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Increasing Transgender Cultural Competency with Youth Through an Online Training Module: A Quality Improvement Project

By

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Abstract

Purpose: Transgender youth face discrimination and mistreatment in many areas of their lives that contribute to poorer mental health outcomes as compared to their non-transgender counterparts. This discrimination and mistreatment extends to medical providers that they entrust with their care. Providers often are not provided with educational opportunities about how to provide high quality care to members of this population. In response to this lack of training, this quality improvement project was created for the staff of Providence Willamette Falls' Child and Adolescent Psychiatric Unit (CAPU). An online training module was developed, implemented, and evaluated specific to the needs of this unit. The aim of this project was to help the staff of this unit to increase cultural competency with population.
Methods: This project involved 2 phases. First, an initial online questionnaire was sent to staff seeking to determine specific questions to answer in the training module. Second, an online training module was developed combining 2 online training modules from The Fenway Institute and a pre- and post-survey called the Sexual Orientation Cultural Competency Scale (SOCCS) to measure effectiveness was used and embedded in training. The span of the project was 6 months.
Results: Comparing the mean scores of the pre- and post-survey showed a statistically significant increase in clinical skills and cultural competency, with a slight decrease in negative attitudes towards transgender youth.
Conclusion: This project had little financial impact, involved material that was freely available, and showed efficacy in improving cultural competency of medical staff. By improving medical staffs cultural competence it can help reduce the health disparities transgender youth face.

Transgendered people face a disproportionate number of psychosocial risk factors that contribute to poorer mental health outcomes than their cisgender (a person whose self-identity conforms with the gender that corresponds to their biological sex) counterparts. They face not only the stigmatization of a society that is only just beginning to understand gender, but also from the medical organizations and providers that they count on for unbiased care. This stigmatization comes from a lack of understanding about transgender populations. This nescience can lead to feeling mistreated by medical staff, being rejected by providers, and feeling unwelcome by healthcare organizations. Ultimately this may lead to avoidance of medical professionals and organizations, which can contribute to higher rates of poor mental health and suicide in this population.

The National Center for Transgender Equality (Grant et al., 2011) estimates that between 0.25-1% of the general population of the U.S. is transgendered, which is roughly between 800,000-3,000,000 individuals. According to Wilson & Kastanis (2015), they estimate that between 1.3-3.2% of youths nationwide identify as transgender. Indeed in a survey conducted by Portland Public Schools (2015), approximately 3% of middle and high school students identify as transgender. However, research on this population is limited as most merges transgender youth with lesbian, gay, and bisexual youth. Therefore, much of the data specific to this population must be extrapolated from transgender adult studies. One such study was published by the National Center for Transgender Equality in 2011 (Grant et al., 2011), which reported out of 7,500 participants, 19% expressed experiencing homelessness, 15.32% were HIV positive (four times the national average), 57% faced familial rejection, 51% were bullied or harassed at school, between 61-64% were victims of physical or sexual assault, and 41% attempted suicide. These experiences could lead to increases in depression, lower life

satisfaction, and higher perceived burden of being transgender (Simons, Schrager, Clark, Belzer, & Olson, 2013). In addition, research has shown that transgender individuals also have a high prevalence rate of depression (41.1%), anxiety (33.2%), and somatization (27.5%) (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). Members of the transgender community also have higher rates of cigarette smoking, 1.5 times higher than the general population, with 26% of having used drugs and alcohol to cope with the impact of discrimination (Grant et al., 2011; Benotsch et al., 2013). As they turn to medical and mental health professionals for treatment they may re-experience many of these traumatizing experiences.

Research shows that between 20-42% of transgender client's experienced verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital (McCann, 2015; Shires & Jaffee, 2015). This creates significant barriers to accessing the health care they need. Specific to transgender youth, in a study conducted by Breland et al, (2016), they were able to identify six key barriers to accessing health care: difficulty finding providers that worked with transgender youth; difficulty getting access to pubertal blockers and cross-sex hormones; providers not using correct pronouns or preferred name; being made to feel uncomfortable or "not normal" by provider; lack of clinical roadmap or protocol; and lack of coordination between providers. These perceived and actual fears cause transgender clients to be more avoidant of seeking medical help when necessary.

