender population (Munhall, 2012).

The liberating quality of AI begins with a core affirming topic question that elicited conversations toward future positive possibilities (Cooperrider et al., 2008). The core affirming topic question is the focus on which AI's following eight principles are based: (1) in every community or group something is right; (2) what is focused on becomes the reality within that group; (3) language creates the reality; (4) reality is created in the moment and there are multiple realities; (5) asking questions of the community or group influences that community or group in some way; (6) carrying parts of the past forward will give people more confidence and comfort when moving forward; (7) if we carry forward parts of the past, it should be the best parts; and (8) it is important to appreciate differences (Moore & Charvat, 2007). Choosing a positive topic to explore was the starting point for this appreciative approach and continuous questions were meant to uncover individual success stories (Cooperrider et al., 2008).

The AI approach aligns with critical social theory's interest in creating conditions where unrestricted discussions was encouraged (Allen, 1987). The appreciating approach of the questions developed created a space where participants were free to be heard, captured their views on what is right and valued, and brought to the forefront the best of what is (Cooperrider et al., 2008). For the transgender person, the sincerity and openness of another to be heard does not necessarily mean *being accepted* by another but more on *not being rejected.* For example, acceptance of a non-cisgendered identify from a health

care provider is not required to access medicalized gender transition but the necessity to surmount barriers of gatekeeping continues to persist in the health care system for transgender people (Haimsen & Veinot, 2020). The empowering element of critical social theory with AI as an approach of study, incorporated a collaborative and constructivist view by listening to voices from the transgender community through asking questions intended to gather participant's opinions towards improving the delivery of nursing care and health care overall (Rosenberg & Tilley, 2021). Evidence of AI's method of exploring the social experience for one group is evident (Ebert, et al., 2020) but AI is an initial step in participatory action research where change in healthcare involves all stakeholders (Auxier et al., 2020; Diedricks et al., 2018; Moore & Charvat, 2007). Therefore, for the purpose of this study, the focus was on one group, the transgender population, towards informing future AI initiatives involving the transgender community, the nursing profession and other health care providers, and organizations.

CHAPTER 2

REVIEW OF LIERATURE

It is imperative to recognize that many of us will never experience what it means to question the core of our being or our gender identity; therefore, the review of literature will begin at the foundational, broad topic of identifying as *other than the binary.* Consistent with the study's purpose, the aim of the literature review is to analyze what is known and to identify gaps in knowledge about the process of transitioning for the transgender population. A traditional or narrative review was used to explore, identify, and refine this broad topic where scarce research is available (Coughlan et al., 2013).

Research regarding the transgender community is relatively young and terminology is still evolving. This dissertation may refer to terminology used in older studies which is currently used as a standard in many countries. Since the study was conducted in Canada, the current terminology used in North America was primarily applied. For example, the term *trans* was used when referring to the transgender and gender non-conforming population. A glossary of terms has been included in attempt to define the most current terminology (Appendix A).

2.1 Search Strategies

The databases used for this review included CINAHL, PubMed, PsycINFO, Ovid MEDLINE, ProQuest Nursing & Allied Health Database and Google Scholar. These databases were used to procure published, peer-reviewed studies, and text documents published in the English language. Non-peer reviewed literature, grey literature published texts, Master's theses, or PhD dissertations were searched via Google Scholar and Google Alerts. If there was no direct or implicit reference to the topic of transitioning, the article

was not included. Due to the dearth of nursing literature on this topic and research on the transgender population more broadly (Shattell & Chinn, 2014), the majority of the literature used in the review was from divergent social and behavioral science disciplines other than nursing.

Keywords and phrases for search included transgender, transition, coming out, process, transsexual, gender, identity, trans*. The snowball technique was used to conduct manual searches when tracking primary sources and seminal works (Coughlan et al., 2013). The literature was analyzed to identify common themes, incongruencies in patterns and perspectives that required consideration (Baker, 2016). Quantitative, mixed method, and qualitative research methods were all included. Due to the marginalized nature of the transgender population and the difficulty of reaching this population for study, editorials and monologues were also included (Connolly et al., 2016; Redfern & Sinclair, 2014). Because of the dearth of literature specific to the transgender population (Bonvicini, 2017), literature relating to the 2SLGBTQ+ community was included as the transgender population is a subcategory within this. There were no population age limits or date ranges for study inclusion criteria due to the relative early stages of the field of transgender health.

Quality appraisal of literature involved a systematic review using the matrix method which is recognized for its ability to bring order from information spread across many sources as nursing literature was not the key majority sourced in this review (Goldman & Schmalz, 2004). Full text papers were reviewed to identify implicit reference to the process of transitioning when the label or word *transition* was not used in the title or abstract. Accuracy and credibility of material were judged as high if literature

was sourced from 2SLGBTQ+ journals, organizations, and/or members of the community as they are considered to have the greatest understanding of the process of transitioning. To improve the chances of identifying all relevant literature, titles and abstracts were screened for any direct or implicit reference to the topic of transitioning or the taking of an active stance away from the gender one is assigned at birth. Exclusion criteria included no direct or implicit reference to the topic.

Extracted text was documented on a literature matrix (Timmins & McCabe, 2005) and a subsequent matrix was used as a summary table to group together themes related to the implicit and explicit reference to the process of transitioning found within articles. The identified themes were organized into concepts with contrasts made between studies and grey literature (Braun & Clarke, 2006). As the process of transitioning is an under-researched area, themes were examined and refined to find the state of understanding of the process of transitioning in the literature.

2.2 Evolution of Literature and Terminology

2.2.1 Lack of Transgender Specific Literature

Much of the literature available on the transgender population has been consolidated or included within the larger lesbian, gay, bisexual, transgender, two-spirited, etc. (LGBTQ2+) literature (Jones, 2020; Trujillo et al., 2017). For example, a study of queer youth examined the well-being of the LGBTQ population but did not recognize well-being factors specific to transgender youth (Higa et al., 2014). A queer orientation is considered broader, intentionally ambiguous and is used to define a non-heteronormative identity (Sprott & Benoit Hadcock, 2018). This trend has minimized the transgender individual's unique and specific needs relating to their trans-related

experiences. Another study comprised of 1,948 LGBT+ participants, investigated factors associated with student mental health outcomes. Results revealed multiple factors and 'being transgender' was one (Gnan, 2019) and therefore reinforces the need for the transgender population to be studied separately (Collazo et al., 2013).

To be lesbian, gay, bisexual, etc. is reference to sexual orientation. Sexual orientation refers to how one expresses desires, beliefs, and emotions and determines the kind of activities and/or relationships that one engages in (Simpson, et al., 2017). However, to be transgender or gender non-conforming means to differ in gender identity from the biology of sex assigned at birth or to self-identify towards a distinct sex, which therefore requires clarification when selecting participants and generalizing results (Bukowski et al., 2017; Maragh-Bass, 2019). Health care providers in the position of assisting transgender clients in the navigation of challenging systems may not be able to recognize the unique needs of their clients if differentiations are not recognized in the 2SLGBTQ+ population (Riley et al., 2011).

2.2.2 Evolving Terminology

To end transgender invisibility, it is important to understand that terminology and language used to define transgenderism is dynamic (Van Duyne & Livingstone, 2019). In a study of transgender youth, results revealed that part of the individual's transitioning process is exploring appropriate labels and self-identity terminology to describe their own gender identity (Schimmel-Bristow et al., 2018). The American Psychological Association (APA) (2015) guidelines recommend that supporting the use of diverse terminology should be viewed as empowering for the transgender person, as our culture continually attempts to grasp the concepts of gender identity. Health care providers need

to be aware that language used by the transgender community is diverse, evolving and expresses the individualism of each person (Love et al., 2018). This could mean, many nurses within the profession may not be aware that the fluid nature of the terms and language used by the transgender population is part of the transitioning process.

2.2.3 Defining Transgender

Many studies include research on transgender people and base the participant pool upon the definition of transgender as being a self-identity different from the biological sex one was assigned at birth (Ashmore & Collier, 2017; Schimmel-Bristow et al., 2018; Schuster et al., 2016). Upon review of the literature, the terms transsexual, crossdresser (Piper & Mannino, 2008), drag queen, and bi-gender (Bockting, 2009) were the best fit to label participants in studies. These labels emphasize the polarity of the binary and not the spectrum of identities in between. As the timeline progresses in research away from the early 2000s, self-identifying terms have become more progressive and expansive, including for example: genderqueer, F2M (female to male), and M2F (male to female) (Norwood, 2013; Veldorale-Griffin, 2014). In contrast, recent literature has listed identity labels used alongside or with transgender, such as gender non-conforming (TGNC) (Puckett et al., 2018). The most recent literature builds on the spectrum of labels, for example trans youth, trans people, trans teens or the stand-alone term of *trans*, to include anyone who identifies as male, female, both, or neither (Cicero et al., 2020; Ybarra, 2019).

Literature from other countries shows a lack of demographic choices or consistency to gender diversify with expanded labels, even in studies within the last six years. A 2018 study that researched transgender peoples' experiences accessing health

care in Sweden listed participants as transsexuals, crossdressers, intergender, genderqueer, etc. with indication of participants changing identities during the study (Persson & Brostrom, 2018). An Australian study that investigated the health and wellbeing of transgender people used *sistergirl* and *brotherboy*, which are not terms found in any of the literature reviewed in this study (Kerry, 2014). A Turkish study that examined the quality of life and social adaptation of people with gender dysphoria chose the labels transman, transwoman and transsexual to categorize their participants (Ozata Yildizhan et al., 2018).

Regarding this review, it is clear there is diversity in gender identity beyond the cisgender label (i.e., when gender identity aligns with the biological sex assigned at birth). When accessing current evidence that reflects research on the transgender population, results need to be reviewed based on the (a) age of the study participant as each generation builds on previous terms to self-identify, (b) country of origin as each are culturally different, and (c) date of publication. The World Professional Organization for Transgender Health (WPATH) standards of care, version 8 uses transexual, transgender, and gender nonconforming people as the most broad and inclusive terms to address gender identity (Coleman et al., 2022). Therefore, nurses need to be aware that since literature has evolved and continues to do so, gender identity terminology and understanding of the transitioning process may also be evolving.

2.2.4 Defining Transitioning

The terminology for referencing the process of transitioning is diverse and reflects the numerous attempts to describe a phenomenon that is difficult to understand. Some references to the process use simple terms such as an *identity transition* (Piper &

Mannino, 2008), and others have referred to the process as a replacement, revision, removal, or evolution (Norwood, 2013). A case study by Campbell and Catlett (2019) defined transitioning as "reaching developmental milestones that affirm gender identity" (p. 467). Ashley (2019) attempted to explain the process of transitioning as "reaching the actualization of a pre-written vision of the self" and uses the term *transfiguration* to further the explanation the achievement of an ideal self (p. 225). Fink (2019) simply refers to the process as a gender transition with the end goal to be male or female. In another study, the term transitioning is not used but "self-actualization of gender identity" through gender reassignment or sex reassignment is described (Ozata Yildizhan et al., 2018, p. 2). A qualitative study on transgender men studied their mental and physical needs during the process of identity development. Reference was made to the process of transitioning within the stages of identity development, but the authors did not provide further details to understand the process (Real-Quintanar et al., 2020). Walter Bockting, a researcher in understanding the process of identity development, acknowledges that many transgender individuals may not experience the transition process because they may not actualize their gender identity in a way that involves a change in gender roles (WPATH, 2012). Literature from the medical perspective may focus on medical interventions to treat gender incongruence but does not discuss the psychological aspect of transitioning which is a critical aspect of the process (Hadj-Moussa et al., 2018; Owen-Smith et al., 2018). Overall, a common language with foundational terms to define the process of transition is lacking and unavailable to health care.

2.3 Transitioning as a Process

2.3.1 Types of Transitioning

As the understanding of transgender people and their experiences have evolved over the years, research has attempted to categorize the transitioning process into types. Earlier literature defines transitioning as the process of living as another gender (Alexander, 2004) or taking an active stance in moving away from the gender that has been assigned at birth through altering one's physical appearance (Piper & Mannino, 2008). Other early attempts to explain the process state that transitioning is undertaken when an individual stops resigning themselves to leading a life of conformance with their assigned birth gender through the act of crossdressing or practicing transsexualism (Alegria, 2010). To summarize, previous literature leads readers to conclude that gender non-conformity is a failure to live in alignment with one's sex assigned at birth (Bullough, 2007; Lawrence, 2009).

The literature reinforces this failure by referring to crossdressing and practicing transsexualism which can be interpreted as attempts to transition in negative contexts. More recent literature recognizes the complexity of transitioning by categorizing the process into types: medical transitioning, social transitioning, and legal transitioning (Campbell et al., 2019; Collazo et al., 2013). Collazo et al. (2013) define these types of transitioning as follows: (a) *medical transitioning* is the use of hormones and/or gender affirming surgeries and describes how a person will never be able to live in a heteronormative cisgender identity and will always have to explain their body to intimate partners, (b) *social transitioning* is the act of reorienting oneself through the world using a self-chosen identity by use of name changes and/or change of pronouns, and (c) *legal transitioning* is the change in names on government documents, such as birth certificates, driver licenses, or passports, and can also include gender marker changes, which may

require physician clearance. The division of the transition process allows health care providers to breakdown the complexity of needs and understand what is required to achieve the desired levels of each type of the transitioning process (Collazo et al., 2013). This review reveals that much of the literature is indiscriminate regarding medical, social, and legal transitioning, which gives the illusion of a simplistic process. Many sources in the literature reviewed consider legal transitioning to be a part of social transitioning and do not differentiate or infer that the legalities of changing a name on government documents are part of the process at all. Differentiating between the types of transitioning may assist health care professionals in facilitating the process, as each type represents its own barriers (Ashley, 2019; Bockting et al., 2016; Whyatt-Sames, 2017).

2.3.2 Identification of the Transitioning Process

Although there is a dearth of literature on the understanding of transitioning as a process, attempts have been identified by various disciplines to theorize gender development which involves transitioning. There were efforts to segment the transition process in other ways than types (as discussed above) in attempts to simplify the process of transition. For example, Staples et al. (2019) lists “steps” to the process of transitioning, which are “coming out,” “nonsurgical cosmetic procedures,” “hormone therapy,” and “gender-affirming surgery” and can be inferred as part social or medical transition. A mixed-method study by Budge et al. (2013) tried to identify the coping needs for the transgender population and categorized transitioning into three distinct phases: pre-transition, during transition, and post-transition. Ashmore and Collier (2017) simply refer to the process of transitioning as the periods before, during and after.

Others have categorized transitioning as *part-time* or *full-time* with the inclusion criteria of with or without body-altering surgeries (Alegria, 2010). *Partial* and *complete* were terms used here to describe transitioning of young transgender people (Dodson & Langer, 2019). Partial transitioning referred to a transgender youth using choice of pronouns and name in one aspect of their lives, such as in their home environment. If they chose to assert their affirmed gender identity into all other aspects of life, such as extended family, school, and society, it was considered a complete social transition. A qualitative study by Morgan and Stevens (2008) contributed to understanding the experience of the transgender individual by stating that an individual goes through stages of transitioning: a) the first recognition of a transgender identity, b) biding time until transition can occur, c) the time of transitioning, and d) eventual comfort and peace after transitioning.

Staples et al. (2019) body of work which described transitioning in steps suggests a linear progress, yet others describe transitioning as fluid and recursive (Kozee et al., 2012). In contrast, there is literature to suggest that all individuals take certain steps in transitioning, while others state this may not be the case with all transgender individuals. Earlier theorists have attempted to explain the exploration of transitioning by building concepts on what was already attempted by Marcia's ego identity paradigm of 'identity formation' developed in the 1990's (Bergh & Erling, 2005; Piper & Mannino, 2008). Piper and Mannino (2008) attempt to use Marcia's concepts of "identity foreclosure", "identity moratorium", and "identity achieved" to further the knowledge of the process. These concepts are considered salient and not a linear progression of the path to established gender identity. The paradigm of identity formation can be compared to the

pre-transitioning phase where an individual is exploring their readiness for further stages of the process to identity confirmation. Identity confirmation begins after identity achieved and is when transitioning is initiated (Piper & Mannino, 2008).

Walter Bockting's work took a turn from the disease-based model, which assumed something "went wrong in the head of the individual" during development, to a gender identity questioning model of care where stages of transition included pre-coming out, coming out, exploration, intimacy, and identity integration (Bockting & Coleman, 2007). Whereas others see transitioning as a concluding event and do not consider themselves as transgender at all but simply as their preferred sex or gender (Collazo et al., 2013). Some transgender people state that transitioning is an ongoing process and never stops (Morgan & Stevens, 2008). Still, other individuals fear that the transitioning process will never be complete, and the end goal is unknown to them (Bailey et al., 2014). If there is the assumption that all transgender people have the same experience, this means that health care may automatically presume transgender people are uncomfortable with their bodies or experiences in the first place, but this is not always the case (Ruth & Santacruz, 2017).

If the path to a gender identity change is considered a transition, it is for that individual to decide, and nurses need to comprehend that it is more than hormones and surgeries. Various studies may not have advanced their understanding that there are different types of transitioning and do not articulate the difference in their reports. Overall, whether individuals go through *steps* or *stages* to transition, and whether they experience partial, complete, part-time, or full-time transitioning, various disciplines have attempted to explain this complex phenomenon. The earlier literature tends to focus on

the medical aspect of transitioning (i.e., hormones and surgeries), while the more recent literature recognizes the psychosocial aspect of the process. The literature infers that the process of developing a gender identity includes transitioning, but there is need for a standard of consistency for breakdown of the process for the comprehension of nursing staff. If nurses acquired knowledge in the topic of transgender health, they could discern a patient's transitioning status and help facilitate individualized care (Trujillo et al., 2017).

2.4 Medicalization of Transitioning

The origins of the process of transitioning can be traced back to the 1950s and 1960s where sexual reassignment surgery was considered a treatment for individuals who were uncomfortable with their gender and sought to modify their bodies (Ettner et al., 2006). This model was used by many in medicine who viewed transitioning as chosen by those who hated their bodies. This perspective reinforced medicine's explanation as to why one would choose to start the process (Garden, 2019). For example, physicians would assess the degree of someone's *transness* and make decisions as the gatekeepers to transition (Fink, 2019). As history moved forward, the evolution of terminology, such as *gender identity disorder*, was changed to the less stigmatizing term of *gender dysphoria*, which is considered less pathologizing (Schuster et al., 2016). In 1994, a monologue was written and performed by an individual who compared themselves—as a transsexual—to the monster in Mary Shelley's *Frankenstein* as if they were less than human (Stryker, 1994). One of the key points in the monologue discussed how changing the physical body to be your "true self" was equated to creating a monster. The monologue's key point stated that the experience of transitioning carried a social meaning of *monstrosity* in

society. The monologue further challenged clinicians not to contribute to the perpetuation of stigmatizing ideas, even subtly in practice. Although this work was published over 25 years ago, this harmful notion of transitioning persists (Jaffee et al., 2016).

Many transgender people endure challenging experiences when accessing medical care. A qualitative study of transmasculine patients in an emergency department found that participants were made to feel like a "freak show" by their health care providers (Samuels et al., 2018). In this study, where the aim was to investigate the transgender persons' emergency department experience and barriers to care, participants shared stories where upon disclosing their trans status, medical residents and clinicians would crowd around them during an assessment because most physicians had never seen a transgender person before. The participants further shared how providers asked both appropriate and inappropriate questions stating, "like it was open season and they could ask anything they wanted." (p. 176). Inappropriate questions asked regarding the transitioning process were common, such as what the patients planned on doing with their genitalia. Individuals are experiencing this phenomenon today and nurses, if given the educational content in transgender health, could work towards normalizing the care given to those transitioning.

