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***Creative Nursing* Vol. 26 #2: Seeing Beyond Gender**

FROM THE EDITOR-IN-CHIEF: Having Our Assumptions Questioned and Our Knowledge Expanded, by *Marty Lewis-Hunstiger, BSN, RN, MA, retired pediatric nurse and preceptor, Editor-in-Chief of Creative Nursing, copy editor of the Interdisciplinary Journal of Partnership Studies, and affiliate faculty member in the School of Nursing at the University of Minnesota.*

In this issue of our journal, our founding editor, Marie Manthey, calls out that “a sea change is challenging society’s notions about gender identification, gender expression, and sexual orientation.” She issues a challenge that enters the personal realm of individual nurses, in our practice and in our lives: “The moral ethic of nursing is caring. If your personal morality doesn’t allow you to call someone by their preferred name or pronoun, I would lovingly ask you to reconsider your vocation.” Marie Manthey’s words resonate in me. I believe that as nurses, and as human beings, it is our actions – our behavior – that we are accountable for, not the thoughts and feelings that occur to us. It is our openness to learn and grow beyond the strictures imposed on us that defines us as professionals. The belief that we must all be sorted into two categories is likely not as ancient and foundational as many believe. While it may have seemed adaptive at some point, it is no longer serving us; people are being hurt, even killed, in the name of sorting people into gender categories. People whose assigned gender matches how they feel may have difficulty relating to those whose experience is otherwise. I have a suggestion. Remember the many, many times when you have been made to feel that you don’t measure up to your assigned category, or, if you do measure up, you have achieved it through exhaustive use of resources that could be much better used elsewhere. All the articles in this issue, rich in their descriptions and challenging in their advocacy, reflect our journal’s commitment to fostering excellence in health care for all people – no exceptions – and to holding our profession to the highest ethical standards.

FROM THE FOUNDING EDITOR: Lesbian, Gay, Bisexual, and Transgender People, and the Nursing Imperative, by *Marie Manthey, MNA, FRCN, FAAN, CEO Emeritus of Creative Health Care Management and Founding Editor of Creative Nursing.*

This article speaks to the legacy value of nurses’ caring for all people, no matter how they feel about the person’s values or lifestyle, including the current issues around gender identity and sexual orientation. This legacy is deeply imbedded in the moral ethics of nursing and supports the proposition that if there isn’t caring, it isn’t nursing. Rapid changes in society will continually present challenges to the status quo, especially if the new culture is challenging age-old values and principles that are familiar and comfortable to the majority of people. Currently, a sea change is challenging society’s notions about gender identification, gender expression, and sexual orientation. A small but growing segment of people are redefining their understanding of themselves, and they are also—quite rightly—unwilling to pretend to be who and what they are not. No matter what the patient’s physiological realities are now or were at birth, socially and relationally, the patient has the right to tell us about their gender, and socially and relationally, we must accept what the patient tells us. No nurse gets a pass because they find someone’s gender presentation confusing. If your personal morality doesn’t allow you to call someone by their preferred name or pronoun, I would lovingly ask you to reconsider your vocation. Humane care means care that recognizes and supports all aspects of a person’s humanity.

FROM THE GUEST EDITOR: Increasing Gender Awareness to Reduce Harm in Health Care, by *Alex Iantaffi, PhD, MS, SEP, CST, LMFT, certified sex therapist, family therapist, Somatic Experiencing practitioner, clinical supervisor, writer, independent scholar, adjunct faculty at the University of Wisconsin- Stout and chair-elect of the Trans and Queer interest network of the American Association for Marriage and Family Therapy.*

This guest editorial first discusses how gender is a historical and biopsychosocial construct; for all of us, our gender is a complex mix of our biology, our psychology, and the social world around us. There are many aspects of gender besides identity, such as gender expressions, roles, and experiences. This theme issue of *Creative Nursing* highlights some of these aspects of gender, but there are many others. Being able to consider our own gender identities, roles, expressions, and experiences is an essential starting point if we are to be competent health-care providers. Reflection can help us notice: How have we been impacted by rigid gender binaries? How do we sometimes perpetuate these harmful stereotypes in our own practices? What is the relationship to

gender that we want to cultivate and nurture moving forward? Stories are one way to learn about aspects of gender we may not be as familiar with, as they allow us to connect emotionally, not just cognitively, with these aspects. Wherever we look, gender is ever present in the stories we are exposed to, from fairy tales to medical case studies; therefore, paying attention to who is telling whose story is vital.