For many providers there historically have been few educational opportunities on transgender issues in their academic studies due to social and institutional stigmas (Poteat, German, & Kerrigan, 2013). In one study conducted by Knight, Shoveller, Carson, & Contreras-Whitney (2014), 24 clinicians were asked about their experiences working with

transgender clients. They were found to either lack "culturally competency" in their practices or expressed frustration that they had never received training on transgender health. In another study conducted by Jr.Vance, Halpern-Felsher, & Rosenthal (2015), they found that out of 2,171 clinicians surveyed, 86.4% stated that they wanted to learn more about transgender-related care. Specific to this project, some basic educational needs of medical personnel are: what names/pronouns to use when addressing transgender clients; gender identity is a non-binary construct and part of a spectrum; gender identity is different from orientation; providers attitudes towards and knowledge of gender identity can affect quality of care; stigma, violence, discrimination, and prejudice can affect health of gender nonconforming client; institutional barriers affect care necessitating a transgender affirming environment; transgendered youth have unique needs and that not all will persist with a transgender identity into adulthood; the clients mental health concerns may or may not be unrelated to gender identity; transgendered clients have more positive outcomes if they are in a socially supportive and affirming environment; changes in gender identity can effect romantic/sexual relationships; parenting and family formation can take a variety of forms; and referral sources (Ash & Mackereth, 2013; Lim, Brown, & Jones, 2013; Lurie, 2005; Sperber, Landers, & Lawrence, 2005; Unger, 2015; American Psychological Association, 2015). Additionally, for transgender youth it is important for providers to understand what medical treatment options are available. Often referred to as "The Dutch Protocol", this set of guidelines offers clinicians a structure of when to initiate pubertal blockers and cross-sex hormones for gender dysphoria in adolescents (Delemarre-van de Waal & Cohen-Kettenis, 2006). A recent study about delaying puberty and starting cross-sex hormone replacement was correlated with decreases in gender dysphoria, anxiety, depression, and suicide (de Vries et al., 2014).

What is required then is ongoing education in the form of annual trainings for medical providers and ancillary staff. This is because community awareness of this population's needs are of vast importance and providers need to stay current on the latest advances in treatment to provide the highest quality care. Both Gendron et al. (2013) and Keiswetter & Brotemarkle (2010), recommend that not only do clinicians need this type of cultural competency training, but all staff having contact with clients should be trained as well. They indicate that those that had specific transgender cultural competency training had an increase in their skills, knowledge, behaviors, and positive attitudes with working with transgender clients. By providing this form of education health disparities can be greatly reduced in the transgender community, while improving patient satisfaction with the quality of care they receive (IOM, 2011; Bockting, Robinson, Benner, & Scheltema, 2004). Indeed in one study of this type of training piloted at an outpatient clinic they found that staff had a significant increase in self-perceived skills and decrease negative attitudes towards transgender clients (Lelutiu-Weinberger, 2016).

The specific aim of this quality improvement (QI) project, therefore, was to determine if an online training module about transgender youth was effective in developing cultural competency. This was specifically tailored for the medical personnel and ancillary staff who work on Providence's Child and Adolescent Psychiatric Unit (CAPU) at Willamette Falls in Oregon City. This project was initiated due to several personnel from this unit approaching this author and expressing a need for this type of training on their unit due to recent influxes of transgender clients.

Methods

Providence Willamette Fall's child and adolescent psychiatric unit (CAPU), is a 22-bed unit that meets the acute psychiatric needs of youth ages 3-17 for the state of Oregon

(Providence Health & Services, n. d.). This program seeks to deliver care that is both developmentally age-appropriate as well as being flexible enough to meet the client's individual needs. They accomplish this by having a multidisciplinary team of doctors, nurses, and therapists that work in concert to provide individual, group, and family therapy. As gender identity data is not available for this unit, it can be expected that approximately 3% of the clients that the staff on this particular unit will come into contact with will identify as, or be in the process of identifying as, transgender based off the Portland Public School survey (2015). While Providence Health & Services has policies in place for non-discrimination of transgender patients they do not have specific trainings on transgender issues (Human Rights Campaign, 2016).