2.4.1 Gender Identity is not a Mental Health Problem

A person's gender identity, outside of male or female, is not a disorder that causes distress in itself; rather it is their degree of dysphoria or body incongruence that causes the distress (Fraser & Knudson, 2017; Hsu, 2019). Because of the lack of transgender health care education and dissemination, primary care providers—as a first point of contact—may refuse health care to those seeking treatment and referrals for transitioning

(Ashmore & Collier, 2017). Ashmore and Collier (2017) elaborated on the difficulties of transitioning by emphasizing that if a transgender patient is mentally healthy and not yet considered dysphoric enough, a gender transition may not be granted. Yet if a patient has mental health issues present, transitioning can still be refused, which may lead to more deterioration in mental health. This difficult situation has resulted in many transgender individuals needing to educate themselves about the medical standards and requirements needed to gain access to transition health services before first contact with health care professionals. Because gender dysphoria continues to be a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) manual (APA, 2013), patients may need to be prepared to say what is expected of them to meet criteria and gain access to medical transitioning (Schulz, 2018). An article that provides an overview of health care for transmen who wish to transition discussed the nurse practitioners'(NP) approach as giving the transgender individual the autonomy to decide their own readiness for transition (Holmes & Freeman, 2012). This article emphasizes the trend towards listening to a patient's needs and facilitating care, as opposed to the medical approach of providing treatment. Therefore, NPs need to ensure an advocate approach to health care instead of reinforcing the gatekeeper role to improve patient outcomes.

As time as moved forward, views have progressed regarding transgender people, the act of transitioning and family experiences. For example, the WPATH (2012) stated that identifying as transgender should not be viewed as inherently pathological or negative. In a case study by nurses who work in mental health, the positive aspect of the transition for a transwoman was described as an experience of euphoria and happiness once she began to live her affirmed life (Watts et al. 2017). This concept of gender

euphoria, as opposed to gender dysphoria, was introduced by an individual who openly identifies as a transperson and sexologist Dr. Benestad (2010) who suggested that the shame and embarrassment of gender incongruence with one's body (i.e., dysphoria) is relieved and replaced with a euphoric release upon transition. There is very little research by nurses found on this topic of gender euphoria versus gender dysphoria, but it appears that nurses may pull from Benestad's understanding to view the transition process not as a treatment for gender dysphoria but as a path to gender affirmation. The nursing research furthers this understanding by including the family's needs during this time of transition (Alegria, 2010). Alegria (2010) explains as the transgender person experiences a sense of euphoria or a moving away from a depressed state, the supporting family may experience a sense of loss or despair of the person they knew. Awareness of this perspective as it relates to a transgender individual's transition will help nurses provide holistic care for the client and the family. This research highlights the need for knowledge in all specialty areas of nursing and a widening of the focus to include the family of the transgender or gender nonconforming person.

2.4.2 Transitioning as a Western Concept

The development of standards of care by health care professionals has been recognized by the transgender community as legitimizing the transitioning experience and thus leading to gender-affirming care (Fraser & Knudson, 2017). However, the WPATH (2012) identify that the standards of care were written by health care professionals residing mostly in North America and Western Europe; therefore, they represent a westernized view (Fraser & Knudson, 2017; Stryker & Currah, 2014; Whyatt-Sames, 2017). Caldwell (2019) suggests that, historically, many Indigenous languages

may not have included gendered terms where the culture had no existing inequality based on gender. He stated that Indigenous scholars have linked the attempted destruction of the gender and sexual diversity system within Indigenous cultures with colonization and westernized ideas. For example, the two-spirited individual is an umbrella term for Indigenous people with differing gender identities or sexualities (Adams & Phillips, 2009). Two-spirit people were simply viewed as a part of the whole community, and each person in that community is valued and important. This suggests that nurses need to be aware that the process of transition may not be a global concept and that anyone who identifies other than the binary does not necessarily share the same views.

2.5 Generational Views of Transitioning

Generational differences and perspectives on transitioning have been reported in the literature. The older population who transitioned later in life may have the added complexity of being married to an opposite sex spouse and may have children from that union (Ashmore & Collier, 2017). They may face the end of a spousal relationship or the loss of custody of minor children as a result of gender role changes based on societal gender identity norms. The older population also faces challenges in the workplace when attempting to gain or retain a job during transition (Jones, 2020; Phoenix & Ghul, 2016).

For the adolescent to older adult population, various illuminating facts were found in the literature related to the experience of transition. A study on transgender adolescents found that older, gender-questioning adolescents who had gone through puberty before transitioning reported puberty to be psychologically traumatic (Whyatt-Sames, 2017). It is also found, for transitioning to occur in the adolescent age group, parents, caregivers, and siblings are generally the first line of support. For example, a qualitative study of

transgender adolescents and their parents reported that despite mixed reactions from parents about supporting their child in gender role changes that accompanied transition, they were the main navigators of health care decisions, school situations, and societal challenges for their child (Schimmel-Bristow et al., 2018). This study also found that siblings of transgender adolescents were quicker in their readiness to accept and offer support than parents or grandparents.

The study also reports that transgender youth rejected by parents and not supported in transitioning, potentially face expulsion from the home resulting in homelessness or foster care placement. Transgender adolescents rejected by families are more likely to attempt suicide than those whose families do support their social and/or medical transition (Ryan et al., 2010; Olezeski & Bamatter, 2020). As a young, vulnerable, transgender person, dependency on parental support for access to transitioning is pivotal (Abreu et al., 2022; Alegria, 2018). The negative aspect of rejection is also evident in the vulnerable elderly population, where the potential exists for not having the transition experience and gender identity supported. In a case study of a transwoman in hospice care, it was observed that due to advanced age, an inability to advocate for oneself may exist (Campbell & Catlett, 2019). The intersection of advanced age and identifying as transgender has the potential for increased vulnerability to victimization, spiritual violence, emotional violence, and a longer lifetime of health care refusal (Kattari, et al., 2020).

The approach to transitioning for all ages has been observed clinically, but little research to date has explored the psychosocial generational differences (Bockting et al., 2016). A qualitative study of older adults found that when the decision to transition was

made, it was done quickly and with a goal to transition fully from one gender to the other (Alegria, 2010). Fink (2019) describes how transitioning in the past would be granted if the physician agreed that the transition process for the transman/transwoman would result in what societal norms would consider what a man or woman should look like. This relates to the idea of *gender passing* today, which in past literature was viewed as a deception that enables a person to adopt certain identities from which they would be barred by in society (Lingel, 2009). Bockting's (2009) work on gender identity development states that for transgender adolescents, a paradigm shift is occurring where transitioning is approached with a curiosity and an exploration of gender possibilities that are self-recognized. The adolescent goal or goal for all ages of transgender people who transition may not be to *pass* as male or female but to explore in ways that do not always reflect the societal mainstream of the binary with no pressure to make decisions regarding gender identity (Bockting, 2009).

Due to the relative ease in accessing the worldwide web, adolescents have access to information that the older population did not have (Huttunen et al. 2020); therefore, they may potentially be more empowered when transitioning (Schimmel-Bristow et al., 2018; Ybarra, 2019). For example, transgender adolescents may have concerns regarding the effects of hormones on fertility which require evidence-based researched recommendations as they consider their options for future childbearing and medical transitioning (Dodson & Langer, 2019). Because of the rapid progression in ways of thinking regarding transition (Ashley, 2019), when facilitating access to care for transgender people, nurses need to be aware of the difference in generational views regarding goals and needs for transition as well as not to assume based on age of the

individual’s transition goals. Working with the very young populations requires recognition of trans youth, who are not at the age of consent, and may not demonstrate clear knowledge of interventions when providers are prescribing medical transitioning such as hormone therapy. This concept of assent versus consent can be compared to the decision of treating a diagnosis of cancer or diabetes which is typically not withheld from the adolescent population and should not be withheld for gender affirmation with parent or guardian involvement (Shumer & Tishelman, 2015).

Overarching similarities in challenges encountered by adolescents and older adults while in transition were revealed in the literature. Bullying against sexual minority adults exists today (Boroughs et al., 2019) and is preceded by a well-known history of bullying against the LGBT population (Pollock, 2006) and is considered a health crisis. For the transgender population, all generations may experience some form of bullying whether as a child in school (Connolly et al., 2016) or as an adult in the workplace, regardless of the phase or stage of transition (Phoenix & Ghul, 2016). A common thread remains throughout the literature that despite age, when not supported in transition, transgender individuals are at risk for discrimination, family rejection, anxiety, depression, violence, and suicidal attempts (Addis et al., 2009; Grossman & D’Augelli, 2007; Steele et al., 2017).

2.6 Needs During Transition

Because the field of transgender health is in its infancy, mental health and physical health needs for the transgender population require research. The Fenway Institute, a national centre in LGBT health research, identifies social or family support to be one of the leading predictors in transgender patient outcomes and quality of life

(Makadon et al., 2015). Having another's support for a non-cisgender identity will increase a transgender person's sense of security in moments of anticipated prejudice from others (McLemore, 2018). A support system is so important that research has shown that transgender individuals will develop a surrogate family or f*amily of choice* if they experience rejection from their family of origin (Love et al., 2018). This surrogate family is generally comprised of their partner's family or groups of friends who share the gender diversity identity. These families may be referred to as *patchwork family* or *fictive kin* (Collazo et al., 2013).

Preventative and promotional health interventions to decrease rates of disease should not be ignored as transwomen may still require a prostate exam, and transmen may still require pelvic exams with pregnancy tests (Pan & Honig, 2018; Stewart et al., 2020). Despite the challenges that transition interventions such as hormones and surgeries bring, they are considered lifesaving and therefore need to be expedited for the transgender client (Bailey et al., 2014). Timely access to information has also been recognized in the literature as one of the most important needs during the pre-transitioning phase (Real-Quintanar et al., 2020). As for any vulnerable and marginalized population, the social determinants of health regarding financial support, housing issues, food insecurity, and access to healthcare continue to be important for improving patient outcomes (Roller et al., 2015). Specifically, those health care providers who provide trans-competent, gender-affirming or life-affirming care are in demand.

The review of the literature highlights the gaps in knowledge for the profession of nursing about the understanding of the experience of transitioning. Research is lacking in the field of nursing regarding transgender health where most of the literature comes from

the fields of medicine, psychiatry/psychology and 2SLGBTQ+ sources. Much of the literature focuses on the 2SLGBTQ+ community and does not specify the unique needs of the transgender community which perpetuates marginalization and diminishes the quality of their lives (Riley et al., 2011). The transgender community deserves to have nurses and all providers of health care educated at the undergraduate and graduate level about the transitioning process as well as other aspects of transgender health needs.

A review of the literature reveals that the process of transitioning has been compartmentalized in types, steps, phases, and stages. The process may or may not be linear, and the length of the process is decided by the person transitioning and not by health care providers that continue to serve as gatekeepers. Also is important not to assume that all trans identified people choose to transition. The medical model has dominated the understanding of transitioning as a disorder, but recent literature reveals a trend away from pathologizing the process of transitioning as a treatment that requires a cure from the degree of gender dysphoria experienced. Stigmatization of the transitioning process continues to persist subtly in healthcare. Nurses need to be aware that the process of transitioning is not part of all cultures and transitioning may not be a global concept. The age of the transgender individual should be considered when providing health care, as the process of transitioning is perceived with differing generational views and challenges regarding gender affirming care (Garrett-Walker & Montagno, 2021). Examples for consideration based on age may include: a) granting hormones to child or adolescent seeking transition when under age of consent, b) long term health effects of gender affirming surgeries or hormone use before/after onset of puberty, and c) implications of surgeries/hormones on ability to bear children in the future.

2.7 Research Questions

This study proposed to gain insight into the experience of the transitioning process for transgender people through the appreciation of their shared reflections. Therefore, the overarching research questions were:

- What were the experiences of the process of transitioning for the transgender person?
- What part did providers of health care and/or nurses have in the positive moments experienced by the transgender person during the transitioning process?
- How might these positive experiences be constructed as possibilities that might create the potential for influencing the transitioning process in a positive way in the future?

New knowledge gained may inform the profession of nursing towards professional practice changes that are diverse and culturally safe with intent to increase competency towards improving transgender peoples' health experiences and outcomes. Because the field of transgender health care is still in its infancy and teachings regarding gender affirming care is inconsistent and sporadic, nurses need to advocate for mental and physical health concerns for transgender people that may not be fully realized by others involved in the circle of care. Care that is performed from a culturally safe perspective is a framework that supports all providers of health care in improving transgender patients' experiences at the clinical practice and institutional system level (Baldwin et al., 2018).

CHAPTER 3

METHODOLOGY

3.1 Research Design

This qualitative, interpretive descriptive study was guided by a constructivist philosophy with a critical social lens (Chinn & Kramer, 2015; Creswell, 2014; Thorne, 2008) and an Appreciative Inquiry (AI) approach. An in-depth discussion of the philosophical and theoretical perspectives that guided the research design were reported in Chapter 1.

A constructivist philosophy acknowledges the existence of multiple, valid realities and it attempts to understand these complex realities through sharing of stories and reflections (Creswell, 2014; Fraser, 2014). This means the transgender community as a marginalized group is valued and important and considered the experts in their own transitioning experience. The application of the critical social-idealogical lens aimed to empower participants through giving them the platform to share freely and to make meaning of their experiences (LoBiondo-Wood et al., 2014).

As the field of study for the transgender population is beginning to have a presence in the literature (Nolan et al., 2020), an interpretive descriptive, qualitative methodology was used to amplify the voices of transgender people and their experiences regarding transitioning needs. Critical social theory's emancipatory orientation was illuminated within the interpretive description methodology to advance nursing's mandate to generate knowledge that meets the social and moral needs of populations (Browne, 2000). That is, nursing has inherently sought knowledge about patterns within people for generalizations so that it can better inform the unique needs of individuals like

the transgender population in this study (Thorne, 2008). Further, interpretive description is rooted in the understanding that nursing is an applied science; nursing exists as a discipline to do something in the world (Thorne, 2008). With an orientation that attempts to see beyond the self-evident of what is already known, interpretive description offers the potential for nurses and all health care professions to develop insights by seeing what else might be there to see (Thorne, 2008). Interpretive description's qualitative orientation was also applied as a reference point to support the AI approach as a first step in future action research. AI methods enabled the discerning of what matters, what is valued and what is important towards future initiatives that strengthen supports for the transgender community (Moore & Charvat, 2007).

3.2 Setting

Trans Wellness Ontario (formerly known as W.E. Trans Support) first opened 2017 in Windsor, Ontario and was the first nonprofit organization of its kind in Canada to support the transgender population and their families. This organization was chosen as an initial point of contact for participant recruitment because it was recognized by the researcher as the gatekeeper to the transgender community and approval was needed to gain access to the site where in-person interviews were performed (Creswell, 2014). This community-based organization's aim is to reduce isolation of transgender individuals and assist anyone experiencing or questioning changes on the gender spectrum. This resource centre is considered a leading organization in the Windsor-Essex County region that provides supportive services as well as a safe space to the population of individuals who identify as other than the binary. Due to the history of transphobic discrimination and violence towards the transgender population, providing *safer spaces* is particularly

important to help this marginalized group feel comfortable in openly expressing who they are (Greubel, 2020). Trans Wellness Ontario's resources include a drop-in centre that offers counselling, peer mentorship, life skills training, clothing exchange program and barrier-free food bank. The Centre assists in legal name changes, referrals for medical care/psychotherapy, provides advocacy in housing support, employment support, and hosts social events for the transgender community and families/friends.

In 2019, Trans Wellness Ontario expanded to Leamington, Ontario to meet the needs of transgender individuals in rural areas. In 2020, the centre relocated its downtown Windsor site to east Windsor, two blocks from Windsor Regional Hospital, to accommodate the need for more counselling rooms and office space. Statistics including number of people accessing the centre per year are unavailable; however, according to the director at the centre, a method to capture the demand is in development. Currently, the centre relies heavily upon grant funding, private funding, student placements, and volunteerism to meet the needs of the transgender population. The centre has three private counselling rooms available for confidential interviews. All three rooms have windows on their doors facing into the main reception area made of transparent glass with no window coverings. All rooms are well lit and equipped with small tables and chairs.

An initial meeting between the researcher and the Executive Director of Trans Wellness Ontario was scheduled to discuss: (a) aim and focus of study, (b) a request for access to connect with participants to perform interviews and (c) a collegial partnership between researcher and the organization. This strategy was useful as it was anticipated that potential participants may be hard to find (Creswell, 2014). A graduate social work

student was in attendance and appointed as liaison for future communication between the researcher and the organization's leadership team. To begin the meeting I, the researcher, introduced myself and offered my background information including pronouns, social status, and student credentials. History of professional work with the transgender community was offered which included health care coordination in a camp setting comprised of adolescence of diverse sexual minority and gender identity. Also, dissemination of research to undergraduate and graduate nursing students regarding the nurses' role in trans competent health care. To demonstrate genuine, long-term engagement, I listed: (a) attendance of past social events at the Trans Wellness Ontario site (i.e., grand opening, fundraising events, social events), (b) activism in the local Pride Parade and, (c) supportive parent of a non-cisgendered person. The introduction of personal and professional history was to outline empathy, personal commitment, and adequate credentials to be objective yet invested as an outsider of the transgender community (Voloder & Kirpitchenko, 2013).

3.3 Ethics Approval

A letter of approval to support the research was obtained from the Trans Wellness Ontario, Board of Directors (see Appendix D). Prior to participant recruitment, the researcher secured Research Ethics Board (REB) clearance from the University of Windsor (see Appendix H).

3.4 Sampling and Recruitment

The target population were members of the transgender community and initially purposeful sampling (Groves et al., 2013) was used to ensure conscious selection of those participants with the desired characteristics in common to gather information-rich

dialogue specific to the experience of transitioning (Coyne, 1997). Fourteen participants were recruited in total. Purposeful sampling recruited 11 participants by utilizing social media accounts and assistance from the Trans Wellness Ontario organization. An additional three participants were recruited through snowball sampling by encouraging the initial 11 to forward the recruitment flyer to those contacts who meet inclusion criteria of the study. The process of snowball sampling was used to reach more participants towards meeting data saturation parameters where the range of common thematic issues are identified (Hennink et al., 2017). Although reliable research claims saturation occurs between seven and 12 interviews (Guest et al., 2006), eight and 16 interviews (Namey et al., 2016) or on the ninth interview (Hennink et al., 2017), effort was made for this study to recruit the maximum participants possible. The importance of collecting the most interviews possible was not only to identify issues, but to fully understand the issues which contributes to the richness of the data and ultimately the themes developed (Emmel, 2015).

Initially, each participant was given the option to share their experiences in a virtual, in-person or phone interview session. If an in-person interview was not feasible, the virtual platform was considered by the researcher as the next in line choice for its' visual benefits. The first participant interview was performed using the virtual platform. Unfortunately, the interview was disconnected which affected the participant's flow of thought. Due to internet quality issues and the disruptive effect on the flow of dialogue on a highly sensitive topic, remaining interviews were performed via in-person or phone session. Therefore, one interview was through the virtual platform, four interviews were in-person and nine were phone interviews. Information obtained from participants

included: (a) age, (b) pronouns, (c) education level, (d) race/ethnicity, (e) place of residence, (f) current gender identity, (g) if participant identifies as a transgender person, and (h) sex assigned at birth.