ARTICLES AND ESSAYS

Transgender and Gender Nonbinary Persons' Health and Well-Being: Reducing Minority Stress to Improve Well-Being, by *Sheila K. Smith, PhD, ANP-BC, AGACNP-BC, clinical professor and specialty coordinator for the Adult-Gerontology Nurse Practitioner Program at the University of Minnesota School of Nursing, and practitioner in adult health in the UMN Nurse Practitioner Clinic, with interests in vulnerable populations and chronic illness care.*

The combination of stigma, social and structural inequalities, and actual discrimination events result in mutually reinforcing dynamics that drive persistent disparities in physical and mental health for transgender and gender nonbinary (TGNB) persons. The experience of minority status in situations of differences in social power can lead to unfair assumptions, stereotype threat, devalued identity, internalized stigma, hypervigilance, marginalization, concealment, unhealthy behaviors, toxic levels of anger, anxiety, and distress, and a host of other deleterious consequences. Intersectionalities of TGNB identity and ethnicity, socioeconomic status, geographic location, social supports, and other social determinants of health differentially affect both health risks and protective factors, making it imperative to identify health needs and approaches in an individualized, patient-centered manner. Reports of overt discrimination against TGNB people include being refused needed care, health-care professionals refusing to touch patients or using excessive precautions, harsh or abusive language, being blamed for their health status, or being treated with physical roughness. Together with distrust of the medical system and health-care providers' discomfort in caring for TGNB persons, minority stress contributes to poorer health outcomes and reduced quality of care for sexual and gender minority populations. Barriers to disclosure can confound health-care decision making when elements of gender identity are important to making the correct diagnosis or to clinical management decisions. As many as 35% of transgender persons may identify as gender nonbinary, making more nuanced knowledge of gender diversity important for health-care providers in caring for a wide array of patients of varying gender identities and expressions.

Two-Spirit Identity and Indigenous Conceptualization of Gender and Sexuality: Implications for Nursing Practice, by *Leah Carrier, BA (Hons.), BScN, RN, an Indigenous nurse, Two-Spirit lesbian, and Killam Laureate at Dalhousie University in Nova Scotia; Jessy Dame, BScN, RN, a Métis nurse and Two-Spirit gay man, a graduate student at the University of British Columbia and staff member in a queer men's health clinic in Vancouver, British Columbia; and Jennifer Lane, BSc, BScN, RN, a lesbian nurse, Killam Laureate, and sessional lecturer at Dalhousie University in Nova Scotia, with a clinical practice in crisis stabilization and psychiatry.*

The word Two-Spirit is an umbrella term used to describe Indigenous peoples who are diverse in their sexual orientation and gender identity, though community-specific definitions and roles for gender and sexual orientation are more extensive and varied. While the terminology of Two-Spirit is recent in its development, Indigenous conceptualizations of diverse gender identities, roles, and sexual orientations have existed since time immemorial, and provide important insights into how cultural safety can be incorporated into caring practices. Two-Spirit is broadly defined as an Indigenous person who has both feminine and masculine spirits residing in their body; however, a consistent theme in literature and community member accounts about Two-Spirit identity is that it is multi-faceted, fluid, and cannot be reduced to a universal definition. Through the cultural oppression of Indigenous peoples, Western understanding and social performance of gender and sexuality were forced onto Indigenous communities, challenging pre-contact views and understanding of gender roles and sexual identity. In many nations, Two-Spirit people are revered, and occupy important and respected roles in the social structures of communities; for example, in some communities Two-Spirit individuals have specific duties to perform and serve as healers, medicine people, or spiritual leaders. Nurses have an opportunity to enhance the therapeutic relationship by learning about local Indigenous communities where they practice, including local conceptualizations and words for gender and sexual orientation.