As an organization, Providence is dedicated to serving underserved populations with compassion. They are a magnet status hospital with a commitment to quality improvement and positive healthcare outcomes of the patients they serve. As this is an employee driven initiative, with support from the medical director and the nurse manager, these could then be seen as facilitators of this project. The significant barrier to this project was the time needed to go through both the training and the surveys. The inclusion criteria were that an employee had to work on the unit and have direct contact with CAPU patients. At the time of the first survey there were 88 employees that met these criteria. The exclusion criteria were those hospital employees that had indirect contact with patients (e.g. housekeeping, engineering, food services, etc.) and those that did not work consistently on the unit (e.g. RN/CNA floated from other units, agency staff, travel nurses, etc.). The goal was to have at least 80% of the staff complete the surveys and training, but do to the voluntary status of the training this goal appeared lofty.

The first step was to contact the IRB for both OHSU and Providence. The reason both

were required was that this author was an OHSU student doing a QI project at another organization. Both OHSU and Providence IRB deemed that this project was not research based, that no medically protected information was to be gathered, and deemed that it was exempt. Providence IRB also wanted to ensure anonymity of respondents would be protected while using Survey Monkey©, an online survey company. They also required that a letter be issued to participants that stated that this training was voluntary and that there would be no repercussions for not participating. Finally, they stipulated that this author could not have direct email communications with participants; therefore all email communications went through the CAPU nurse manager. However, I was allowed to being on the unit as a student to explain the project and answer questions as they arouse.

This quality improvement project was set up to have three separate phases. In the first, an email was sent by the CAPU nurse manager to the staff that met eligibility criteria with a brief intro about this phase of the project and a link to an online questionnaire through Survey Monkey©. This questionnaire was to determine what information about transgender youth they wanted to learn about. Staff were alerted prior to taking the survey that participation in the project was strictly voluntary, that there was no repercussions for not participating, and that they needed to agree to the terms prior to starting the surveys and training. This survey consisted of two questions: “What would you like to know about transgender populations?” and “What would you like to know about transgender children and adolescents?”. Under each question they were provided with multiple choices to choose from or they could write in a specific response. They were given 30 days, from mid-October to mid-November of 2016, to complete this phase of the project. A scheduled window of 30 days, from mid-November to mid-December of 2016, was then taken to create and complete the online training module. Upon

completion this training module was sent to the CAPU nurse manager for final approval. However, due to unforeseen scheduling conflicts within the CAPU department, the implementation of phase two was delayed until February 2nd of 2017.

The next phase involved a combination of a pre- and post-surveys as well as an online training module. The CAPU nurse manager was asked to send out an email with a brief script written by this author about the project, the voluntary status of the participants, and how anonymity would be ensured. This email also had an attachment to a powerpoint presentation that were embedded with a link at the beginning and end of the presentation to the online survey set up through Survey Monkey©. Survey Monkey© was used so that respondents could answer survey questions anonymously and data could be readily analyzed. The survey utilized was entitled Sexual Orientation and Cultural Competency Scale (SOCCS) created by Markus P. Bidell (2015). This is a freely available assessment tool used in research and education to determine mental health provider's knowledge, skills, and personal beliefs around working with sexual and gender minorities. This is a psychometrically valid and reliable tool that can be used in pre- and post-tests to determine efficacy of LGBT training programs. It contains 29 questions that use Likert-type 7 point scores. There are three subsections: skills, attitudinal awareness, and knowledge. There are also three versions of this tool available: one specific for mental health providers; one for general health care providers; and one for transgender competency. Version 3, transgender competency, was utilized for this project. While Bidell states that this can be modified to fit certain settings, it was felt that this would alter the tests validity and/or reliability and was therefore administered unedited.

The training module was based off of two online training modules from the National LGBT Health Education Center, a program of The Fenway Institute, (n.d.) entitled: "Improving

health care for transgender people" and "Caring for LGBTQ youth in clinical settings". The Fenway Institute was contacted in mid-October of 2016 to seek permission to utilize their presentations in a combined format and to inform them that additional information would be added for this project based on survey responses. They granted this author permission to use parts or all of their slides and to include additional information as long as the slides and information used from the Fenway Institute were correctly cited for their organization. The training was divided into four sections: 'Terminologies, Demographics, and Disparities'; 'Providing Affirmative Clinical Care for Transgender Youth'; 'Gender Affirmation Treatment: Hormonal and Surgical Care'; and 'Creating Health Care Environments that Increase Access for Transgender People'. Staff were to be originally given 90 days to complete this section, but do to time constraints this was limited to 60 days, from the beginning of February to the beginning of April of 2017. The CAPU nurse manager was asked to send out weekly reminders for the last 4 weeks of the project with a reminder of when the project would come to a close. This was done to try to get the most amount of participants for the project as the numbers coming in seemed low.