3.4.1 Inclusion Criteria

Participants for this study were individuals whose gender identity included but was not restricted to nonbinary, gender fluid, gender variate, gender non-conforming, gender queer, Two-Spirit, man, woman or option to list participant's own Preferred Identity Label. Consent to participate was voluntary with participants possessing the capability to make informed decisions, understand the risks and benefits of the study, and was not in any way coerced (Groves et al., 2013). Participants had experience with one of more of the following: (a) contemplating the transitioning process, (b) engaging in the transitioning process or (c) have completed the transition process. These experiences were also referred to as pre-transitioning, during transition or post-transitioning (Budge et al., 2013). The three types of transition *social, medical and legal* ways were clarified to participants for inclusion. Participants needed to be able to communicate in the English language.

3.4.2 Exclusion Criteria

Those transgender individuals who do not acknowledge the transitioning process were excluded as this was found to be the most competent screening means available to determine possession of the desired characteristic for inclusion. Participants who were not able to make informed decisions, or who have diminished capacity to make informed decisions, as well as those who were not able to communicate in English were excluded from the study.

An invitation to participate was distributed through Trans Wellness Ontario in Windsor, Ontario, Canada. Initial recruitment for participants began with a post on social media via the Trans Wellness Ontario's Facebook account. The Executive Director assisted in connecting with transgender people through a recruitment poster provided by the researcher on social media, bulletin boards inside the Centre, and through word of mouth (see Appendix E and F). Eleven participants were initially recruited and to strengthen thematic rigor of this study, extra effort using snowball sampling (Groves et al., 2013) as a social network technique captured three more participants for a total sample of 14. Participant sample was determined based on saturation of thematic data (Groves et al., 2013) and data saturation was established when no new cluster of same ideas or patterns formed from interviews with participants (Francis et al., 2010).

3.5 Participant Characteristics

The following demographic information was collected using a structured set of questions asked by the researcher (see Appendix B) and summarized in this section. The age of the participants ranged from 17 to 40 years. Highest education level achieved among participants included: a) two participants with graduate degrees, b) six participants with undergraduate degrees or college diploma, c) five participants with high school diplomas and d) one participant in high school, grade 12. Of the 14 participants, one resided in the United States of America and 13 resided in the country of Canada. Of those living in Canada, two resided in the province of Quebec, and 11 resided in the province of Ontario. Within the province of Ontario, four resided in the southeastern region and seven participants resided in the southwestern region. All 14 participants identified their ethnicity/race as "white".

The pronoun use of participants was diverse with five of the 14 participants using one set of pronouns which included: one participant used *he/him*, one participant used s*he/her,* and three participants used *they/them*. The remaining nine participants reported multiple pronoun use. For example, four participants combining *he/him* and *they/them* and three participants combining *she/her* and *they/them*. One participant stated he used five sets of pronouns and offered the following examples, *he/him, aut/auts, it/its*. One participant, who identified as *genderfluid*, stated they did not use pronouns.

Table 1

Demographics of Characteristics of Participants

Participant #	Ethnicity	Age	Gender Identity
Participant 1	White	25	transmasculine
Participant 2	White	40	nonbinary
Participant 3	White	20	gender fluid/nonbinary
Participant 4	White	20	transmasculine/seasonal gender fluid
Participant 5	White	36	transwoman
Participant 6	White	26	nonbinary/transmasculine spectrum
Participant 7	White	18	transmale
Participant 8	White	31	nonbinary/woman
Participant 9	White	27	transman
Participant 10	White	17	transman
Participant 11	White	24	nonbinary
Participant 12	White	24	trans/nonbinary
Participant 13	White	27	woman/transgender
Participant 14	White	23	transwoman/nonbinary

Participants were asked ‘What label best describes your current gender identity?” and the report of this demographic collection also revealed diversity in identities. Six participants identified on the masculine spectrum and used terms which included *transmale*, *transman, transmasculine*. Three participants identified on the feminine spectrum, two participants reported *transwoman* as a label, and one participant reported *woman* as her gender identity. The remaining five participants, who did not use a version

of masculine or feminine, reported *nonbinary* as their gender identity. Of the 14 participants, seven chose a single label to describe their gender identity, the remaining seven participants used multiple, labels including *trans, seasonal gender fluid,* and *transmasculine spectrum*. This dynamic use of gender terminology will be further explored in the 'Discussion Section' of the manuscript. Of the 14 participants, 13 identified as transgender with one participant preferring not to answer the demographic question, instead stating: "I am part of the trans community sometimes". Ten participants reported *female assigned at birth*, three reported *male assigned at birth* and one participant preferred not to answer this demographic question.

3.6 Data Collection

Interview questions were formulated based on the AI method of unconditional positive questioning (Reason & Bradbury-Huang, 2007) and drew from participants the strengths and capabilities of systems to generate ideas towards potential, future change (Auxier et al., 2020) (See Appendix C). The 4D Framework for Appreciate Inquiry was adapted to guide prepared questions asked by the researcher to encourage participants to explore and share experiences regarding the process of transitioning (Kung et al., 2013; Munhall, 2012). The 4D framework consisted of questions based on the concepts of discovery, dream, design and destiny. The data collection involved the audiotaping of the narrative answers based on the questions developed.

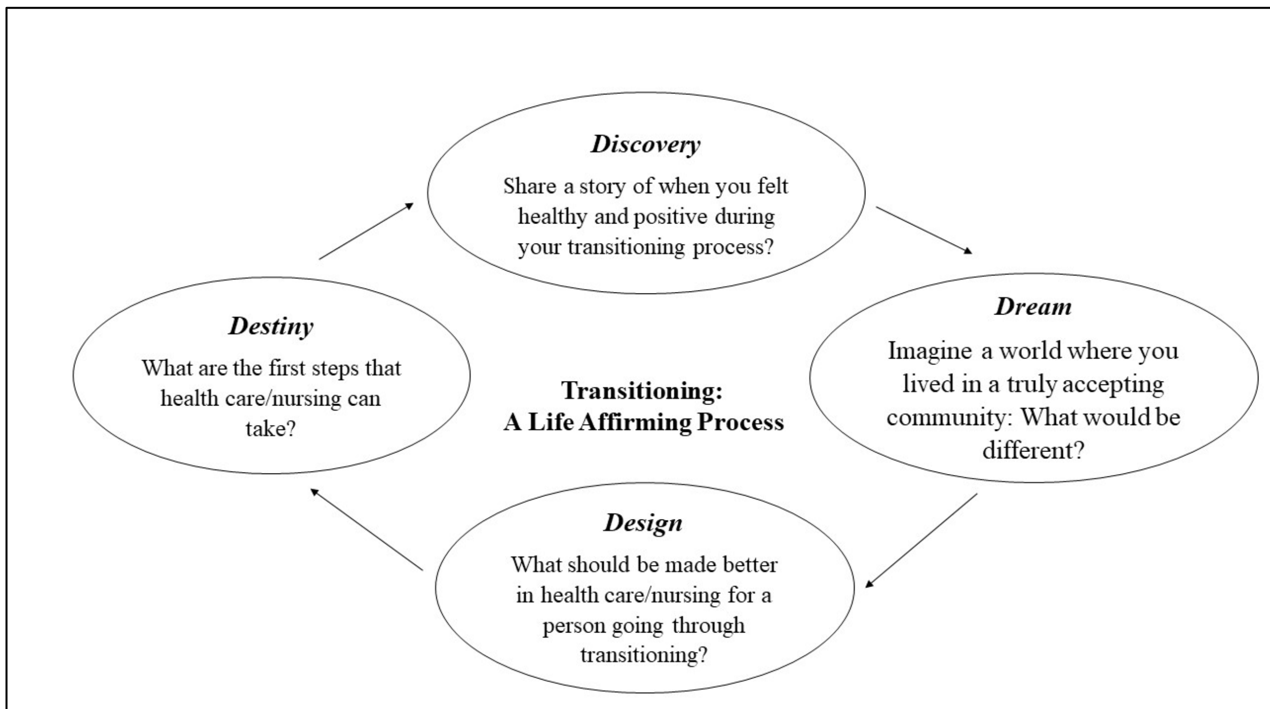
The first set of questions developed were designed to discuss the core life-giving forces experienced for a health, positive transition and reflects the *Discovery Phase* of questioning (Diedricks et al., 2018; Moore & Charvat, 2007). These questions were intended to direct participants' reflections back to positive, feel-good experiences. This

allowed an open, non-restrictive format for participant sharing before narrowing participants' reflections to potential contact with nurses or any health care provider contacts encountered during those positive moments. During the *Dream Phase* of questioning, questionings developed were meant to challenge the status quo and invited the participant to think great thoughts (Diedricks et al., 2018; Moore & Charvat, 2007). These questions allowed participants to visualize living in a society free of rejection and invited an opportunity to declare their needs for mental and/or physical wellness. The questions then directed participants to share their visions in a wish format in attempts to remove the restrictions of reality that would limit depth of expression in narratives. Questions asked during the *Design Phase* were created to elicit statements of possibilities from participants, by generating provocative ideas about social structures and/or health care systems (Diedricks et al., 2018; Moore & Charvat, 2007). The last set of questions asked during the *Destiny (deliver) Phase w*ere developed to draw participants into discussing actions they could take to realize their new affirmed visions (Diedricks et al., 2018; Moore & Charvat, 2007). In summary, the first step in the AI method started with storytelling from transgender participants regarding their positive experiences with the transitioning process. From there, participants were asked what they would envision would be the best scenarios for possibilities in the future. The questions were asked in a progressive direction towards achieving future action plans. Through this method, AI gave voice to the transgender person's hopes and dreams regarding their health outcomes. As opposed to revamping the foundations of an entire health care system, AI's strength-based approach allowed for a creative way to address inequities in the system for a more positive and gender inclusive future (Moore & Charvat, 2007).

3.6.1 4-D cycle

The following substruct (Figure 1) lends a more comprehensive view of the core topic; transitioning: a life affirming process. The reflective cycle around the core helped depict the relationship among; a) the experiential stories shared, b) the conceptualizing of strong, provocative images, c) the imaginative possibilities for the future and d) the construction of positive actions going forward (Wolf & Heinzer, 1999)

Figure 1: Adaptation from 4D cycle Appreciative Inquiry (Cooperrider et al., 2008)



3.6.2 Interview Procedures

In-person, virtual and phone interviews were scheduled at the participants' convenience via email. When the pandemic resulted in a lockdown in the county of Windsor-Essex, phone and virtual interviews were implemented as the alternative for data collection. In-person, virtual or phone appointments were scheduled in advance at a convenient time for the participant. If no government restrictions were in place at the

time of data collection and participant's preference was to be interviewed through virtual or phone, the same accommodations were made.

3.6.3 In-person Interview

When entering the Trans Wellness Ontario Centre, the researcher and participant adhered to covid screening policy procedures. After screening, the participant and researcher entered and sat in one of the pre-reserved counselling rooms. While performing the in-person interview, social distancing recommendations was followed including masks, hand sanitizer and/or handwashing, and maintaining a two-meter distance between researcher and participant. The door was closed to ensure a confidential, non-threatening environment for the participant to share. The participant and researcher partially face away from the window and in towards the room to prevent outside activity distractions for the participant and to ensure active listening by the researcher (Groves et al., 2013).

The researcher followed a semi-structured question format while audiotaping the interview to ensure consistency in data collection (see Appendix C). This format of questioning aided in gathering narratives related to the transition experience (Grove et al., 2013). The interview began with the researcher collecting demographics (see Appendix B) on the participants including chosen name, pronouns, gender identity, age, race and education level as well as city/town of residence. The researcher provided a verbal explanation of the background, aim, focus and significance of the study. The participants were given time to ask questions regarding the introductory information provided. Consent for participation and audiotaping was read out loud, reviewed and verbally obtained (see Appendix G). The participants were instructed on the format of the

interview and the ability to withdraw consent to participate from the interview at any time.

Participants were instructed to express their need to stop for a break at any time during the interview. Participants were informed that interview recordings will be deleted after review of audiotapes are no longer required for analysis. The researcher asked each of the four section questions and participants were given an opportunity for clarification if needed before answering each question. The participants were informed that interviews may take 45 minutes to one hour but time could be extended to give as much time as needed to provide a thorough explanation of the questions asked. To conclude the session, the researcher encouraged the participants to express an overall opinion on their outlook regarding their health care experienced before, during and/or after the transitioning experience. Each participant was encouraged to express any additional thoughts regarding the study before audiotaping was concluded. The researcher requested permission to retain participant contact information for the purposes of a future invite to offer opportunity to expand or give additional information. All participants were given the interviewing researcher's contact information including email and phone number and were encouraged to connect, if needed. To anticipate the participant sharing information during the interviews that may be potential triggering or upsetting to them, they were given resources which were offered at the centre and in the community for follow up regarding mental wellness and physical wellness concerns (Creswell, 2014). A $25.00 gift card for groceries was offered at the end of each interview via in-person, mail or e-mail to demonstrate respect, appreciation, and reciprocity for participation (Creswell, 2014).

3.6.4 Virtual or Phone Interview

Virtual or phone interviews were opted by those participants who did not reside within a reasonable driving distance to the Trans Wellness Ontario Centre. Some participants expressed the inability to get to the Trans Wellness Ontario site due to lack of personal transportation or absence/inadequacy of a transit system within their area in Windsor-Essex County. Many participants expressed the preference of phone interviews due to the anonymity and ease while sharing sensitive stories. The researcher followed the same steps and semi-structured question format as the in-person interviewed minus covid restriction concerns. Before the phone or virtual interview was started, the additional question was asked, "Do you feel comfortable and safe to talk to me freely where you are?" This was to ensure participant was in a safe environment that is free of interruptions and not overhead by a third party. All participants responded in a verbal affirmative manner as possessing a sense of safety.

Emails to participants offering follow up interviews were sent approximately two weeks after the interviews were collected. Of the 14 participants, one expressed a need to add additional information and the participant opted out of the in-person/phone interview and preferred to write their additional thoughts in an email. Offering the time for a follow up interview gave participants opportunity to expand or add any additional thoughts ensuring validity and accuracy of narratives (Rosenberg & Tilley, 2021). All participants who expressed a desire to participate in the study were found to meet inclusion criteria and there were no situations where a participant refused to continue or dropped out of the session. No one else was present during the in-person interviews that were conducted and there was no one present that I, the researcher, was aware of during the virtual or phone

interviews that were conducted. All interviews were performed over six weeks beginning August 13, 2021, with the last interview completed September 22, 2021. No length of time for the session was set and all interviews were completed within one hour. Field notes were taken during the interview and reflective journaling was performed post-interviews. As one researcher performed the interviews for this study, data collection and analysis were undertaken simultaneously allowing for the researcher to be immersed in the data and to recognize when no new patterns of themes were found and to stop recruitment. Upon study completion of dissertation defense, information regarding access to the final dissertation results will be sent to participants via email.

3.7 Data Analysis

Due to the interpretive descriptive research approach of the study, analysis with thematic formulation was considered for bringing forth insights into the experiences of the transitioning process for the transgender individual (Braun & Clark, 2006). Braun and Clark's phases of analysis guided the synthesizing and recontextualizing of meaningful text to both describe and interpret the transition experience (Thorne, 2008). AI's method in making sense of the data included identification of themes towards discovering how to do more of what worked well, therefore, analysis identified the best stories, practices and wishes from people who seek to transition (Cooperrider et al., 2008). Data saturation was discussed with select committee members and consensus was reached that saturation had occurred with the sample of 14 participants. Interviewing of participants, listening of audio-records and viewing of transcripts during initial analysis were performed by the researcher. Audiotaped interviews were typed by an independent transcriber. The researcher formulated the initial themes, and they were refined following discussion with

the researcher's supervisors. The frequent process of reflection and collaborative input strengthened dependability and credibility of the narratives gathered and patterns of themes. (Lincoln & Guba, 1985). During the analysis, comparison of the participants' responses and principal ideas enabled the researcher to capture the importance of what was being said when compared to the research question (Braun & Clark, 2006; Van den Hoonaard, 2012). The analytic process is described in the following steps.

For the purposes of a doctoral study, I independently performed the initial stages of analysis (steps 1 and 2) including listening to audiotapes, reading of transcripts and initial coding using data analysis software. To explore the narratives and gain insight into the experience of the process of transitioning for the transgender person, I conducted and analyzed the fourteen interviews by following the six phases of thematic analysis developed by Braun and Clark (2006). During this initial phase of thematic analysis, the interpretive descriptive strategy supported this way of analysis including immersing myself in the records where choice words or phrases took prominence in my attention and required consideration as patterns of themes were identified (Thorne, 2008). First, to becoming familiar with the data, the interviews was reviewed by: (a) listening to audiotaped individual interviews in their entirety and repeatedly in notable sections, (b) reading the typed transcripts of the interviews while listening to the recorded audiotapes of individual interviews in their entirety and then repeatedly in notable sections, and (c) grouping transcript interviews according to the questions asked and reading repeatedly. To become immersed in the narratives involved repeated reading and is vital to have a full understanding of the depth and breadth of the content (Braun & Clarke, 2006).

Second, phrases with similar meanings were grouped together and initial codes were generated. By developing two questions to ask while in the initial coding phase of analysis, kept the research question in focus and assisted with the initial stages of reduction and elimination as initial codes. These two questions were as follows: (1) "Can this statement be reduced to its explicit or implicit, underlying meaning?", and (2) "Is this statement important to the purpose of gaining insight in the lived experience of transitioning?". This phase of grouping together segments of texts and assigning terms for categorization for later comparison between transcribed interviews is known as bracketing (Creswell, 2014). The act of bracketing during analysis also assisted to ensure the potential for biases were set aside to what is known and open to what is to be discovered (Grove et al., 2013). For example, as the researcher, I have experience in supporting a loved one who has transitioned but I have not experienced the process personally. Therefore, I cannot assume to know all aspects of the transitioning experience and need to approach analysis with an inquisitive, open mind.

NVivo 12, a qualitative data analysis software, was chosen and considered the best choice as a tool to assist in the analysis process. This coding program optimized organization of common terms, procedures, and concepts identified allowed for contrasts to be made given the number and length of transcribed interviews. Also, utilization of NVivo assisted in storing and organizing the data and strengthened reliability as initial analysis was performed by one investigator. Themes and subthemes, formed from patterns found in the narratives, were documented using evidence of participant quotes and were constantly compared to enhance accuracy of their meaning (Creswell, 2014; Grove et al., 2013).

This second step of initial coding produced 24 categories and continued adherence to guidelines for coding steps strengthen validity of the study (Braun & Clark, 2006; Creswell, 2014). While participants quotes were collected as evidence, words or phrases of the surrounding text was retained with the quote to minimize the potential for the context of the meaning to be lost (Braun & Clark, 2006). Also, according to Braun and Clark (2006), this active way of extracting quotes into groups of clustering patterns and themes would not exclude the potential for finding what might be interesting later. A miscellaneous folder of quotes was developed to group what did not seem to belong. For example, specifics about medical transition regarding routes of hormones administration or dosages of testosterone and estrogen were not deemed to fit into theme development. The third step involved sharing my independent preliminary codes with Co-Supervisors for review and feedback. The plethora of initial codes were discussed and efforts to place them into an initial set of overarching themes with subcategories began (Braun & Clarke, 2006). Fourth, the thematic structure of four main themes with supporting quotes were finalized and discussed with Dr. Pfaff and Dr. Cruz, and revisions with adjustments to definitions of themes and word choices were made. With Dr. Pfaff and Dr. Cruz, the fifth step was carried out by reviewing definitions of themes, organizing the thematic structure into table format, and revising wording of theme titles. The sixth step involved Dr. Pfaff and Dr. Cruz reviewing the report of findings which included discussions with me to ensure I could demonstrate the ability to verbally support the findings.