How Myths about Nonbinary People Impede Delivering Quality Care, by *Drew Simms, MSc, BSc, BA (Hons), an advocate for victims of transphobic hate crime in Galop, United Kingdom, and a psychiatric nurse at South West London and St George's NHS Trust.*

Nonbinary is an umbrella term for a kaleidoscope of genders that do not fit the male/female dichotomy. Everyone has their own way of doing gender. Myths that bring into question the validity of nonbinary genders are commonplace; they persist even in supposedly trans-friendly spaces, and are espoused by many people who claim to stand against transphobia. Many of the myths stem from a particular understanding of history: that throughout time and space there have been only men and women. Sure, some people are born in the wrong body and need support to become the man or woman they have always known themselves to be, but “someone saying they are neither a man nor a woman seems like a Dadaist intrusion into an otherwise simple narrative.” The proliferation of these myths compromises the chances of nonbinary people being treated with dignity and respect when they seek health care. Nurses can play an important role in advocating for nonbinary clients and supporting them to build resilience through showing the acceptance and kindness that is at the heart of nursing, but which misconceptions can impede. Resilience is a house that community builds; simply telling an individual to “build resilience” is about as helpful as telling a homeless person to build a house. Good care for nonbinary patients boils down to the universal basis of nursing: listening, believing, and being kind.

Betwixt, Between, Besides: Reflections on Moving Beyond the Binary in Reproductive Health Care, by *A.J. Lowik, PhD(c), PhD Candidate with the Institute for Gender, Race, Sexuality and Social Justice at the University of British Columbia, researching all facets of trans people's reproductive lives, and a freelance consultant on trans-inclusion.*

This article is a personal reflection on the need for reproductive health-care spaces and services that challenge sex and gender binaries and that make room for non-binary people; it is also a critical commentary on why and how cis- and trans-normative understandings of sex and gender form the foundation of reproductive health care as it is currently delivered. Taken together, it is a call to action for nurses to be creative in challenging sex and gender binaries in their provision of reproductive health care. Western medical establishments as we know them were built to serve white, cisgender, heterosexual, able men; the system is not broken – it is doing exactly what it was designed to do. The health of cis women, of people of colour, of queer folks, of disabled folks, of poor folks, have historically been ignored. When cis, white, able, straight women entered post-secondary education, medical schools, and the workforce, they made spaces for themselves that filled a very real gap in our knowledge and our delivery of health care. However, the cisnormatively gendered silos of health care – a door marked women's health and another marked men's – don't necessarily work for trans people. Not only women menstruate, have cervixes, get pregnant, lactate – some men do. Not only men produce sperm, have testicles and prostates – some women do. There are all kinds of non-binary people – agender, gender neutral, genderqueer, neutrois, genderfluid, plurigender, and countless more, not to mention intersex people – who simply have no door to walk through. What would reproductive life and health look like for trans people of colour; for Two-Spirit people; for folks who describe their genders in languages other than English; for disabled, poor, or street-entrenched trans people – if we moved beyond the binary?

Building Resilience in Gender and Sexual Minority Youth, by *Diana Verrochi, MSN, RN, Assistant Professor of Nursing at the University of Hartford in Hartford, Connecticut.*

Lesbian, gay, bisexual, transgender, and/or queer/questioning (LGBTQ) youth are at particularly high risk for various health disparities, many of which are often attributed to the concept of minority stress, the excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position. Seminars using peer support strategies are helpful in supporting this age group. This article describes a workshop offered at a conference for LGBTQ youth to empower them to build resilience to the many stresses they will experience as they grow into tomorrow's leaders. The design of the workshop combined elements of Pender's Theory of Health Promotion, encouraging participants to reflect on their individual experiences with various forms of stress and coping, recognize the impact of certain behaviors on their affect, and then plan for behavioral outcomes; and Bandura's Self-Efficacy Theory, acknowledging the impact of environmental factors that may or may not be modifiable, and modifying behavioral and personal factors in response. Participants identified coping strategies they already used (healthy or not) as well as coping strategies they would like to try

(with an emphasis on healthy choices); they then developed an individual wellness plan consisting of practices they planned to use regularly, and practices to employ on particularly stressful occasions.

Being an African American Male in Birth Work, by *William Moore, CPE, health educator and certified perinatal educator at St. Paul Ramsey County Public Health, and one of the first two men in Minnesota to be a certified doula and lactation educator.*