The third phase was planned to take place 30 days after the completion of the training, originally planned for the beginning of April of 2017. Again the SOCCS was to be utilized to determine attitude changes over time. Participants were to be given an additional 30 days, from the beginning of April to the beginning of May of 2017, to complete this portion of the training. However, due to time constraints this phase was cut from the project.

Results

Of the 88 employees on the CAPU that met inclusion criteria, only 35 completed the initial survey around what questions they had about transgender populations. For the pre- and

post-test only 23 completed all 29 questions of the pre-test (1st SOCCS) while only 15 completed all 29 questions of the post-test (2nd SOCCS). Therefore, while 40% completed the initial survey, only 17% completed both the pre- and post-tests. As pre- and post-surveys were submitted anonymously online there was no way to link those who completed the pre-test with those that completed the post-test. Of all the eligible participants, none explicitly declined to participate.

Table 1 presents the results of the initial survey and lists the frequency of the answers chosen. As the responses were in a multiple-choice format, respondents could chose as many or as few answers as they wanted, with an option to write in a response. For the question of "what would you like to know about transgender populations", the most frequent responses were about: the difference between transgender and transsexual; the difference between transgender and gender non-conforming; and what medical options were available. As for the write in option of this question, respondents wanted to know more about: social experience; how to educate families; how to document; and how to define sex and gender. For the question of "what would you like to know about transgender children and adolescents" the overwhelming response was around what are the developmental challenges for children and adolescents. As for the write in option of this question, the one respondent asked about the effect media had on transgender people.

Table 2 presents all 29 SOCCS survey questions as well as frequency of the answers chosen in both the pre- and post-surveys. From this the questions were broken down into their subscales of attitudinal awareness, knowledge, and skills according to the instructions of how to use the SOCCS. Questions 2, 10, 11, 15, 17, 21, 22, 23, 27, 28, & 29 were reverse scored. The means of the subscales for pre- and post-surveys were determined and a paired T-test was used

for the two sets of data to determine statistical significance. Statistical significance was defined as $p<0.05$. Table 3 presents the results of this statistical analysis on the impact the training had on participant's attitudinal awareness, skills, and knowledge of transgender people and the issues they face. From the pre-test to the post-test, the most significant areas of improvement were in clinical skills (M=3.36 vs. M=4.17; $p<0.05$) and cultural knowledge (M=4.92 vs. M=5.57; $p<0.05$). There was a slight decrease in participant's negative attitudes towards transgender people, however this was not statistically significant (M=6.40 vs. 6.35).

Discussion

The results of this quality improvement project show that this type of training was statistically significant in developing cultural competency for medical personnel. It was shown that this type of training specifically increased clinical skills, cultural competency, and somewhat decreased participants negative attitudes towards transgender populations. The findings from this project were somewhat similar to the study conducted by Lelutiu-Weinberger (2016). They also found that this type of educational training improved cultural knowledge among their participants. However, as where they found minimal improvement in clinical skills and significant decrease in negative attitudes towards transgender people, this project found the opposite.

Even though this project was developed for medical personnel working with transgender youth, the vast majority of the content was on general information about transgender populations. This would mean that the project could be easily altered to fit multiple medical settings where transgender education is needed. As this presentation was electronically based, and only impacted the time and energy of the author in creating this, it also means that this type of training is portable and cost effective. Additionally, the source material and evaluation tools

are freely available by the organizations that produce them. This means that organizations could readily utilize this training for new hires and annual competencies with little to no financial impact. It is, therefore, recommended that this type of training become an annual training for all employees across all disciplines.

However, this project had several limitations. First, only a small number actually completed both surveys of the project, which might alter the statistical significance of the project. As the staff of the CAPU had stated they wanted this type of training, it was expected that this number would be much higher. However, this does not mean that only a small number actually went through the slides of the training. Certainly the possibility exists that many more participants actually went through the slides, but simply did not do the surveys. Therefore, this training might have served its purpose of training staff to work with transgender clients, but the lacking data cannot show better evidence of doing so. Second, as the training was sent via email, it is possible that many participants might have lost this email due to the dearth of daily email they receive. However, attempts were made during the final for weeks to remind staff of the project and resend the trainings. Finally, both the SOCCS's and the training itself were fairly long and could be time consuming to complete. However, it was felt that altering the SOCCS would affected its validity and reliability. Additionally, while the training had numerous slides, the content of each slide was purposefully not information dense to assist with ease of use and retention of information. This training was also performed and timed by this author to see how long it would take to go through. The CAPU nurse manager and the CAPU nursing educator also previewed this training prior to distribution to assist with condensing this material.