3.8 Scientific Rigor

To ensure the quality of the analytic process was addressed in this study, members of the committee were thorough in their guidance during every stage of the study process,

and measures to promote credibility, transferability, dependability and confirmability were all incorporated as measures to increase trustworthiness of this study (Lincoln & Guba, 1985; Shenton, 2004). *Credibility* referred to the degree to which the participants had been included in the research process; *transferability* determined whether the findings of the study can be applied in another similar context; *dependability* determined the consistency of the study if repeated and *confirmability* ensured as much as possible that the findings were as a result of the input of the participants (Munhall, 2012).

3.8.1 Credibility

Early establishment of relationships with the Trans Wellness Ontario Centre and a work history with the queer population established a relationship of trust between the researcher and the organization. Triangulation through frequent peer debriefing sessions with co-supervisors compared the current literature, field notes, reflections and ensured thematic analysis was reviewed to avoid flaws in the direction of the interpretations and strengthened credibility of the study (Shenton, 2004). Trustworthiness and credibility of the study, which is the degree of participant inclusion in the narrative research process, were addressed by giving participants the opportunity to reflect and share their stories regarding their experience of transition (Munhall, 2012). Credibility was also increased through continual review of themes, subthemes and coding strategies with co-supervisors. Both supervisors discussed their impressions and shared reflections of their response to the findings and supportive quotes of the study. Co-supervisors also kept notes to ensure all suggestions based on their expertise were addressed and followed through in the final report. Audit trails including field notes, personal notes and reflections were kept throughout the study process to ensure trustworthiness of the reports and supported

findings related to gaining insight in the lived experience of the transitioning process (Munhall, 2012: Nowell et al., 2017). All sessions with co-supervisors contained debriefing moments which ensured interviews reflected saturation of data, findings were fully disclosed, themes with subthemes reviewed and next steps considered (Creswell, 2014). Credibility and trustworthiness may also strengthen the research if emotions are evoked by those reading the findings, as the comprehensiveness of participants' narratives tends to the completeness and richness of stories shared (Munhall; 2012).

3.8.2 Transferability

The findings of the study were considered within the context of application to the wider or global population of transgender and nonbinary people. The Appreciative Inquiry approach to advance positive change is a method that can be useful in the future when working in partnerships, and as one of the main stakeholders in the non-cisgender population, this is an important place to begin. If all those who provide health care have a basic and foundational insight into the process of transitioning for the transgender person, then the study's findings can be used in broader areas as long as specific contexts are taken into consideration (Lincoln & Guba, 1985). For example, policies and human rights laws for the transgender and nonbinary community in other countries should be considered before determining how far the findings and conclusions of this study can be presented. Therefore, a thick, rich description, using quotations presented in the research report, will help readers have a proper understanding of the topic of this study to decern it's degree of transferability (Shenton, 2004).

3.8.3 Dependability

Audiotaped interviews were typed by an independent, skilled transcriber to increase trustworthiness and reliability of the study (McBrien, 2008). The process of analysis within the study was reported fully and in detail to ensure reliability despite the possibility of a change in the way transgender people may experience their transition in the future as this study represents a static or frozen moment in North American in this time frame where societal perspectives continue to evolve (Shenton, 2004).

3.8.4 Confirmability

Triangulation was useful to ensure confirmability as meetings with the co-supervisors and myself continually explored potential biases while analysis was performed. Triangulation was performed by examining multiple interviews for overlapping perspectives towards theme development while recognizing different participant experiences of the same event (the process of transitioning) and added richness to the findings (Creswell & Creswell, 2018). The role of triangulation ensured that during the analysis stage, the findings reflected the participants ideas and experiences rather than the input or preferences of the one performing the analysis (Shenton, 2004). To reduce the effect of investigator bias, reflexivity was performed before, during and after each interview through writing memos to promote honesty and transparency which may impact the meaning and context of the experience being investigated (McBrien, 2008). Member checking was performed by having a member of the transgender community review the findings to ensure no unintended harm or sensationalizing of the transgender community reflected in this report (Rosenberg & Tilley, 2021). Audiotapes and other raw data will be kept for length of the dissertation process and after thorough review, will be discarded to protect participants and others who might misappropriate the

data (Creswell, 2014). All transcripts, field notes, personal notes and reflections will be kept on devices with passcode protection locks although this information will be retained by the researcher as no personal information that may contain identifiers was retained past the raw data stage.

3.9 Ethical Considerations

The participants were informed at the beginning of the interviews that items discussed in the study session would be kept confidential. Participants were informed that the data (information) will be kept until the findings of the study are completed. Numbers were assigned to the participants and no names were used to increase anonymity. Names of people shared during the interviews, such as health care providers or those not part of the research were removed to ensure protection of bystanders to the research. No identifiers or descriptors were used in the study other than the demographics collected from the participants. If participants chose to share information regarding gender expression during the audiotaped interview which may be unique in its identification of that individual, the characteristic was excluded in the data collection of the study to prevent *outing* of the participant. *Outing* a person is the act of disclosing an individual's transgender status and can be stressful, cause anxiety as well as a pose a safety risk to the individual given the history of violence against the population (Goldberg, 2019; Haimson & Veinot, 2020). By ensuring participants experienced the security of a safe space during interviews, authentic view sharing was optimized and may contribute to ensuring accuracy of trans narratives. Ultimately the report of findings will be disseminated in other public venues which will ensure against exoticizing and sensationalism of this

subject matter (Rosenberg & Tilley, 2021) as this has proven to be a concern to the transgender population in the past.

Due to the marginalized nature and high rates of discrimination towards this population, extra efforts were made by the researcher to ensure participants felt they had a safe space with the researcher in the interview room by using respectful language, for example, preferred name and honouring pronouns. As the interviewer, I considered the participant's well-being by taking the time to build rapport and allow them time to feel comfortable (Pinto et al., 2022). This was done by clarifying the consent form and stressing they did not need to answer questions they did not wish to as they shared their experiences. I took into considering that participants may find talking about experiences cathartic, but others may find the discussion difficult, and I needed to rely on my years of experience as a registered nurse to strike a balance between ensuring their contribution was valued while avoiding the possibility of inflicting distress amongst participants. As the researcher and interviewer for this study, I chose to disclose possession of a degree of understanding regarding the transitioning process. I do not identify as a member of the queer population (social status: cisgender/heterosexual) but am a parent of a son who does. By having some level of shared experience with the participant, those who study trans-related research may be able to develop a rapport quicker to gain a participant's trust (Voloder & Kirpitchenko, 2013).

3.10 Reflexivity

Researcher bias was considered as the interpretation of data required reflexivity given my personal experiences with transgender people yet recognizing the cultural sensitivity needed when working with the transgender population and their individual

experiences (Rew, 2022). As the researcher, I recognized my past experiences with the transgender community may substantiate a claim to insider status but as a cisgendered person, I remain an outsider of this community. Therefore, I am neither an *authoritative insider* nor an *unfamiliar outsider* (Voloder & Kirpitchenko, 2013). For this study, bias was considered as I claim to be an ally of the transgender community and have acted intentionally to reject discrimination by participating in activism for the community (Pickett & Tucker, 2020). The literature has shown the idea of allyship to increase confidence in advocating for the queer community through the context of professional work (Rostesky et al., 2015). I engaged in reflexivity through using a research journal that tracked important decisions made as well as musings about the participant interviews and analysis process.

CHAPTER 4

FINDINGS

The purpose of the study was to gain insight in the lived experience of the process of transitioning for the transgender person. Findings of this study may contribute to nursing knowledge and equip the profession to address the discriminatory and unwelcoming health care spaces the systems have created for transgender and nonbinary people seeking to transition. Participant characteristics are situated before the four principal themes and subsequent subordinate themes are reported. The principal themes were discovered through a detailed examination of experiences shared by transgender people who seek to transition, are transitioning or have transitioned. Four main themes were revealed from the interviews: 1) having responsive gender-affirming health care, 2) social gender affirmation, 3) support, and 4) transitioning on my own terms.

4.1 Presentation of Themes

Across the interviews, the following main themes highlight greater understanding of the lived experience of the process of transitioning. Within the following sections, I describe: (a) moments involving gender affirming experience from health care providers or others during transition, (b) the most important needs required to support transition, and (c) changes that can be made in the health care system towards a better transition experience. Illustrative quotes are provided to give those who have experienced transition voice to these themes. Table 2 provides definitions of the main themes identified.

Table 2

Themes, sub-themes and interpretation of themes

Themes	Sub-Themes	Interpretation of Themes
Having responsive gender affirming health care	Access to reliable information Timely care Local access to resources - Financial barriers Trans inclusive care - Nurses doing it right	Gender affirming care that includes any aspect of timely, reliable and/or trans inclusive competent care has a positive influence on the transition experience
Social gender affirmation	Respectful language Recognition from others	Recognition of the transgender identity and use of respectful language has a positive influence on the transition experience
Support	Family, friend or community resources	Having the backing and love of another has a positive influence on the transition experience
Transitioning on my own terms	The nonbinary identity Transitioning may not be what you think New norms = no need for *safe spaces*	Societal gender norms that reset and create a sense of security have a positive influence on the transition experience

4.2 Theme 1: Having Responsive Gender Affirming Health Care

The first theme that emerged from interview analysis centralized on the non-cisgender person's dependency on the health care system during the process of transition. The following categories contributed to the explication of the first main theme: a) access to reliable information, b) timely care, c) local access to resources, and d) trans inclusive care.

4.2.1 Access to Reliable Information

Five participants expressed the importance of having the ability to access transgender related information during the stage of questioning gender identity.

Participants expressed a gap in knowing about the existence of transgender people or what it means to be *trans*. This participant expressed their wish for transgender related information at an age where being an adolescent and dependent on others may cause a barrier. They said, “If I had this information when I was like 14, maybe I wouldn’t have been so confused” (Participant 4, age 20, genderfluid/nonbinary). Another participant substantiated this line of thought by stating their only source of information regarding the transitioning process came from “finding information on-line” (Participant 2, age 40, nonbinary). Some participants stated their experience of transitioning would have improved if information was accessible in an organized and reliable format as this participant narrated:

> I kinda wish that there was a book, if I’m gonna be honest, just to like, so you want to transition or so you’re going to transition. Just like a little guide of like all the different things, uhm, oh my gosh! I also wish that I knew more history about being LGBT and being trans… (Participant 14, age 23, transwoman/nonbinary)

Listening to the transcript of this dialogue, one could hear the excitement in the participant’s voice. Their narrative expressed hope for accessible health care information related to the transitioning process and for literature about the culture of the queer population of which they felt a part. This participant later explained that their main source of trustworthy information came from sourcing members of the queer community found through an on-line peer support group. Another participant expressed the same need for trustworthy health information and specifically wanting to learn more about the three ways of transitioning. The following passage has identified the three ways of transition for clarity:

> When a person starts thinking about transitioning or whatever, if there's like, I don't know, like a document or something where you can like, ask questions.You can check off what exactly what it is that you want and struggling with and maybe it can connect to like, to what you need to do, what steps. 'Cause there's just so much steps and it's so easy to get like, so lost in it, 'cause there's like so much. You can go the hormone route,you can go the hormone blocker route, you can go the surgery route [medical transition], you can just do the social route [social transition]. So, like you click on that link and maybe it'll bring you to, okay, this is what you need to do legally [legal transition].
>
> (Participant 1, age 25, transmasculine)

The same participant goes on to express how he felt about the decisions he made based on his lack of access to information regarding the health effects of transitioning.

> I just didn't know anything at that time, but I just knew I was so unhappy and like, ill. I had to just go for it. Even though, I just didn't really know how things were going to react…like my body. (Participant 1, age 25, transmasculine)

Additionally, participants may have made different decisions regarding the process if information was more accessible as Participant 13 (age 27, woman/transgender) stated, "I didn't realize transitioning was something I could do until I was like 21 or 22 [years old]".

4.2.2 Timely Care

Although many patients appreciated having access to transgender-specific care, seven participants explicitly expressed that an improvement to their transition experience would include medical appointments with reduced wait times. One participant reported

lengthy delays in receiving gender affirming surgery and described the experience of being on a wait list as 'arduous' (Participant 6, age 26, nonbinary/transmasculine spectrum). Another participant expressed the desire for expedited care by stating "I wish some of the referral processes could be a little faster" (Participant 13, age 27, woman/transgender). Another participant substantiated this point by stating:

> ...being able to talk to doctors without having to be bottlenecked into like one or two endocrinologists, right. Where there are only one or two people in the city who can help you, right. So, you have to face that person even if they don't treat you well or even if, uhm, they're unavailable. They have a long waitlist.
>
> (Participant 9, age 27, transman).

Additionally, participants felt the transition experience was not only affected by delays in scheduled appointments but also by health providers who gatekeep access to initiate medical transition as one participant angrily expressed:

> ...it just felt like a slap in the face to me because it was just like, why do I need to prove to you that I'm transgender? It's just proving to a cis man that I am trans. I'm telling you I'm going through the steps. I'm waiting the ridiculous months that you put me through and you're still telling me I need more proof.
>
> (Participant 3, age 20, genderfluid/nonbinary)

Another participant expressed strong feelings against gatekeeping and believes this contributes to the delay in care to those who seek to transition, in this statement:

> I think its ridiculous that we tell trans and nonbinary people that they have to go get a certification from a psychiatrist… that they have dysphoria and there they need to be cured through this surgery or this access to treatment.

(Participant 8, age 31, nonbinary/woman)

This participant offered a solution on a global scale towards positive change to improve timely access to care saying:

> I think what needs to be changed is the whole WPATH model [World Professional Association of Transgender Health] that's in place that Canada follows. There needs to be a switch to just an informed consent model where trans and nonbinary people or even people who want to act on transition services but don't necessarily identify as trans or nonbinary. They should be able to access those services as long as they're fully informed of the procedures and outcomes.
> (Participant 8, age 31, nonbinary/woman)

4.2.3 Local Access to Resources

Four participants discussed how local access to resources played an important part in their transitioning experience. One participant discussed how rare and fortunate it is to have a gendered clinic in the community where they reside:

> So, my initial response from the first [trans] person that I talked to was that I would have to leave [city name] to try to find gender care. And when I found out that there was a clinic right here in [city name] and I wouldn't have to travel and figure that out, that was like a kind of a euphoric moment. Just to know that there's even the ability to access care in my town and without having to travel to Toronto or Montreal or Ottawa. (Participant 13, age 27, woman/transgender)

The above participant, who identified as a woman/transgender, continued to explain the gender affirming procedure, they sought was available in another province and required extensive travel. Another participant pointed out the difficulties experienced by their

support system when gender affirming surgeries were not available locally. “I was in the hospital eight days, yeah. My best friend had to fly down, pick me up, bring me back” (Participant 5, age 36, transwoman). This distance calculated to approximately 850 km which is an eight-hour drive by car. Another participant, who engaged in social transition, is discouraged from seeking care for medical transition and explained why: “I’ve heard it’s so hard, we have one endocrinologist in the area” (Participant 4, age 20, transmasculine/seasonal genderfluid). An additional participant echoed the challenges of finding specialized gendered care in this statement saying:

> I think there’s voice training, I don’t know how affective that is. I have heard very, very little about it ‘cause every single trans person, or every transmasc person who is on testosterone is just on testosterone. They aren’t doing the voice training. I don’t know if there’s anybody in the area. I’ve asked like five people [trans people] and they haven’t known anybody. (Participant 9, age 27, transman)

4.2.3.1 Financial Barriers

Most participants reported their dissatisfaction on how health care dollars are spent and how this in turn affected their ability to access services related to their transitioning process. Nine participants spoke directly to the financial concerns experienced in all aspects of transitioning. Participant 1 (age 25, transmasculine) expressed their thoughts on how health care dollars should be allocated for gender affirming care in the following terms: “There should be no financial barriers because I think this is life-saving stuff [HRT, surgeries] and it [transition] should be like, treated as such.” Similarly, Participant 10 (age 17, transman) questioned their right to government-supported gender-affirming care by stating, “I don’t know if it would sound like greedy at

all but, I guess, a wish would be like financial aid for top surgery and stuff like that." These following statements from participants also reflect their perspective on the disparities they believe exist between the general population and the transgender population regarding how government funds are allocated for health care:

> Not having to pay for eye wear, not having to pay for basics like medical services Like facial feminization or like chest sculpting. Like those thing[s] shouldn't have to be paid for to be considered cosmetic. (Participant 8, age 31, nonbinary/woman)

Another participant remarked,

> I don't have any health care coverage and money's a problem right now. So, Probably having free healthcare would be amazing. So, my hormones and my top surgery would be covered, that would be amazing. (Participant 7, age 18, transmale)

Another participant, with clear frustration in their voice, expressed the out-of-pocket cost For hormone therapy needed for their transition:

> Put yourself in a trans person's shoes for a minute. Like imagine, you're assigned she at birth right but imagine you wanted to be, like you want to present as a man, and it's like you have features of your body, and you just feel trapped and you don't feel like yourself. Like, this is health care. It's health care. People should be able to feel like themselves in their body without having to pay for it… It's ridiculous and even like, you know, like my testosterone, it's not free. I have to pay 40 dollars a month to have it put in my body every single day.
> (Participant 3, age 20, genderfluid/nonbinary)

4.2.4 Trans Inclusive Care

Eleven of the fourteen participants agreed, based on narratives from their interviews, that trans competent care, otherwise known as a provider who possess a competent knowledge base to provide care to the transgender population, plays an integral role in the transition experience. For example, this participant describes a dysphoric moment with a provider who lacked an understanding in the nuances of providing gender affirming care while decreasing the potential to elicit a dysphoric moment for the transgender person in the patient role saying:

> I was having an ER visit in which my anatomy was assumed as well as I was touched on my chest [by the physician] without knowing why. Without giving a heads up. It was a very hard experience. (Participant 12, age 24, trans/nonbinary)

Compounded with some negative health care experiences, participants also felt the burden to teach health care providers about *being trans* and their unique health care needs as this participant expressed:

> I find most of the time when I'm interacting, I feel like I'm teaching them [healthcare providers] about me and the medications or my transition. In an ideal world, more of the primary frontline nurses, doctors would have a little bit more information. I've been told I'm an enigma. In terms of medical things and having surgeries, top surgeries, bottom surgeries, any doctor that I have had so far, I mean I've had to explain what that means. (Participant 2, age 40, nonbinary)

Despite the lack of knowledgeable trans competent care providers, participants felt moments of genuine caring from their providers which made a difference in their transitioning experience.