As an African American male working in public health, the author has few peers in the field who can relate to his experiences from a gender and race standpoint, and even fewer in his work as a doula and lactation educator. Drawn to this work because of awareness of the historical role and significance of birth work in the black community and the ongoing disparities in maternal and infant mortality, his experiences as a trail blazer in this field have provided him with a unique lens into the world of birth work and how nuances at the intersection of gender and race affect his peers. He has met many health-care professionals who are eager to collaborate, network, and spread the word about the unique resources or perspective he provides as a male in birth work. There have been many who share a genuine excitement and gratitude for bringing awareness to other men about the importance of male involvement in birth work and breast feeding, especially when one of the main reasons many women give up on breast feeding is lack of support. Who better to support a woman through this than the father of the baby or the partner? He has also met with skepticism and actual rejection, including moments of disbelief and wonder about why he would want to be involved in “women’s work.” He has contracts that specifically articulate permission from both the mother and her partner to work with the family. When working with mothers, in an act of professionalism, he always has someone else (a partner or nurse) in the room, to help the family (and himself as well) feel comfortable and protected; for some men, having another man seeing their significant other in a very intimate way is a big deal that must be taken into account. The families he serves have been uniformly accepting: a few questions about how he got into birth work, no questions about his credentials, but questions about how he can best help them as individuals, and as a family, bring their child into the world and lay the strongest possible foundation for successful co-parenting.

Design Thinking in Nursing Education to Improve Care for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Two-Spirit People, by *Erin Ziegler, NP-PHC, PhD, assistant professor in the Daphne Cockwell School of Nursing at Ryerson University in Toronto, Ontario, and a primary health-care nurse practitioner; Benjamin Carroll, RN, MNsc, PhD student and teaching fellow at Queen’s University in Kingston, Ontario; and Chris Shortall, MSc, director of Rainbow Health Consulting Ltd. In Newfoundland.*

Design thinking methodology, a collaborative strategy with the potential to create innovations, is being used increasingly in health care; successful implementation of design thinking in health care can improve clinical practice, quality of care, and patient outcomes. Design thinking innovations involving community collaborations may be more acceptable and effective compared to more expert-driven methods. Design jams are interdisciplinary events that bring together experts and community members to use design thinking to collaborate on creative solutions to health-care problems. Recommendations have been made about key content for nursing education to provide a strong foundation for cultural humility with lesbian, gay, bisexual, transgender, queer, intersex, and Two-Spirit (LGBTQI2S) patients, yet there is no evidence that these recommendations have been implemented in nursing curricula. This article describes the design thinking process (Empathize, Define, Ideate, Prototype, and Test) and includes reflection on the authors’ participation in a design jam event aimed to address the knowledge-to-action gap that exists in health care for LGBTQI2S people; they designed a multi-modal nursing education curriculum to address this gap.

Registered Nurses as Optimizers of Gender Affirming Care within a Transgender and Intersex Specialty Care Clinic, by *Alissa R. Zimmerman, MSN, RN, RN-BC, inpatient nurse manager for a general and plastic surgery unit; Zachary C. Missel, BSN, RN, CCRN, outpatient/ambulatory nurse supporting the Transgender and Intersex Specialty Care Clinic; LeAnn M. Bauman, RN, outpatient/ambulatory nurse manager supporting general and plastic surgery care; and Cesar A. Gonzalez, PhD, ABPP, a board-certified clinical psychologist and clinical director of the Transgender and Intersex Specialty Care Clinic; all at Mayo Clinic in Rochester, Minnesota.*

An estimated 1.4 million transgender adults live in the US, approximately 0.6% of the population. Clinical focus on gender dysphoria has significantly increased over the past 30 years, with burgeoning cross-discipline

evidence of the positive outcomes associated with gender-affirming interventions. This article by staff members from the Transgender and Intersex Specialty Care Clinic at the Mayo Clinic in Rochester, Minnesota, illustrates how registered nurses support patients' choices toward psychosocial congruence (changes of social identifiers such as clothing, hairstyle, gender identity, name and/or pronouns, and management of minority stress), hormonal congruence (use of medical approaches such as hormone blockers or cross-hormone therapy to promote physical, mental, and/or emotional alignment), and surgical congruence (addition, removal, or modification of gender-related physical traits). Nurses provide gender-affirming care through performing comprehensive assessments, coordinating care, and providing education and health coaching.