> My primary care physician, when I told her I was trans was like, 'I only have one

or two trans clients but I will look into it. I'll figure out how to do what you want me to do.' (Participant 4, age 20, transmasculine, seasonal genderfluid).

and Participant 14 stated further:

> She [primary care physician] is not really informed on it [trans health]. She tries. It's unfortunate because she is actually pretty fresh from med school. I wish there was a physician, specifically that I could kinda go to, who would be a good resource for all of this. 'Cause, I really don't know what I am doing'. (Participant 14, age 23, transwoman/nonbinary)

and Participant 13 stated,

> I had contact with healthcare in the past, uh, a long time ago. They kinda helped. I Made efforts to go to a youth clinic and talk about being transgender. I went into that meeting wanting to be told that I'm transgender… I was offered hormones at the time and realized that I was not ready to make that decision yet… (Participant 13, age 27, woman/transgender)

Participants also discussed how encounters with the health care system would have greater potential for positive experiences if provider is: (a) sensitive to the needs of a transgender person and (b) takes steps to gain knowledge in transgender health. This was aptly described by Participant 12 when they stated:

> I now have a doctor who has actually taken a special course in queer health and trans health and was able to actually be one of the first doctors in which I felt comfortable that they were able to treat me as well as understand the medical system more than I do. (Participant 12, age 24. trans/nonbinary)

Four participants pointed out the lack of evidence-based information that exists for transgender health and feel this affects providers ability to give competent care. For example, one participant explained the reasons for not initiating steps towards medical transition.

> That's one of the main things that's keeping me off testosterone [hormone replacement therapy] because I I have a history of breast cancer in my family. What's that gonna do? What's top surgery gonna do? Is this gonna make things harder? I don't know. They [provider] don't know.
> (Participant 4, age 20, transmasculine/seasonal genderfluid)

Additionally, this participant views their care given to transgender people as experimental and also wants more research in transgender health.

> How do hormones affect this? How does surgery affect that? Learning what trans people's bodies are supposed to look like when they're on hormones so that you're not surprised or shocked or treated like, you know, a medical experiment. We just need to provide that information [research] to doctors already so that the patient doesn't have to come in anxious about the care that they're going to receive. (Participant 9, age 27, transman)

This participant, who recognizes the unique needs of the transgender community, shared hopes for all providers to be knowledgeable in transgender health as echoed in this statement.

> I think that having doctors who are educated in trans specific healthcare, then also doctors who are educated on all healthcare through a trans lens, to understand that trans people may have different experiences of certain types of healthcare. We

> might have different bodies than people are expecting and so (…) when it comes to STI testing, sexual health, oncology, all these different types of things that being a trans person is different than if you were a cisgender person. (Participant 9, age 27, transman)

4.2.4.1 Nurses Doing it Right

Analysis of the transcripts revealed five participants of the 14 interviewed shared moments where nurses incorporated gender affirming care in their practice. The importance of the gender inclusive nurse in the overall health care experience in transitioning is highlighted in each narrative. One participant shared their impression of their first health care experience while transitioning involving a registered practice nurse (RPN) in the primary care provider role. "I was in the military, so she [RPN] was working on base and so just that first experience with medical professionals as I was exploring my gender identity was like, very, very positive" (Participant 6, age 26, nonbinary/transmasculine spectrum). Another participant shared multiple examples of how nursing staff at a gender affirming clinic displayed trans competence and the importance of a transgender identity: "Nurses used pronouns, chosen name and knew about the surgery I had. Yeah, it was just good." (Participant 5, age 36, transwoman). This quote describes how nurses created a gender inclusive space into practice during a follow up appointment for this participant who had gender affirming surgery.

> I went to my family doctor and the nurses did that injection [hormones] for me and I just felt as though I was treated very normally. Like I didn't feel any type of like, the discrimination or confusion or any type of questioning from the nurses... I was very vulnerable at that time and .... It was good for me to be in the presence

> of someone who just made me feel normal (…). They didn't ask any questions about my surgery, right, that would've been like prying or uncomfortable.
> (Participant 9, age 27, transman)

Participant 2 (age 40, nonbinary) was able to receive gender affirming care from a nurse practitioner who was the primary care provider at a gender-specific clinic in their local town. Participant 1 (age, 25, transmasculine) shared a comprehensive narrative where nurses, as part of the medical staff at a summer camp for "queer youth," demonstrated trans inclusive care. This quote highlights the importance of the nursing role as an integral part of the health care team when providing gender affirming care:

> At the camp there were nurses, doctors who specialized in queer health and stuff. (…) They [nurses] held all the medications for the campers, so you would have to see them daily if you're a med taker, [HRT]. And you would just have causal conversations with them. It would be very chill 'cause like the camp environment, you go into the infirmary and discuss whatever you want… It's like a walk-in clinic style but without any of the worries of not being able to have people, you know, like know about your topic [being trans]…Everyone was very aware of how important it was to ask about pronouns and not assume, and just like respect that people are gonna wear what they're gonna wear.
> (Participant 1, age 25, transmasculine)

4.3 Theme 2: Social Gender Affirmation

The word *social* as an adjective can be defined as: to live in a way with human beings where their dealings with one another affect their common welfare (Collins, n.d.). The word affirmation as a noun means the existence or truth of something (Collins, n.d.).

As participants reflected on the experience of transitioning, the importance of gender affirmation, when interacting with strangers in daily life, emerged as a main theme. The following two categories contributed to theme explication: 1) respectful language and 2) recognition from others.

4.3.1 Respectful Language

Twelve of the fourteen participants described the expectation of respectful language from others as a foundation for social gender affirmation in any facet of daily life including school, work or health care settings. One participant, who had engaged in social transition, but had not legally transitioned, described the actions of a nurse in hospital, who understood the importance of the use of chosen name and pronouns.

> I've had a nurse write in her notes about me when they pass off my information to the next person. Like, these are my pronouns… this is the legal name [assigned name at birth] but this is what he uses [chosen name] and that was positive because then it took away the need for me to do it every single time and it was just information passed down. (Participant 1, age 25, transmasculine)

This participant further explained the importance of understanding how and why pronouns are used, in this quote: "I get really irked about people saying like, preferred pronouns or preferred name because it's like, no, these are my pronouns and this is my name." (Participant 14, age 23, transwoman/nonbinary). This participant reflects on the importance of respectful language as they describe how they ensure a positive health care experience: 'I would walk into a doctor's office and tell them what I prefer to be called before they even call me by my dead name" (Participant 11, age 24, nonbinary). It is

worthy to note that many participants shared non-affirming experiences through the act of misgendering as relayed in the following statements:

> We know who we are better than anybody else and it's just unfair to use to have to try and just convince you… It's just infuriating.
>
> (Participant 3, age 20, genderfluid/nonbinary)

and

> The nurse said, she's over it, she kept misgendering, calling me the wrong pronouns and kept using my birthname and not [chose name] even though it's legally changed... and she kept rolling her eyes and sighing heavily.
>
> (Participant 7, age 18, transmale)

The following quote demonstrates the influence that non-affirming care can have on a person's decision to disclose their transgender status: "I find I'm going back into the closet when I'm accessing healthcare." (Participant 11, age 24, nonbinary).

Despite the above non-affirming experiences, four participants offered forward thinking examples of how others can respect diversity in gender identity in various settings. Two participants suggested writing patients' chosen name with pronouns on white boards that hang above hospitals beds (Participant 4, age 20, genderfluid/nonbinary; Participant 5, age 36, transwoman). This action had the dual benefit of consistency in gender affirmation for patients and continuity of care for health care staff, as reinforced in this quote; "Everyone knew when they walked in the room what [name, pronoun] you were choosing to go by" (Participant 5, age 36, transwoman). Another participant remarked on the demographic collection of pronouns despite the

incongruency that may exist when legal names have not changed and the advantage of ensuring medical records reflect respectful language.

> I had chosen a name, but it wasn't legally done yet. So, every interaction, I had to keep reminding them [organization], asking them to put my name on file, my chosen name, not the legal name on the health card and that's really inconsistent. So, I would dread of sitting in a waiting room and then hearing my old name being called. So, I don't know if that is like a system thing but once I was legally able to change my name, it was hugely important.
>
> (Participant 2, age 40, nonbinary)

Participant 10 explained how the social setting of a high school classroom can be affirmed by a supportive educator, in this statement:

> I know, it's not like super easy to run, like a new name or anything, but I think… teachers talking it over with students and being like, okay, this student wants to be called this name, kinda thing and like, not being mean but being a little, not strict but correcting it if someone dead names." (Participant 10, age 17, transman)

This participant reflected on their work life experience and offers examples of gender affirming language that should exist in the job application process.

> None of the applications that I've done have I been asked my pronouns. I feel like, if I am applying for a job, you should at least kinda know. Like I'd like to let you know…Any sort of application anywhere I'm putting my name and my birthday and whatever, pronouns should also be there.
>
> (Participant 4, age 20, transmasculine/seasonal genderfluid)

Some participants struggled to be affirmed and their interviews reflect attempts to look

for the best in others, as in this statement: "Even the nurses who I've had negative per say interactions with, I've never felt that it was them personally attacking me as much as the stress of the situation or what was happening that day" (Participant 2, age 40, nonbinary). Although this participant expressed strong emotions regarding non-affirming language, they are articulate in their insights to the importance of gender affirmation, by stating:

> Treat us how you would like to be treated in like a healthcare situation and if we say, oh my name is this and if I say I'm trans, like don't make a big deal out of it, just say okay, and use the name and just move on."
>
> (Participant 3, age 20, genderfluid/nonbinary)

4.3.2 Recognition From Others

Nine of the 14 participants remarked on the essential need for recognition from others as an essential part of being affirmed in one's gender identity. Although, all participants referred to the feeling of not being seen and respected in one's identity as transgender or nonbinary. This participant described their vision of a world where discrimination based on diverse gender did not exist saying:

> I feel like people should, or least, I would feel comfortable in a place where I have the thought that I could be like, hey, please refer to me this way and they won't be like, no." (Participant 4, age 20, transmasculine/seasonal genderfluid)

Participants shared ideas on incorporating trans representation into initiatives aimed at change to ensure the transgender community is counted and given equal consideration.

> To have trans people help teach, to be paid to do this labor-intensive work, to be listened to, I think is one of the highest priority… If it is not done in partnership with the [trans] community then it will never work."

(Participant 12, age 24, trans/nonbinary)

and

> Having a person who is like a representative, who is trans, who is like queer, who can be a voice for those people… These people can come forward and speak with health care professionals who some might not know how or some might be too scared to know what to do. That would be a really good step.
>
> (Participant 11, age 24, nonbinary)

Another participant described how trans representation will increase visibility despite constant attempts to be erased saying:

> Years and years, our voices haven't been heard in what we need. This is why we are here today in this situation [lack of social gender affirmation], to put trans people at the very front and like make suggestions and call the shots. That's our best bet of moving forward in a positive way 'cause what's been working, what's been happening in the past, obviously isn't working.
>
> (Participant 1, age 25, transmasculine)

Twelve of the fourteen participants felt that education is the key to understanding concepts that support gender affirmation, validate the existence of trans/nonbinary people and avoid erasure of the transgender community. Many participants remarked that education institutions, teaching health care related curriculum, should include transgender affirming care, as in this quote:

> Something in nursing school, where folks can learn the most important ways to be trans affirming, and like general empathy and compassion. And there's so many more nurses in the world, more than doctors… So, people who are in hospitals,

> people who are in doctor's offices, people who are in nursing homes and things like that. There are nurses everywhere. (Participant 9, age 27, transman)

This participant included not only the profession of nursing but all providers of health care and called for them to take initiative in their learning, as stated: "I wish all general practitioners would not be afraid of transgender healthcare and to educate themselves" (Participant 12, age 24, trans/nonbinary). This participant described concepts to be taught in health care curriculum like bias training and foundations of gender diversity, in this quote:

> I think it's getting health care professionals to reflect on their own understanding of gender and how that impacts their own lives and then being able to understand that you do not need to have a full conceptualization of what it means to be trans or nonbinary or different than you, but to be able to then take the initiative to learn as well as to listen. (Participant 12, age 24, trans/nonbinary).

The following participants quotes express views on targeting societal change through teaching young children. Participants believe this is when minds are beginning to form ideas about societal gender norms.

> I guess from like birth basically, is when we have to start having these conversations around gender and body parts.
>
> (Participant 8, age 31, nonbinary/woman)

and

> Teach in schools so that we avoid future people hating on it and like seeing it as negative so, you can just like, catch it young.
>
> (Participant 1, age 25, transmasculine)

and

> Start teaching at a young age. I don't think there's an issue with teaching people who are older than grade three about queer identity and pronouns. (Participant 4, age 20, transmasculine/seasonal genderfluid)

and finally,

> Education should start in public school. Education around our bodies, around sex and gender, around being able to explore and understand yourself in a way that you want to and not necessarily in the way society has told you to understand yourself. (Participant 12, age 24, trans/nonbinary)

This participant wanted to target adults who are parents and/or caregivers of transgender and nonbinary people and offer peer support opportunities, as stated in this quote:

> Not a class, but where parents could go in and talk with each other about like, Everything going on or maybe to talk to a parent of like, someone who's transitioned. (Participant 10, age 17, transman)

Participants shared their conclusions that topics regarding inclusivity and diversity need to be taught but ease of understanding needs to be taken into consideration. One participant believes pronouns are a good place to start teaching for gender affirmation.

> Pronouns are the way to begin because they're easy. They don't take a lot of effort. Like everybody's got pronouns, it's not like something super foreign to so many people. I can go to my mom, she's got pronouns. I can go to you, you got pronouns. I got pronouns. Everybody's got pronouns. It's not like you have to explain gender identity if you don't want to. It's simple. It's quick. It's easy and everybody's got 'em. (Participant 4, age 20, transmasculine/seasonal genderfluid)

This participant believes teaching the difference between gender identity and biological sex would be an appropriate introduction and feels the burden to educate would be lightened.

> So many people don't know the difference between sex and gender and it's like, I have to explain my identity to people who are just confused and it's like, I shouldn't have to do that. It just gets so tiring to have to explain who I am to people. (Participant 3, age 20, genderfluid/nonbinary)

This participant also feels the burden of educating individuals in the community regarding the gender binary.

> I can't take on educating everyone in my community about maybe less gendered language. I don't identity as male or female. Pretty much every single interaction I have in the world whether it's a grocery store and the bank is gendered. It's just part of our culture and how we interact with each other. I've had to learn not to take those things personally because you have to pick and choose. I only have so much energy. (Participant 2, age 40, nonbinary)

4.4 Theme 3: Support

The importance of a support system when contemplating or choosing transition was a main theme that emerged through participants' narratives. Twelve of the fourteen interviews described how having the support of a person who is loving and affirming was pivotal towards experiencing a healthy and positive transition. The following participant described their feelings of uncertainty and low self-worth felt during initial stages of gender exploration and how a supportive person played a crucial role in helping them during this most vulnerable and stressful time.

> When my mom came with me [doctor appointment], she understood what was going on, especially at a time when it's so new to me and I felt like such [sh*t] about it [being trans]. This is before I even came out. You can't even talk about it and then you're expected to like, talk about it to these new, random people after like, the stress. It's just even hard to say out loud in the beginning. So, it's nice to have like a person who is knowledgeable and it's also just nice that she's there. (Participant 1, age 25, transmasculine)

Of the 12 participants, who identified family and/or friends as essential to the positive transition experience, seven of those interviewed revealed transgender friends as opposed to cisgender friends as the main support. One participant talked about how their friends' *trans status* made a difference and described them as "happy" and "joyful" while further explaining: "they [trans friends] were doing things with their life, they were active. I think those interactions, definitely played a huge role in shaping my understanding" (Participant 8). Another participant highlighted the significance of having support from a member of the transgender community in this statement:

> I've never really felt healthy and positive during my transitioning around like, other cis people. It's only been trans people who I have actually like, helped me. (Participant 13, age 27, woman/transgender)

Three of the seven participants remarked how their gender identity and/or sexual orientation may have caused family strife. Therefore, these friendships, also known as chosen families, patchwork families or fictive kin, may have taken the place of biological family relationships and became an important aspect of their lives as well as the reason for a more positive transition experience. 'It was definitely my friends. I wish it was my

family, but it was definitely my friends who were supportive and helpful.' (Participant 11, age 24, nonbinary) and "We were both kind of two queers running from our families…They [partner] have given me a lot of like, hope and a lot of support." (Participant 14, age 23, transwoman/nonbinary). This statement from another participant further emphasizes the importance of a friend support system when families are unable to be affirming.

> My family, they're not really like…they're kinda like blue collared boomers so they don't really get it. They still don't call me by my preferred name or pronouns, they're still trying to get it but it's like, whatever…Positive encounters along my transitioning has mainly just been my friends. The majority of my friends are all other trans people too.
>
> (Participant 3, age 20, genderfluid/nonbinary)

Five of the twelve participants claimed one or more members of their biological family as main support during their time of transition. A list of family members, gathered from the collective interviews who were affirming included: parents, grandparents, siblings and a brother-in-law (Participant 1, age 25, transmasculine; Participant 4, age 20, transmasculine/seasonal genderfluid; Participant 7, age 18, transmale; and Participant 9, age 27, transman). Participant 10 (age 17, transman) expressed wanting to social transition but was unsure of family reactions towards their declaration of a non-cisgender status. This participant is demonstrating hesitancy to come out and highlights the importance of having at least one family member's support during this time of contemplation.

> I live with my grandparents and my Pa doesn't really know yet and my Ma isn't like super open about it…In my dream world, my grandparents would be more open, I guess…My sister knows, she has been a huge help.
>
> (Participant 10, age 17, transman)

Two of the fourteen participants, who did not indicate the presence of family or friends for support in transition, did refer to the importance of a peer support group as a pivotal resource offered in their community. The first participant discussed the feelings of isolation they experienced during the time of contemplation and the role of peer support.

> My family was one of the last people to know about me… I had a few friends, but they didn't understand, they were eventually supportive but still kind of not, yeah…I was very late in realizing my gender identity…I was very confused and very alone…I eventually did find a peer group in [town]. For the most part, it was really just me seeking out, umh, what's wrong with me?...So once I was able to identify that, then I was able to access the supports that were ultimately incredibly supportive. (Participant 2, age 40, nonbinary)

The second participant, who did not reveal support from family or friends, implicitly illuminates the potential impact isolation may have during gender exploration and the importance of community resources as support for transitioning saying:

> I think it would've been nice for me to meet other individuals who are in similar stages in their transition as I was… Like meetings have been really down, but that's a very covid problem… And that's also another layer on top of somehow the isolation that we feel particularly for a person who is looking to transition and need some support during that time. (Participant 12, age 24, trans/nonbinary)

According to participant interviews, whether having family and friends as support or having community resources to access as support proved to be essential towards a positive transitioning experience.

4.5 Theme 4: Transitioning on My Own Terms

Twelve participants shared the view that a transgender persons' transitioning experience is impacted by pre-conceived societal assumptions about gender identity and ways to transition. These views were discussed through topics such as: (a) why the nonbinary identity label exists, (b) why differences in the utilization of affirmation needs exist and, (c) what societal elements should exist for *safe spaces* to become a thing of the past. The following three subcategories contributed to the explication of the main theme: 1) the nonbinary identity, 2) transitioning may not be what you think and, 3) new norms equal no need for safe spaces.

4.5.1 The Nonbinary Identity

Participants believe there is an increased use of the nonbinary term by members of the community when the goal of transition is not necessarily towards the binary opposites of male or female for gender affirmation. As stated in the Glossary of Terms (see Appendix A), a nonbinary identity label refers to people who do not fit the normative assumptions of male or female and may reject the gender binary entirely. As seen in this exemplar quote below, the nonbinary status may not always be affirmed or safe and may lead non-cisgender people to withhold their true identity in order to access care for transition needs.

> If I'm in a health care environment talking to a doctor and they ask [medical history], I would say that I'm transgender just for simplicity purposes. It's, like, a

> well-known word. People for the most part understand what it means now, but like in other settings, I would explain more of my gender identity. But in health care it's just gotta be more clear, because being nonbinary isn't clear still.
>
> (Participant 1, age 25, transmasculine)

Another participant reflected on how they control their narrative to gain acceptance when there existed a potential to be refused care by a provider who is uncomfortable working with transgender patients outside their frame of reference.

> You're not really giving the full account of who you are because you don't want to risk getting denied services 'cause you don't meet the expectation of what the gatekeeper [physician] thinks being trans or nonbinary is about.
>
> (Participant 6, age 26, nonbinary/transmasculine spectrum)

Some participants discussed how fear, of not receiving the health care needs they seek, will lead to nondisclosure of their nonbinary status. This narrative demonstrates how the participant modified both their gender identity and gender expression to ensure a positive outcome in their health care experience.

> I like to present a little more androgynous, like, that's how I like to dress. But I made sure, that day [doctor appointment] that I dress super masculine because I know, if I dress a little more androgynous, that I'm not going to be taken as seriously as I would if I was someone who had dressed more masculine… If I don't pass to the cis binary, then I am not a good trans person. Dr. [name] even told me himself that he likes binary, binary, binary man/woman…
>
> (Participant 3, age 20, genderfluid/nonbinary)

Another participant spoke on their lack of confidence in having an affirming experience with a provider if they disclosed their nonbinary status because it does not fit with mainstream normative transgender identity labels.

> I wish doctors were more accepting of nonbinary people. Specifically, endocrinologists…who just disregard trans nonbinary people, who don't want every single effect that testosterone is going to give me or, who don't want to be a full macho man or, who don't have really, intense dysphoria. I don't think I would be treated the same if I went back at this stage [identifies as nonbinary] right now. (Participant 4, age 20, transmasculine/seasonal genderfluid)

Another participant spoke further on the stressors of using the nonbinary label and shared this thought on why they may adapt their language or gender expression to prevent non-affirming situations. "It's a lot easier to exist as a transgender or nonbinary person on my own terms rather than the terms and expectations of others." (Participant 6, age 26, nonbinary/transmasculine spectrum). Additionally, this participant emphasized the importance of the nonbinary label as a term of best fit for self-affirmation.

> I think, when I got my binder, I felt really happy and healthy because I was able to control my body in that sense. Because as someone who is nonbinary, like myself, I experience some days where I want to be rid of my breasts. I want to be flat chested. So, I wear that [binder]. And some days. I dress more masculine and some days it's kinda in between. (Participant 11, age 24, nonbinary)

The increased prevalence of the nonbinary identity and hope for a shift in what society considers 'the norm' in gender identity, is poignantly shared in this participant's sentiment.

> In a perfect world, gender identity isn't like; how do I say this? It would just be how it is with cisgender people. It's just so normal and like there's no stigma, there's nothing attached to it. It is just what it is.
>
> (Participant 1, age 25, transmasculine)

4.5.2 Transitioning May Not Be What You Think

Participants believe that society has preconceived assumptions regarding transition that need to be clarified or refuted. This participant, who is 17 years old and in the stage of contemplation for transition, cautioned parents to take seriously a declaration of a non-cisgender status from a child, in this statement: "Parents should accept their child. You should come to terms with things. It is not a phase" (Participant 10, age 17, transman). Another participant refuted society's expectation that all transgender people transition to the opposite binary of assigned sex at birth and proclaimed an affirmed sense of self in this statement, "I never wish that I was born a woman. Like, I'm happy being a transwoman kinda thing" (Participant 11, age 24, nonbinary). Another participant discussed how gender affirmation can be with or without medical transitioning but, if hormones and surgeries are used, it is not necessarily to treat gender dysphoria.

> Just because a person is trans does not mean they want to medically transition or that they have gender dysphoria. Trans peoples' identities and transition are not inherently medical, but through which we usually see trans people. Especially within the medical system, it is pathologized.
>
> (Participant 12, age 24, trans/nonbinary)

Another participant also believed that society perpetuates transgenderism as a medical

problem and dispels this myth by sharing feelings about their anatomy, gender identity and transition experience saying, "I generally feel euphoria when I'm presenting the way I want, I generally don't have dysphoria. I don't experience self-hatred kind of things. I could look at a mirror and smile." (Participant 13, age 27, woman/transgender)

4.5.3 New Norms Equal No Need for Safe Spaces

All fourteen participants in this study discussed their wish for a new societal norm, when being seen and respected for one's gender identity, would eradicate the need for safe spaces. All participants discussed that receiving affirmation from strangers would mean all people understanding the foundations of gender diversity and no longer have restricted, gendered expectations based on the binary as the only way to be. Since these expectations do exist, all participants implicitly or explicitly shared their fear of transphobic attitudes and need for love and acceptance. Fear from a stranger's discrimination, stigmatization, harassment or violence was expressed in the following participant statements. This participant, who identifies as transmasculine/seasonal gender fluid, shared his fear of strangers' reactions against those who gender expressions in ways that do not fit the mainstream: "There are some places around here that I would not feel as safe, just walking around, 'cause sometimes I wear skirts" (Participant 4, age 20, transmasculine/seasonal genderfluid). Additionally, this participant relayed the same fear as they reflected on the everyday act of filling a prescription at their local pharmacy.

> They [pharmacy staff] will be like, 'Why do you need Oestradiol [feminizing hormone]?' really loud and I'll get a couple of weird looks. I feel like, really insecure, like, I don't know what's gunna happen once I step outside the facility. (Participant 14, age 23, transwoman/nonbinary)

Another participant echoed the same safety concerns upon having to disclose their transgender status in the triage area of a local emergency department.

> I go to the ER. I went to triage. You have to explain your situation and it's just so open and there's people in line. The doorway's open. So, they're asking what meds I'm on and I'm like leaning over 'cause I'm on testosterone. I'm trans… I'm living in a city, I've gotta walk home after.
>
> (Participant 1, age 25, transmasculine)

This participant gives an example of on a non-affirming experience, while admitted in hospital, and hopes for change where health care staff incorporate gender-affirming knowledge in the future.

> I have a different kind of presentation [gender expression]. It's like, the nurse will be kind of confused. I guess what I would want is like, don't treat me like, I'm special or don't treat me like, I'm weird or like, I don't know, just treat us normally. (Participant 3, age 20, genderfluid/nonbinary)

Another participant shared their wish for a shift in societal views where normalization of gender expression means 'how you look and/or what you wear' is never rejected and therefore safe to do.

> Just like free judgement. Like being able to just walk down the street and just be, you know, present the way I want to without fear, like comments or looks or whatever. I felt scared. I felt like me, being trans was embarrassing to people and it was, like my fault. It was, like I was making them uncomfortable and it's, like that should not be the case, you know?
>
> (Participant 13, age 27, woman/transgender)

These following statements reinforce the shared need expressed by participants for society to understand that there is gender diversity beyond the binary leading to acceptance and a safe world for all.

> A society that's safe, that's inclusive, where people don't feel like they have to hide, where they don't feel ashamed of who they are…Every aspect of society is like supposed to be informed and more open hearted and open minded. I have accepted the fact that I live in a binary world but I live outside the binary. (Participant 2, age 40, nonbinary)

Participant narratives included depictions on how the world would look if it were a safer place for the transgender and nonbinary community and offered solutions to changes in public environments where people come together in everyday moments. For example, in this statement a participant offered two ideas for global change they believe would make a significant difference: "I don't think we need gender markers and for where it's really relevant, you can ask the person" (Participant 6, age 26, nonbinary/transmasculine spectrum). This participant goes on to offer an example of a societal change that moves in the direction of a new normal: "I really do appreciate when I see gender neutral washrooms in places" (Participant 6, age 26, nonbinary/transmasculine spectrum). Many interviews shared a common wish for global change and safer spaces, but this participant is specific and focused on educational institutions as a target for change.

> If I lived in a world where people were more accepting, I wouldn't get harassed and bullied for that stuff. I went through that stuff during high school and if I lived in a world where people weren't like that, that would make me feel a lot more better knowing people were okay with it and people weren't off bulling each

> other. I've been through bullying and harassment from both students and teachers. (Participant 7, age 18, transmale)

Another participant shared a dream of what it would look like to have a sense of security in community spaces because these spaces are shaped around who they are.

> There should be change everywhere for it [gender diversity] for it to be normal. Like in high schools, like grade schools or like hospitals, wherever you can just have gender neutral bathrooms. It's like normal everywhere. Everywhere has to change because then it's hard if you pick and choose, like certain spaces to be accommodating or safe places for us. Just to have it everywhere and then it's just the norm. (Participant 1, age 25, transmasculine)

The same participant described what the rainbow symbol means to them. Their hopes for the symbol's existence to become obsolete, is insightfully simple in its reasoning.

> It's nice where you see, like those little rainbow things or stickers in places 'cause then you feel like it's a safe space. But in a perfect world, you wouldn't even need that 'cause it just already is. (Participant 1, age 25, transmasculine)

CHAPTER 5

DISCUSSION

5.1 The Positive Experience of Transition

The findings of this study are largely consistent with the existing body of literature regarding the importance of the process of transitioning as it leads to an improvement in general well-being (Johansson et al., 2010; Van De Grift et al., 2017). However, the findings of this study are important because they provide insight into the positive influences that may support the medical, social and legal transitioning process for the transgender and nonbinary individual. Participants appreciated a system that comes together to meet their transitioning needs through; a) affirmation and support, b) understanding evolving gender identity labels, paths, and goals to transition, and c) normalizing diversity of gender identity/labels making *safe spaces* outdated. These findings are unique because of the study method's ability to make the non-cisgendered participant the expert in their own transitioning experience as they describe, from their point of view, the need for a health care system that meets their individual needs comparable to the way the system attempts to meet the individual needs of each cisgendered person (Lobiondo-Wood et al., 2014). I will address each key finding through comparisons with the scholarly literature, discuss implications for practice, identify limitations and strengths of the study and discuss direction for future research.

5.1.1 Affirmation and Support

The findings substantiate evidence that suggests that the act of social affirmation of gender identity has a positive influence on a person's transition experience (Ashley, 2019). The only path to medical transitioning for the transgender person is accessed

through the support of the health care system (Hall, 2013) and there is a global lack of trans competent providers (Matwiej et al., 2022) and nurses (Burton et al., 2019). According to participant's, receiving gender affirming care for transition was considered positive based on participants' perception of health care appointment availability, timeliness, and trans-competence. Nevertheless, participants stories confirm barriers to gender affirming medical care continue today as reflected in the literature (Real-Quintanar et al., 2020; Roller et al., 2015).

Findings of this study also expand on prior reviews regarding the greater LGBTQ population (Lee & Kanji, 2017), and how health care professionals, who are educated in transgender health may positively influence the transitioning experiences for their non-cisgender clients. Participants listed examples of educated, health care professionals as those who use chosen pronouns, chosen name, avoidance of misgendering or deadnaming and, if a provider demonstrates these concepts in practice, are viewed as acts of respect and authentication of a transgender identity. This study contributes to the explanation of importance by shedding light on the 'why' of these interconnections, such as, how using respectful language means recognition of the transgender person as equal, valued, and important as everyone else in society. Being recognized, as participants discussed, is a finding consistent with Trujillo and colleagues' work (2017) that the impact of a nurse who attempts to use social gender affirming terminology in delivery of care is valued as high. Specifically, participants believe the impact of a nurse who advocates and makes effort to include affirming language for the non-cisgendered person has a positive influence even when others in the circle of care do not. In other examples, participants felt genuinely cared for in situations when an under-informed health care provider would

admit lack of knowledge about transgender health, commit to seeking trans competency and/or make efforts to use social gender affirming language while providing care. Therefore, despite the paucity of nursing literature and slow dissemination of available transgender health knowledge acquirement for nurse best practice, a positive difference can be made on experiences during transition with nurses' efforts (Carabez et al., 2016; Samuels et al., 2018).

The body of transgender related literature describes social support as an important factor during a successful transition (Abreu et al., 2022; Makadon et al., 2015) and findings of this study expands on how social support causes a positive influence on the transition process. Prior research (McLemore, 2018) states social support in a transgender identity increases a sense of security in moments of anticipated prejudice from others. Participants discussed the importance of a supporting person during their time of transitioning when their gender expression may not have aligned with societal norms. Their sense of security increased knowing someone would be there for them if they faced harm and expressed feelings of luck to have even one person's acceptance of their trans-identity. Participants voiced concerns for transgender people who face possible isolation due to rejection or fear of rejection as they reflected on their own struggles with mental health and/or depression during their time of transition when facing rejection issues. Findings also add to the existing literature on the importance of community social supports during transition (Love et al., 2018). For example, participants whose family or friends did not affirm a non-cisgender identity, their single source of positive wellbeing and acceptance was found through the support of other queer/transgender groups and/or any social setting visibly marked as transgender positive and 2SLGBTQ+friendly.

5.1.2 Understanding Evolving Gender Identity Labels, Paths and Goals to Transition

The findings are consistent with existing literature that state all transgender people do not have the same reason to transition, experience of transition and goals for transition (Evans et al., 2021; Ruth & Santacruz, 2017). The adoption and changing of gender labels discussed by participants, is an extension of the idea that transitioning is a process that is to be experienced as an exploration of the self as opposed to assuming one is moving towards the other gender. Participants believe that the definition and reasoning regarding the decisions made to transition continues to be misunderstood. Registered Nurse Association of Ontario's best practice guidelines (2021) is an example of current efforts to disseminate and reinforce the positive influence of supporting a person's self-determined path for gender authentication as a part of the transgender individual's transitioning process.

The findings also shed light on the term nonbinary, a label found in the literature (Coburn et al., 2022), as this study reveals participants perceive the term as continuing to be misunderstood. Participants expressed the need for people to accept the nonbinary identity as a label that defines a person who may be both masculine and feminine, experience fluidity in gender or may identify with a gender outside the binary all together. Participants shared that the nonbinary label correlates to the path chosen for transitioning as each is open to definition and determined by the person having the experience. It can be argued that the use of a nonbinary label by the transgender population for gender identity may be similar in use as the queer label by the 2SLGBTQ+ community for sexual orientation and/or gender identity found in the literature review (Bockting, 2009; Sprott & Benoit Hadcock, 2018). A self-affirming label like the

nonbinary label and the queer label may be adopted to intentionally avoid demarcating one's identity in ways that reflect societal mainstream views and is a source of affirmation.

The findings of this study also offer valuable contributions to the literature on prejudice and anticipatory prejudice towards transgender people through the stories shared by participants who identify as nonbinary (Aversa et al., 2020). The nonbinary participants feel their identity is misunderstood because of being considered as being under the transgender-umbrella which continues to perpetuate the idea that the goal of transition is to the other gender. This could be because there is less common knowledge disseminated about the nonbinary identity within society. The findings shed light on mitigating actions taken by those who identify as nonbinary to prevent the potential of being discriminated against. For example, participants explained how they withheld sharing their nonbinary label to a health care provider if they feared the provider would not recognize the label and gatekeep access to hormones or surgeries. This explanation adds to Schulz's work on *Informed Consent* (2018) that found the transgender community will be prepared to say or not say what is expected of them to gain access to medical transition. This finding also may confirm that the perpetuation of stigmatizing ideas in clinical practice, even subtly, still exists (Jaffee et al., 2016). Further, participants described feeling a degree of anticipatory fear of repercussions from others in society based on the potential to be perceived as not fitting in with the mainstream normative cisgender binary as another example of withholding outing themselves. This idea of anticipatory fear from societal transphobic attitudes substantiates the historical oppression and violence found in the literature against the transgender population that

still exists (Liss, 2020). Participants expressed that if social affirmation of the nonbinary identity is anticipated, they would share and declare with confidence and a sense of security.

Acceptance of the nonbinary identity is associated with a positive transitioning experience according to participants and aligns with the literature that states the support of diverse terminology is empowering for the transgender person as they continue to live amongst a society that continues to grasp the concepts of gender identity (Schimmel-Bristow et al., 2018).

Contributing towards participants' empowerment was also facilitated through AI's method of creating conditions that allowed for reducing participant's defenses to encourage sharing of these insights regarding the liberty to withhold or disclose the nonbinary label. The revealing of these insights aligns with the study's critical social theory perspective (LoBiondo-Wood et al., 2014) and constructivist philosophy (Creswell, 2014) where understanding the complexity of the nonbinary label can be captured through study and opinions formed towards future actions that have a positive influence on the transitioning experience.

These findings further support previous literature (Bockting, 2009; Lingel, 2009) that the approach to transition is not to *pass* as male or female but is an exploration of a path to wellness and affirmation towards the realization of the authentic self (Ruth & Santacruz, 2017). Participants believe that declaring a transgender status is not a transient phase which may resolve or fade in time. They believe seeking transition does not necessarily mean a person is experiencing a degree of gender dysphoria that drives them towards transition as a treatment but, may be towards a sense of euphoria. Participants

also expressed the need for health care providers and society to know that the process of transition does not necessarily follow a standardized path for correcting a pathologized diagnosis involving a sense of self-hatred which is also a consistent finding found in the literature (Garden, 2019). Findings also suggest improvements like modifying regulating criteria that grants transition is empowering to the one seeking transition and in turn, would promote a positive experience. The study demonstrates that the experience of transition is complex and is positively influenced by many contextual elements, particularly the transgender person's sense of identity and intent for transitioning, and a stranger's/health care provider's knowledge base and their intentionality.

5.1.3 Normalizing Gender Identity

The existing body of literature (Grossman & D'Augelli, 2007; Addis et al., 2009; Steele et al., 2017) has identified that safe spaces are created to mitigate the discrimination, rejection, and violence that transgender people are at risk for when not supported in transition. This study is consistent with those findings and adds to the current literature (Greubel, 2020) through participants' describing that to feel safe in public spaces there needs to exist a freedom from the fear of being outed and/or targeted when not knowing if strangers would be dangerous. Participants' examples of perceived situational fear of reprisal from transphobic attitudes clarifies that this freedom is more attainable when in the presence of a familial member who supports their non-cisgendered identity. Participants also shared examples of what constitutes a safe space which includes, respectful language, recognition of the transgender identity and logos with rainbows and transgender colours that signify queer friendly spaces and is consistent with the literature (Greubel, 2020).

The body of literature about transgender people describe universal normalization of transgender identities and this study's findings accentuate the normalization of wellness for 2SLGBT+ people (Adams & Phillips, 2009). Participants posit such normalization will make a world where 'coming out' means acceptance and health affirmation without fear of rejection or transphobic attitudes. Overwhelmingly, all participants expressed the wish to feel safe in their everyday lives. Participants shared the following opinions to improve their transitioning experiences and may make feeling safe a reality. Participants expressed that if gender diversity was the baseline standard of existence, as opposed to the existing man/woman westernized standard, a shift in society's expectations of what is considered the normative gender ideology would occur. A shift or a reset to a *new normal* would mean all facets of everyday public and private life would abolish fear of rejection based on gender norms, on a global scale. Participants expressed the need to be free from judgement where gender expression is never rejected. Therefore, transitioning needs would be based on individual's innate needs and not on what the individual believes society will accept and therefore keep them free from transphobic attitudes where the need for *safe spaces* would become obsolete. Participants expressed that global dissemination, on the fundamentals of transgenderism and transitioning, would remove societal assumptions and therefore ultimately positively influence the experience of transition.