INTERVIEW: Care for LGBTQIA Communities When Advocacy is All About Inclusion: A Conversation with Jackie Baras, MSN, MBA, RN, *LGBT Navigator and Quality Nurse Manager of PeriOperative Services at Robert Wood Johnson University Hospital/RWJBarnabas Health in New Brunswick, New Jersey. Interviewed by Lorraine Steefel, DNP, RN, CTN-A, Director of LTS Writing and Editorial Consulting Services in Marlboro, New Jersey.*

Nurses have the obligation and duty to care for all people, and to treat them with dignity, respect, and compassion. To address equitable care for lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) people in her community, Jackie Baras, MSN, MBA, RN, serves as LGBT Navigator at Robert Wood Johnson University Hospital/RWJBarnabas Health in New Brunswick, NJ. As a transgender woman, Jackie advocates as liaison and representative for all LGBTQIA patients and employees, focusing on health promotion and disease prevention, addressing knowledge gaps, and identifying community referrals, while working closely with hospital and clinical leadership to ensure that health-care services are coordinated seamlessly. In this article, Baras discusses her advocacy for equitable care for LGBTQIA communities, and ways nurses can provide culturally congruent care. It takes courage for transgender people to seek care, especially when many have experienced negative interactions with uninformed providers in the past. The transgender experience is diverse; not everyone takes hormones or undergoes surgery. Nurses need to understand this aspect clearly in order to provide individualized care. In day-to-day interactions, education is key to gaffe prevention; Baras recommends reading evidence-based studies that provide accurate information about this population, their needs, and how to address these needs.

OUTCOMES: Peer Responses to Trans Youth Tweeting About Self-Harm and Suicidality, by Drew Simms, MSc, BSc, BA (Hons), an advocate for victims of transphobic hate crime in Galop, United Kingdom, and a psychiatric nurse at South West London and St George's NHS Trust.

Transgender youth are at higher risk of experiencing common mental health problems than their cisgender peers, but there has been little research into the mechanisms of peer support among this group. Feeling that they have no outlet to talk has been identified as a risk factor for suicidality among LGBT+ youth, so the opportunity to share their thoughts and feelings online with relative anonymity may be a protective factor for trans youth. Research into how young people communicate about self-harm and suicidality on social media has found patterns in which young people encourage each other's risky and self-injurious actions; whether this holds true among minority groups such as trans youth has not been established. In this study, Twitter biographies were searched for self-identifying trans people aged 14-18 years. Those accounts were searched for key words related to common mental health issues; the 1,468 identified tweets and their replies, from 235 accounts, were coded into themes: Support, Feeling the Same Way, and Advice. There were no incidents of replies that were dismissive of or encouraged self-injurious behavior; this has implications for caring for trans youth in mental health settings, where social media use is normally discouraged, as its use may be a protective factor for trans youth specifically. Expressing distress may be an end in itself for many trans youth, as a form of catharsis or to build a narrative that makes sense of their difficult experiences. It appears that there are unspoken social norms of giving each other space to "vent" but intervening by replying to offer support when the content of tweets suggests an escalation of risk.

THE VOICE OF PATIENTS AND FAMILIES: Loving Unconditionally, by Anonymous. *Creative Nursing* does not accept unsigned submissions, but we do publish articles without identifying the author when there is a compelling reason for anonymity. In this article, a nurse and mother writes anonymously about her transgender child, whose safety is protected in this way, and describes her feelings through the multi-layered coming out

process. The parental dreams for her child that were based on societal norms changed to reflect the goals and dreams of her child. While the LGBTQ community has had wide acceptance nationwide (the author says, “I am very grateful that my child is living in a time when they have the same human rights as I do.”), there still is work to be done where discrimination occurs in several states.

MEDIA REVIEW: *Trans Allyship Workbook* by Davey Shlasko, *Reviewed by Erik McIntosh, DNP, RN, ACNP-BC, a nurse practitioner at Rush University Medical Center in the Department of Hospital Medicine, an assistant professor at the Rush University College of Nursing, a board member of the LGBTQ Leadership Council of Rush’s Diversity Leadership Council, a medicine consult for Rush’s post-operative gender affirmation patient population, and a recognized provider in OutCare Health.*

Members of the transgender community face significant social, legal, and medical discrimination, and frequently avoid accessing health care for fear that health-care spaces will be unsafe for them. State and federal laws that define gender in traditional binary terms (either male or female based on sex assigned at birth) have adversely affected the transgender community and left them vulnerable to discriminatory practices and treatment. The author of *Trans Allyship Workbook*, Davey Shlasko, a scholar, teacher, and consultant, defines allyship as “not something you are, nor something you think or feel, but something you do. It is informed, accountable action that contributes to other people’s ability to survive and thrive in a context of inequality.” Shlasko’s book walks the reader through how to be an ally to the transgender community and how to provide competent care and safe spaces for the transgender population, in chapters that define what allyship is, explain transgender identity, share transgender experiences, review standard definitions and concepts related to transgender people, and help readers learn how to put transgender advocacy into action.