5.2 Philosophical and Theoretical Synthesis

Since there is little known about the experience of the transitioning process, the findings of this study may be considered foundational. The interpretive description methodology and AI approach provided a basis for interpreting the complexities of the

findings, increasing confidence in the contribution to nursing knowledge (Thorne et al., 1997). The constructivist philosophy provided the basis for this research as, according to Lincoln and Guba (1985), a constructivist world view acknowledges multiple socially constructed truths and realities versus a single reality (Hunter, 2008). Therefore, this constructivist principle grounds the AI approach by including members who experience the transitioning process, and developing questions intended to gather their opinions of what could improve their experience based on the best of their past experiences (Diedricks et al., 2018). Constructivism anchored the study's aim by (a) finding what is to be known about the transition process for transgender people, (b) supporting the flow of naturalistic inquiry between the researcher and participants and, (c) accessing multiple views of the experience of transitioning (Appleton & King, 1997). I was drawn to this line of inquiry due to my experiences as a registered nurse in an inner-city emergency department, the health coordinator of LGBTQ2+ adolescences in a camp setting and a parent of a transmasculine, genderfluid son. Through these privileged experiences, I have gained personal and intuitive knowledge in the field of transgender health (Appleton & King, 1997). I am not a member of the queer community but a well-meaning ally. I hope these insights will strengthen my ability to guide the inquiry process and allow space for input from the transgender and nonbinary community.

Critical social theory supported the aim of this study through its orientation towards understanding the reality of the world through people with the most power at a particular point in time (LoBiondo-Wood et al., 2014). In this study, the power of the transgender participant was acknowledged by providing the population a platform to share freely which aligns with the theory's foundations of raising consciousness as they

are the experts in their own transitioning experience (Lee & Kanji, 2017). Perspectives shared from the findings will be honored towards future initiatives with the community as they are recognized as one of the key stakeholders towards positive change. Critical social theory also provided a basis through participant's narratives to recognize how westernized society has enabled the healthcare and societal systems of gendered care to benefit cis people who currently dominate and influence the experience of transitioning (Browne, 2000; Jaffee et al., 2016). This was evident in stories from participants who encountered providers who had no general base of transgender-related health care knowledge or had no experience with transgender people. In some instances, despite participants' who offered to share their knowledge, providers were found to substitute their judgement as opposed to empowering the patient as a partner in their care. This study also supported participants by listening to their voices with openness and sincerity by the researcher with no fear of rejection and this aligns with critical social theory's interests to create an unrestricted and safe condition for people to discuss sensitive topics (Rosenberg & Tilley, 2021). For example, when participants discussed the positive effects of affirming language but also spoke of health care providers who they perceived as purposefully harmful through acts of misgendering and deadnaming, the researcher did not prompt to explore those perceptions of intent allowing the participant the unrestricted space to share. Critical social theory was also a good basis for this study to recognize the transgender population as a marginalized community yet powerful as a group with a persistent history of social action for change (Abeyratne et al., 2022). For example, participants were given the platform to offer suggestions towards future initiatives that would make it possible for them to determine the conditions that would positively

influence their transition experience in all areas of life including their personal/family, health care and societal life.

Appreciate Inquiry (AI) was chosen as the study approach for its ability to bring about desired change starting from the positive stance of what is currently functioning (Munhall, 2012). In this case, looking at the best of system or systems that is supporting the experience of the process of transition for the transgender person. AI originates as a method for organizational development and has been used at all levels of organizations within business, government and recent use in the health care arena (Moore & Charvat, 2007). The AI approach was appropriate for this study given (a) steps to transition may require support that cannot be accessed in any other way than through the health system where nursing is one of the largest health professions globally (Hall, 2013), and (b) gave voice to the expressions of hope from an unprecedented number of LGBT individuals that 'things will get better' when accessing healthcare (Orel, 2014). AI added to the purpose of this study by giving voice to finding what matters, what is valued, and what is important combined with generating potential new ways to shape future initiatives (Ebert et al., 2020).

Using AI allowed this research to give insight to the experience of the process of transition from the basis of the constructivist philosophy (Appleton, 1997; Creswell, 2014) where meaning of the process is through the perspective of the transgender population's ideas or constructs. Through the positive unconditional questions developed for participants (Munhall, 2012), the ontological aspect of constructivism revealed participants' multiple perspectives and realities along with thoughtful suggestions towards helping non-cisgendered people understand the complex and dynamic process of

transition (Fraser, 2014). Through the nature of allowing participants to share their experiences, truths based on these experiences aided in making sense of the meaning of realities such as; a) affirmation and support, b) what makes a responsive health care system and c) what normalizing gender identity means. From the epistemological aspect, the researcher-participant interaction allowed cisgendered people insight into a world they will never experience and what it means to feel the constraints of questioning your gender identity within the confines of a binary system that does not make room to endorse a nonbinary or genderfluid position.

5.3 Tension Within the Appreciative Inquiry Approach

To the best of my knowledge, this is one of the first qualitative studies to examine the experience of the process of transitioning for the transgender and/or nonbinary person through the nursing lens while using the Appreciative Inquiry approach (Cooperrider et al, 2008). Despite the use of this appreciative line of questioning to elicit positive narratives, participants' interviews revealed a trend of tension between positive and negative reflections. For example, when asking participants to reflect on a healthy and positive time in their transition experience and the role health care played in those moments, participants narratives would contain positive reflection, but would tend to drift towards perceived disrespected moments encountered or the struggles endured. This finding of opposing tensions substantiates the existing literature of marginalization and oppression experienced by the transgender population (Galupo & Orphanidys, 2022; Grant et al., 2011; Knibbs et al., 2012) and highlights the need for increased understanding regarding the status of access to healthcare for gender diverse people.

To increase understanding of the existence of positive/negative tension found in this study's narratives, the Minority Stress model can assist to illuminate and support this finding. The model offers a framework for understanding the relationship between minority-related stressors such as discrimination and stigmatization for the transgender and gender-diverse population and the negative impacts on the populations' mental health (Rabasco & Andover, 2021). The model has been used with transgender and gender diverse people to explore the experiences of the community (Olezeski & Bamatter, 2020) and can be applied here to the transgender population as evidence of negative and positive experiences continue today (Lee et al., 2022). Positive feelings associated with having support for transitioning has been found to contribute to positive mental wellness (Stewart et al., 2018). The findings in this study have illuminated the importance of having at least one person's support of a transgender identity improves the experience during transition. Studies also reveal that negative perceptions will overpower the positive when negative experiences are perceived by the population (Lovejoy et al. 2022). As shown in this study, despite participant's attempt to reflect on positive moments during their transitioning experience, barriers restricting health care access to transition continue to exist for this minority community that strives for recognition and visibility. Using the Minority Stress model (Meyer, 2003), stress and resiliency have been found to exist specifically, in regards to a minority gender identity, as it is with transgender people who use the nonbinary label. Stress and resiliency can be correlated in terms as negative stress and positive resiliency and can illuminate the existence of the positive/negative tension found in this study.

5.4 Recommendations

5.4.1 Nursing Practice

The discussions highlight why nurses, other health professionals and health professions need an understanding of the transitioning process, and this study is an effective starting point in revealing 'what is working' in nursing practice for the transgender person experiencing or contemplating the process. There is a need for action towards strengthening these supports which is consistent with nursing values and this study's use of Appreciative Inquiry (Kung et al., 2013). Nurses have strived to operate from a strength perspective as a profession and this is reflected in documents such as Primary Health Care (Canadian Nurses Association, 2015) and Registered Nurses Association of Ontario (RNAO, 2021). Canadian Nurses Association (2015) reinforces principles such as fostering health empowerment through public participation and collaboration and the Registered Nurses Association of Ontario (2021), position statement reinforces the essential need to consult with 2SLGBTQI+ people in the development of all policies to promote inclusive and appropriate care. Therefore, a formal way to incorporate a strength-based approach could mean designing and using checklists and tools within the nursing process that captures what is working for the transgender person. For example, standardized checklists that incorporate nurses collecting demographics regarding gender diversity leading to use of chosen name and pronouns for the patient or transfer of care reports that include gender identity and transitioning status of patient. The strength-based approach should become instinctual and universal (MacDonald, & Dickinson, 2021) where nurses introduce themselves at first point of patient contact by declaring their pronouns regardless of knowing if patient is cisgender or non-cisgender. Then, upon knowing a transgender status, moving forward

to including choices for patients regarding affirming language such as asking about 'chest feeding' as opposed to 'breast feeding'. The strength-based approach also includes the transgender person as active participants in health plan decision-making as they are the experts in many of their health care interactions due to the lack of transgender health educated providers.

For nurses to provide the best possible health care experience for all transgender individuals, an overhaul of the health care system is needed to create a better society. This will include nurses demonstrating role modeling behavior regarding what is considered acceptable in society regarding gender norms at patient's bedsides and in public sectors.

5.4.2 Education.

In the future, more comprehensive education focused on the transgender person's experience of transitioning should be integrated into existing 2SLGBTQ+ health information at the curricular level of all health care programs for trans inclusive competency. Nurse leaders at the clinical level need to support transgender competent education in all areas of clinical and community practice. Nurses competently demonstrating the ability to create *safe spaces* in their practice and providing social gender affirming care is foundational towards improving the culture of health care environments and processes that can improve the rights and safety of transgender patients. Participants valued nurses who advocate for gender diverse people which is a competency that cannot be performed without the knowledge, a sense of responsibility, an open, empathetic attitude and assertive, confident communication. Therefore,

exploring implicit/explicit bias and attitudes regarding the queer population should be encouraged.

Furthermore, the responsibility of trans-inclusive care should be taken up by all healthcare professions and the systems they work in towards developing excellence in quality standard of care for transgender people. This can begin by incorporating the framework of cultural safety into health care curriculum and clinical practice which can enhance a health care provider's knowledge about the nuances of the transgender populations' transition experience and all other aspects of a transgender person's wellness needs (Baldwin et al., 2018). Cultural humility should also be imbedded in teachings of transgender health which aims to raise a health care provider's appreciation for the expertise of the transgender patient and equalizes the patient-provider relationship by creating an opportunity for a health care provider to explore their perspectives of authority (Lekas et al., 2020).

Findings also suggest that education regarding gender diversity should continue and expand into society into the school systems where programs like the Gay Straight Alliance (GSA) have been established in high schools to teach allyship and foster connections between straight and queer youth (Scheer & Poteat, 2016). School-based nurses need specific education on the gender exploring adolescent and how best to communicate and support families during this critical time of contemplation of transitioning needs. Whether in primary or secondary grades, school nurses need the education to help establish or build rapport to support GSAs in schools as these groups have been shown to be a potential protective resource for transgender youth (Poteat et al., 2020). Participants also suggest teaching foundations of gender diversity in all facets of

society and should begin with the youngest population in primary grades before discriminatory habits are taught. Therefore, as point of first contact with questioning youth, school-based nurses should be either supported in teaching the nuances of sexual orientation and gender identity and/or supported by out-sourcing an expert to help plan the best route of dissemination of the topic as the world moves towards normalizing the exploration of gender identity.

5.4.3 Policy.

The findings of the study also point to the role of systemic changes in healthcare that may positively influence the experience of transition. Participants emphasized the need for a responsive gender affirming health care system that provides access to reliable information, and swift, local, trans competent care to positively influence their transitioning experience. For this reason, recommendations include partnerships between leading nurses, local policy makers with funders to support health care systems in their critical roles to create more gender affirming clinics and trans-specific support centres that support transitioning needs. Health care standards should include policies that ensure utilization of existing trans-related education such as Registered Nurse Association of Ontario's (RNAO, 2021) best practice guidelines for the 2SLGBTQI+, Rainbow Health Ontario's (2021) education and training on-line courses and Rainbow Nurse Interest Group's (RNIG, 2022) resources regarding gender identity and sexual orientation are disseminated to all health care professionals at all levels. There is a need to invest in creating and expanding roles for nurses such as *nurse navigators* to reduce disparities of access and communication (Wagner et al., 2022) and *best practice champions* (Woodall et al., 2013) where disseminating knowledge and bridging the gap from trans-related

research to the point of patient care in health care systems is needed. A critical social lens has long been used as a framework to teach nurses how to examine power structures and challenge dominant norms prevalent in society that restrict vulnerable people (Stanley, 2013). Nurses should become *change champions* and permeate the systems through role modeling, educating and advocating as facilitators for the delivery of gender affirming care. This should be done until the need for this type of champion becomes obsolete.

The study's findings are also consistent with and adds to prior research that identifies the significant value a supportive person, an 2SLGBTQ+ support group and a trans-friendly space has on a transgender person's overall transitioning experience (Love et al., 2018). Therefore, nursing leaders, funders and policy makers need to implement trans-specific/2SLGBTQ+ supports and resources for transgender people and their families and consider adding 2SLGBTQ+ signs and symbols in public places. Since the nature of the clinical environment has an impact on the transitioning experience, welcoming and safe places should be advertised and marketed through the sign of the rainbow symbol, the progressive pride flag colours or simply the transgender pink and blue. Health care systems exist throughout the world and are best positioned to demonstrate inclusion and diversity through role modeling respective language, recognizing diverse gender identity including the nonbinary label, establishing gender neutral bathrooms, and supporting safe spaces.

In addition to systemic barriers, social norms regarding gender identity also create context that can positively influence the transitioning process. Findings suggest that normalizing the practice of disclosing pronouns when introducing oneself beyond the health care setting and in casual to everyday work life settings can increase positive

social affirmation experiences for transgender and nonbinary people in their communities. Participants suggest expanding the use of gender-neutral bathrooms and similar spaces in society that conduce correct gendering of individuals. There is a need for and benefit of community connections with the transgender population such as resource centre, Trans Wellness Ontario, Windsor, Ontario and community research project, Trans PULSE, Toronto, Ontario that should have continued government sponsorship with models expanded globally. Health care dollars should be invested in Nurse Practitioners educated in trans-specific health needs to reach rural areas where choices of providers and health care facilities are limited. Nurse leaders such as the Nurse Practitioner or Nurse Navigator should be fiscally supported in partnership with centres like Trans Wellness Ontario to provide care until the day they are no longer needed. Nurse practitioners are in an excellent position due to their increasing numbers, to meet the growing demand of gender affirming care and can be utilized in area where there is limited access to primary care providers knowledgeable in transitioning needs (Doescher et al., 2014).

Policymakers and funders should continue and enhance existing policies regarding respect and recognition of the transgender identity towards normalizing the inclusion of transgender people within the community. Violence towards the transgender population persists and policies geared towards ultimately eliminating the existence of the need for safe spaces is imperative (Westbrooke, 2022). Normalization of gender diversity for the transgender person can begin in the health care systems with providers who are delivering culturally safe, competent and equitable healthcare which requires a whole service commitment. Cultural competence and safe clinical practice have shown to

minimize discrimination and support health care providers working with minoritized groups (Haitana et al., 2022). These movements will have a positive influence on the transitioning experience. As gender identity views reset, shift and normalize; every public and private area that carry the rainbow symbol will no longer be needed.

5.5 Position of the Researcher

This research study has changed me as a researcher and forced me to reflect on the depths of my personal investment and closeness to this topic. In aim to address the quality and ultimately rigor of this study, I share the following self-critical account of my values and position as a researcher that was revealed to me during this time (McBrien, 2008). For example, I did react emotionally to a few of the interviews to the degree that caused me to make extra effort to divert my thoughts away from those feelings, avoid any facial reactions and caused a slight struggle for me to keep focused on the interviewer's words. I rebounded in these moments without the participants knowing, except for one incident, where I became overwhelmed creating a noticeable pause in the interview. I share my reflection written in my journal notes after that experience.

> I did not respond professionally during today's interview. I recognize for the first time that I am triggered by my past experiences with my own child's transition experience. When I hear a young person who says they are afraid to tell their family about a trans status…. wish they were born in a different body… dependent on others to get an appointment to see a doctor…. really had me flash back. I remember my own child's struggles…the thoughtlessness of people… I am still concerned today about how my child is being treated if he is outed…that someone is going to hurt him. (Sept. 11, 2021)

I have witnessed the challenges that still exist for a person who is questioning their gender identity despite having family or friends for support.

As a registered nurse, I am more attuned to my patient population and continue to work towards perfecting language that is inclusive while wearing symbols with transgender colours indicating a *safe space* knowing my nursing interventions will influence their health care experience today and their considerations when accessing healthcare in the future. I am becoming more comfortable in my everyday life to actively demonstrate allyship and role model social gender affirmation beyond the role of a Registered Nurse at the bedside. I worry for all gender questioning people who do not have someone to confide in, *come out* to and/or fear rejection. No one should have to experience that type of fear. As time has passed, I have had opportunity to feel as an 'insider' within the academic community with others who are acquiring knowledge on the trans/2SLGBTQ+ community through research. This has lessened my sense of isolation and given me a sense of belonging with others who care about this topic. Studying for a PhD has become more than earning the credentials as a researcher for the next stage of my career but also an opportunity to research a topic I am passionate about. I hope to make change. I am beginning to question my closeness to this subject matter and my ability to research this topic long term. My closeness is my strength and my weakness. Writing this reflective piece is emotional for me and comes with no answers. I question where to take what I have learned through my dissertation experience to make the most impact towards improving the transgender person's transition health care experience. I question how to build a self-regulating check into my research to ensure I am working alongside the transgender community. I question if I will see any degree of

change during my lifetime in societal norms regarding gender identity and sexual orientation that make needing *safe spaces* obsolete.

5.6 Study Limitations and Strengths

All participants in the study were Caucasians. This lack of diversity in race is a limitation to the applicability of this research to the wider population of transgender and nonbinary individuals. Despite Trans Wellness Ontario's geographical placement in Windsor-Essex County, an area known for its culturally diverse make-up, the pandemic's barriers may have contributed to the lack of non-caucasian recruits. There is also the possibility of a lack of culturally diverse, transgender, people of colour geographically located in the reach of recruitment. Therefore, the ability to analyze the multiple racial and ethnic intersecting considerations that make up a person in the transgender or nonbinary community is limited. Research that includes intersectionality is proven to increase transferability (Shenton, 2004). For example, the most recent national economic estimates in the United States show non-cisgendered Black individuals experience significantly higher poverty rates, greater food insecurities and have lower household incomes compared to similar non-cisgendered White individuals (Carpenter et al., 2022). The intersectional influence of sexual orientation was also not considered in this study. Many participants referenced partners/wives/husbands in their discussions and those references were explored for their meaning on the main theme of *Support* during analysis. Overall, various intersectional characteristics may have shed a wider, multi-lens view on the insight to the experience of transitioning if demographics had reflected this opportunity.

A complication of the virtual interview was revealed when the internet connection was interrupted during the first interview. The abrupt disconnect, interrupted flow of the participant's thought process, dialogue and recording of the interview. When the connection was re-established, the participant stated they were using a borrowed laptop and apologized for their lack of access to "good internet". Upon reflection, this situation revealed a potential stressor put on participants to meet a researcher's or society's standards for technology where barriers may exist to support virtual platforms and is consistent with evidence found in existing literature (Moore & Charvat, 2007; Olezeski & Bamatter, 2020). Potential for unfair social inequities experienced by the transgender population (Rosenberg & Tilley, 2021) may have existed for participants in this study and efforts by the researcher to make participation equally available needs to be considered in future studies. Due to the importance of maintaining flow of discussion and the highly sensitive nature of the topic, I deemed it appropriate to offer phone interviews when in-person interviews were not available. Interruptions were not experienced for the duration of the remaining interviews. Data collection for this study was completed during the height of the COVID-19 pandemic. With social distancing guidelines continually changing, recruitment was reliant on a social media platform. Thus, the researcher was only able to initially reach participants who had access to the internet and were connected to the Trans Wellness Ontario resource centre. It is also worthy to note that participant's interviews may have been influenced by past health care experiences not related to the transitioning experience. This was taken into consideration during the initial analysis of transcripts and to minimize this possibility, texts were screened for narratives. For

example, a participant during their interview, reflected on the experienced of being misgendered and deadnamed during the process of receiving a COVID vaccination.

The study did not include nurses' or other health care providers' input of their experience with transgender or nonbinary people who seek to transition. The Appreciative Inquiry method used for this study is one step of a participatory element where all stakeholders are needed to develop goals for future changes (Cooperrider et al., 2008). This study focused on one group, the transgender and nonbinary community as a stakeholder. The transgender voice is a pivotal piece of the partnership pie but other community stakeholders of the whole need opportunity to participate for goal development (Diedricks et al., 2018). The lack of healthcare's input is not necessarily recognized as a limit for this study. but worthy to note that optimal benefits for all stakeholders who are involved in the transitioning process are only possible if all steps for participatory action research are followed through. Strength of validity to ensure accuracy of findings regarding data analysis needs to be considered as this is a study for PhD dissertation purposes with one reviewer to interpret transcriptions (Creswell, 2014). Ideally interpretation of data would be considered more robust and reliable with more than one interviewer and reviewer of original transcripts and should be considered in research moving forward (Francis et al., 2010).

Despite these limitations, the study had several strengths. Thematic saturation was considered at 11 recruited participants but to strengthen thematic rigor of this study, extra effort using the snowball technique captured an extra three participants for a total of 14. This study targeted the non-cisgendered person, a population that has been merged with the greater 2SLGBTQ+ community historically in research. This strength addresses the

paucity in existing transgender specific literature (Rosendale et al., 2018) and identifies the unique needs of one who is on the gender identity spectrum. There was also diversity in gender identities revealed in the demographic collection. This provided a glimpse into the diversity of gender identities, illuminates the growing diversity in gender labels for non-cisgendered people and adds to the literature stating terminology of gender identities are ever evolving.

5.7 Future Research

The findings and limitations of this study support the number of areas for future research regarding the experience of transitioning for the transgender individual. Calls for participants in future studies should include up to date terminology and the understanding that more than one term may be needed to capture all meanings of the adjective *transgender.* Nurses and all health care providers need to accept that foundational terms related to gender diversity may shift in their fundamental meanings and be open to varied definition based on what the person says is the definition. Future research must knowingly be done with the understanding that transgender knowledge and terminology is continually evolving or we risk undermining transgender identities.

Further research should examine the specific challenges faced by those members of the non-cisgender population who identify as nonbinary and this study reveals participants perceive the term as continuing to be misunderstood. Future research would benefit from exploring the positive experiences or characteristics of transitioning that embrace gender identities as this is important to understand more fully, the lived experience and positive influences for transgender people. Appreciative Inquiry should be considered as a lens in future research to gauge whether transgender peoples'

experiences are shifting away from negative towards more positive and supporting encounters during transition. Work of this type should also be done nationally and internationally and focus on positive outcomes that transgender people experience when they decide to transition.

There also needs to be the continual reflection of questioning the focus of the research questions in studies, as the field is ever evolving, to ensure investigations target on the most pressing needs of the transgender community for meaningful progress to be made. Efforts to develop partnerships with 2SLGBTQ+ communities and organizations like Trans Wellness Ontario in Windsor-Essex County, would ensure transgender representation in research, identify research priorities and raise awareness of non-cisgender identities.

5.8 Contribution

Potential contributions may include adding to the knowledge base and addressing the lack of research through the nursing lens regarding the transgender and nonbinary population (Bonvicini, 2017). Knowledge dissemination regarding the importance of nurse competency in trans inclusive care including the process of transitioning is needed to improve this marginalized population's health outcomes (Ashley, 2019). Education needs to be provided in all levels of nursing where clinical and community nurses are including nurse managers, clinical nurse educators, hospital policy makers and those providing direct patient care in hospitals, clinics, public health and out-reach settings (Trujillo et al., 2017). Nursing school curriculum needs to include transgender health through all program levels (Holmes & Freeman, 2012). Initiating *pockets of change* is recommended as an effective way to stimulate innovative learning when a global system

health care change may seem overwhelming and finding a place to begin is difficult (Owen & Khalil, 2007). A pocket of change, for example, can begin with a nurse reading the reports of this study, using the new knowledge in combination with other trans-related research, and changing long standing habits in their own practice of assuming pronouns and gender of the patient based on gender expression or heteronormative expectations. Nurses adopting new modelled behaviors, can influence other nurse colleagues or health professionals and this is the beginning of a small pocket of change in the healthcare arena. Educating the profession of nursing within the various levels beginning with educational institutions and nursing curriculum to the bedside nurse at point of care can shift the learning from multiple smaller pockets to a system wide health care change given that nursing is the one of the biggest professions of the health care team.

Benefits to the participants may include: (a) the ability to have input into future development of nursing practice to improve the delivery of care to the transgender population during the transitioning process, (b) ability to have input in what is taught regarding gender affirming health in nursing education and potentially all professions in health education on a global scale, and (c) potential to address the inequities for the delivery of health care for the transgender population with system changes towards an affirming philosophy.

5.9 Conclusion

This study fills gaps in the literature by examining the experience of transition for the transgender and nonbinary person and seeks understanding of what influences this complex experience in a positive way. These findings provide evidence of the importance of change to support and improve the transitioning experience. These insights may

encourage health care professions to strive for the ability to deliver trans competent care by possessing the health care knowledge to meet transgender individual's needs. Incorporating concepts of cultural sensitivity and cultural safety to review the power imbalances within the health care system, is necessary as a part of becoming trans competent for all who practice. Most importantly, transitioning experiences can be influenced in a positive way through demonstrations of caring, despite a provider's inability to fully meet all trans competent needs for an individual. Through more acts of social gender affirmation and by promoting support of family, friends and community 2SLGBTQ+ resources, coping and other minority stressors within this high-risk population may be reduced. Universal normalization of transgender identities within society will help emphasize wellness for this community and all marginalized communities. A shift in societal and systemic cis-normative standards or *what is considered normal* will make a world where *living your authentic self* is healthy and is free of the fear of rejection. If we commit to common objectives, gender-based fear and health inequities will recede further into the distance. This study is one of the initial steps towards future actions and plans to support positive influences for the process of transition.

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APPENDICES

Appendix A: Glossary of Terms

Cisgender	A term to refer to people whose gender identity matches their sex at birth
Gender-affirming healthcare	A term referring to medical services that help people physically transition to their identified gender. This can include HRT and surgical interventions. (trans competent care, life affirming care)
Gender binary	A term that is used to refer to the Western cultural norm that dictates that there are only two recognized genders, male and female
Gender expression	A term referring to the social presentation and communication of one's gender identity to others
Gender fluid	Refers to a person whose gender identity and gender expression shifts between masculine and feminine
Genderqueer	A term that refers to people who have a gender identity that does not fit normative assumptions of male or female. It can be used as an umbrella term, or a specific identity.
Gender variant	Refer to a people who do not fit into the strict male-female gender binary.
Heteronormative	The assumption that all or majority of people are heterosexual and that being heterosexual reflects the default state of being.
HRT	Acronym for 'Hormone Replacement Therapy', the use of hormone treatment to either masculinize or feminize physical appearance
LGBTQ2+ or 2SLGBTQIA+	An acronym that refers to people within the Western culture who identify with either a non-heterosexual sexuality or a non-cisgender gender identity. Letters stand for Lesbian, Gay, Bisexual, Transgender, Queer, 2-Spirited, plus (+) refers to Intersex, Asexual, and many other labels.

Nonbinary	An identity label that refers to people who do not identify with the normative assumptions of male or female and may reject the gender binary entirely.
Queer	An umbrella term that refers to non-heteronormative sexualities or to describe the diverse community outside of heterosexuality; it may not be used by everyone.
Transgender	A term referring to people who do not identify with the sex they were assigned at birth. Often used as an umbrellas term for all those who do not identify as cisgender. Often shortened to "trans".
Transition	When speaking of transgender and gender non-conforming people, refers to the process of change. *Medical Transition*: the taking of HRT and/or surgical interventions. *Social Transition*: use of preferred name and pronouns. *Legal Transition*: changing names and/or gender markers on legal documents.
Transman	(***Transmasculine*** - towards masculine tendencies) A term to refer to people who transition from female to male.
Transwoman	(***Transfeminine*** **–** towards feminine tendencies) A term that refers to people who transition from male to female.

Note: Adapted from Trans Wellness Ontario (2022).

https://www.transwellness.ca/glossary-of-terms

Appendix B: Demographic Questions

Question about pronoun use

"What pronouns do you use?" OR "What pronouns honour you?"

Question about age

"What is your age?"

Question about education

"What is your education level?"

Less than high school diploma
High school graduate or equivalent
Some college or university, but have not graduated
College or University degree
Master's Degree
Doctorate or Professional degree

Question about race/ethnicity

"What is your race/ethnicity?"

Question about city/town and province of residence

"What is your city/town and province of residence?

Question about gender

"Which of the following label best describes your current gender identity?"

Agender
Feminine nonbinary
FTM
Gender nonconforming
Gender neutral
Genderfluid
Man
Man assigned female at birth
Man of transgender experience
Masculine nonbinary
MTF
Multigender
Non-Binary
Polygender
Trans

Trans feminine
Trans girl
Trans boy
Trans guy
Trans man/Transman/Transgender man
Trans masculine
Trans woman/Transwoman/Transgender woman
Transgender
Transsexual
Two-Spirit
Woman
Woman assigned male at birth
Woman of transgender experience
Without gender
Not listed (Write in option)
Prefer not to answer

Questions about identification as transgender and gender diverse individual

“Do you identify as transgender?”

Yes
No
Other
Prefer not to answer

“What sex were you assigned at birth?”

Male Assigned at Birth
Female Assigned at Birth
Intersex

Appendix C: Interview Questions

Discovery phase:

1) Tell me a story of when you felt particularly healthy and positive during your transitioning process?
2) How were the health care providers or nurses involved and how did they help? What other situational factors contributed toward this positive time or who else was involved and how did they help?

Dream phase

1) Imagine a world where you lived in a truly accepting community, what are the most
   important things you would need to take care of your own health care? What would be different from the way things are now in health care or from nursing care you received?
2) What interactions from health care providers, nurses, health care appointments or health care resources worked for you in moments before, during or after your transition?
3) If I were to give you three wishes that could be used to improve your transitioning experience, what would those three wishes be?

Design phase

1) What should be changed, made better or included for a person going through the transitioning process? What in health care should be changed, made better or included, especially in nursing?

Destiny phase

1) What are the first steps that health care can take? What are we going to do to start this process? **(**Who, what, when, where, why, and how of the first steps in the action plan are discussed**)**

Appendix D: Approval Letter

W.E. TRANS SUPPORT
LGBTQIA2S+ COMMUNITY HEALTH & WELLNESS CENTRE
1-833-WE-TRANS

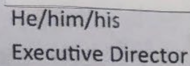
1435 Tecumseh Rd. East Windsor ON N8W 1C2 (P) (226) 674-4745 Email: Reception@wetranssupport.ca

Shelley Letter of Approval:

To: The University of Windsor,

This is a letter of approval for Shelley Evans, to have access for research purposes at our center, Windsor Essex Transgender and Allied Support, located in Windsor, Ontario, Canada.

Regards,
Alexander Reid, B.Ed



He/him/his
Executive Director

Appendix E: Facebook Post for Recruitment

<u>**Facebook Post for Recruitment**</u>

Recruitment Letter

The Experience of Transitioning for the Transgender Person: An Insight To Improve Health Outcomes

The research team is inviting **trans individuals who have experienced the process of transitioning (pre-transition, during transition or post-transition) to share their insight.**
You will be asked to participate in an individual, phone or virtual **interview approximately 60 – 120 minutes** in length.
You will answer questions for the purpose of gaining insight into of the experience of transitioning.
Due to covid restrictions, interviews are conducted by phone or virtual session.

If you want to find out more information regarding participating in the interview please contact Shelley Evans, PhD student, at reaume6@uwindsor.ca or call 519-253-3000, ext. 7477.

As a token of our appreciation for participating in the study, you will be given a $25.00 grocery gift card.

This research study has received ethics approval from The University of Windsor Research Ethics Board.

Appendix F: Letter of Intent

Title of Study: The Experience of Transitioning for the Transgender Person: An Insight to Improve Health Outcomes

You are asked to participate in a research study conducted by Shelley Evans, PhD student, Dr. Jamie Crawley, Department of Nursing, Dr. Debbie Kane, Department of Nursing, Dr. Kathy Pfaff, Department of Nursing, Dr. Kathy Edmunds, Department of Nursing and Dr. Michael Boroughs, Department of Psychology at the University of Windsor. Shelley Evans, as the principal investigator, will be leading the interview sessions.

If you have any questions or concerns about the research, please feel to contact:
Shelley Evans at reaume6@uwindsor.ca or 519-253-3000 #7477
Dr. Jamie Crawley, jcrawley@uwindsor.ca

PURPOSE OF THE STUDY

This study will explore the lived experience of the transitioning process for the trans person.

PROCEDURES

The research team is inviting trans individuals **who have experienced the process of transitioning,** (pre-transition, during transition or post-transition) to share their insight. You will be asked to participate in an individual, virtual or phone interview approximately 60 – 120 minutes in length. Due to covid restrictions, interviews may be conducted by phone or virtual session. You will answer questions for the purpose of gaining insight into of the experience of transitioning.

If you choose to participate, please contact Shelley Evans (reaume6@uwindsor.ca) or call 519-253-3000, ext. 7477 to sign up for an interview session.

Phone or virtual interviews will be scheduled at your convenience.

POTENTIAL RISKS AND DISCOMFORTS

There is a potential for you to become uncomfortable by sharing your personal experiences. Minimal risks are anticipated for those who volunteer to participate in the individual interview.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Your opinions may contribute toward: a) improving the delivery of health care to the trans population during the transitioning process, b) addressing the inequities in the delivery of health care for the trans population and c) input in teaching gender affirming health in nursing education. You will be given an opportunity to answer questions designed to shed light on the truths, realities and perspectives of transitioning.

COMPENSATION FOR PARTICIPATION

You will be given a $25.00 grocery gift card as a token of our appreciation for participating.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. You will be assigned a number which will be used throughout the study – your actual name will not be used during the session and will not be used in the results. The recordings of the session will be accessible only to the members of the research team and the individual who transcribes the recordings.

PARTICIPATION AND WITHDRAWAL

You may withdraw from the study at any time. There will be no consequences if you withdraw. If you decide to withdraw, information obtained up to that point will remain in the study.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of the results of this research will be made available on the University of Windsor site, the address to which is:
Web address: https://scholar.uwindsor.ca/research-result-summaries/

SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

Appendix G: Consent to Participant In Research

Title of Study: <u>The Experience of Transitioning for the Transgender Person: An Insight to Improve Health Outcomes</u>

You are asked to participate in a research study conducted by Shelley Evans, PhD student, Dr. Jamie Crawley, Department of Nursing, Dr. Debbie Kane, Department of Nursing, Dr. Kathy Pfaff, Department of Nursing, Dr. Kathy Edmunds, Department of Nursing, and Dr. Michael Boroughs, Department of Psychology, at the University of Windsor. The principal investigator, Shelley Evans, will be leading the interview.

If you have any questions or concerns about the research, please feel to contact:
Shelley Evans at reaume6@uwindsor.ca or 519-253-3000 #7477
Dr. Jamie Crawley at jcrawley@uwindsor.ca or 519-253-3000 #4816.

PURPOSE OF THE STUDY

This study will explore the lived experience of the transitioning process for the trans person.

PROCEDURES

You will be asked to participate in an individual, virtual or phone interview approximately 60 – 120 minutes in length. Due to covid restrictions, interviews will be conducted by phone or virtual session. Phone or virtual interviews will be scheduled at your convenience.
You will share your experience with one or more of the following processes: pre-transition, during transition or post-transition. You will be given an opportunity to answer questions geared towards providing a comprehensive understanding of the experience of transitioning.
Your opinions will contribute towards improving the delivery of nursing care and health care overall.

POTENTIAL RISKS AND DISCOMFORTS

Minimal risks are anticipated for those who volunteer to participate in the in-person/phone or virtual interview. There is a potential for you to become uncomfortable by sharing your personal experiences.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

You may gain some intrinsic benefit from having input into future development into improved nursing care and overall health care for the trans population during the transitioning process. The profession of nursing also stands to gain by addressing the lack of knowledge regarding trans health worldwide and potentially contribute to nursing education globally.

COMPENSATION FOR PARTICIPATION

A $25.00 grocery gift card will be given for compensation for participation in this study.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Your actual name will not appear in the published results. If you choose to share information regarding gender expression during the interview which may be unique in its identification to you, this characteristic will be excluded in the data collection upon your request to prevent *outing* you. The recordings of the session will be accessible only to the members of the research team and the individual who transcribes the recordings.

PARTICIPATION AND WITHDRAWAL

You may withdraw from the study at any time. There will be no consequences if you withdraw. If you decide to withdraw, information obtained up to that point will be included in the study.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of the results of this research will be made available through the Research Ethics Board on the University of Windsor research website, the address to which is located below.
https://scholar.uwindsor.ca/research-result-summaries/
Date when results are available: Sept 1, 2022

SUBSEQUENT USE OF DATA

The data may be used in subsequent studies, in publications and in presentations.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand the information provided for the study (The Experience of Transitioning for the Transgender Person: An Insight to Improve Health Outcomes) as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Appendix H: REB Approval

Today's Date: June 01, 2021
Principal Investigator: Ms. Shelley Evans
REB Number: 39111
Research Project Title: REB# 21-073: "The Experience of Transitioning for the Transgender Person: An Appreciative Inquiry Approach To Advance Nursing Knowledge"
Clearance Date: May 31, 2021
Annual Renewal Date: May 31, 2022

This is to inform you that the University of Windsor Research Ethics Board (REB), which is organized and operated according to the Tri-Council Policy Statement and the University of Windsor Guidelines for Research Involving Human Participants, has granted approval to your research project.

An Annual Renewal/Progress Report must be submitted 1 year after the clearance date for renewal of the project. The PI may request a modification in this annual reporting date to align with other annual reporting requirements. The REB may ask for monitoring information at some time during the project's approval period. A Final Report must be submitted at the end of the project to close the file.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the REB. Approval for modifications to an ongoing study can be requested using a Request to Revise Form.

Investigators must also report promptly to the REB:
a) changes increasing the risk to the participant(s) and/or affecting the conduct of the study;
b) all adverse and unexpected events that occur to participants;
c) new information that may affect the risks to the participants or the conduct of the study.

Forms for submissions, notifications, or changes are available on the REB website: www.uwindsor.ca/reb. If your data are going to be used for another project, it is necessary to submit a secondary use of data application to the REB.

Sincerely,

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