It was noted that of the survey questions asked, the most surprising answer was around

the question for transgender people needing special rights. While in the minority, there were some that felt that it was 'totally true' that transgender people do not need special rights (i.e. for housing, employment, marriage, legal). This minority answer appeared to hold true even after the training. Two explanations exist for this: either they believe this to be true or somehow the reader misinterpreted the question. Possibly the wording could have been phrased as 'equal protection' instead of 'special rights', which might have changed these answers. Another answer to a survey question that was unexpected was a small minority that believed that it was 'totally true' that a transgender client would benefit most from a provider that endorsed conventional norms and values about gender. This again was persistent even after the training. A possible explanation is that this training was geared towards those working with children and adolescents, some of whom were taught in their training that many transgender children will desist in their gender dysphoria as they mature. The belief was that by not allowing them to exhibit non-stereotypical gender expression that they would the social difficulties of transitioning back to stereotypical gender expression of their sex assigned at birth (Zucker, 2008). Therefore, their response might be seen as trying to protect as opposed to trying to punish. In many psychological circles allowing children to express non-gender conformity is still controversial despite evidence that not allowing them to do so can cause long lasting psychological scars (Bryant, 2007).

As for next steps this project should be piloted in other areas of the hospital across different disciplines. Further research should compare a face-to-face presentation with the online training module presented in this paper. The ultimate goal would be to see this formalized and presented to all staff as part of their annual education.

Conclusion

In conclusion, transgender youth face multiple health disparities, not the least of which includes access to competent and compassionate medical personnel. Unfortunately, most medical personnel lack adequate cultural competency with this population. This project has shown that significant improvement in cultural competency can be produce for medical personnel working with transgender children and adolescents with little economic impact. As hospitals and employees try to provide the highest quality of care to the clients that they serve, it would make sense to start with increasing the cultural competency of those that work in that system.

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Appendix

Table 1: Transgender Population Survey	
What would you like to know about transgender populations?	
Answer Options	**Response Count**
What is the difference between being transgender and being transexual?	17
What is the difference between sexual orientation and gender identity?	8
What is the difference between being transgender and being gender non-conforming?	17
Should transgender people be counseled to accept their assigned gender at birth?	7
What are some medical options for transgender people?	17
What is 'gender dysphoria'?	16
Why is transgender equality important?	3
Decline to answer.	1
Other (please specify)	4
What would you like to know about transgender children and adolescents?	
Answer Options	**Response Count**
Is this attention seeking behavior?	7
Is using the label 'transgender' just a trend?	15
How does 'gender dysphoria' apply to children and adolescents?	24
What are medical options for transgender children and adolescents?	20
Should children and adolescents be taught to have appropriate gender behavior?	6
Does identifying as transgender mean that romantic relationships are only of the same gender assigned at birth?	4
What are developmental challenges for children and adolescents?	28
Decline to answer.	0
Other (please specify)	1

Table 2: Pre- and Post-SOCCS results by question							
1. I have received adequate clinical training and supervision to work with transgender clients/patients.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	6	6	6	3	2	1	1
post-survey:	0	0	0	6	1	9	0
2. The lifestyle of a transgender individual is unnatural.							

Scale:	Not true at all	2	3	Somewhat true	5	6	Totally true
pre-survey:	18	2	3	2	0	0	0
post-survey:	11	4	0	1	0	0	0
3. I develop my clinical skills regarding transgender clients/patients via consultation, supervision, and continuing education.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	3	5	2	8	1	4	1
post-survey:	0	0	0	4	4	4	3
4. I have experience working with transgender clients/patients.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	1	0	1	6	4	7	6
post-survey:	0	0	0	5	4	5	2
5. Transgender clients/patients receive less preferred forms of clinical treatment than non-transgender individuals.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	3	5	4	8	1	2	1
post-survey:	0	1	0	9	1	5	0
6. At this point in my professional development, I feel competent, skilled, and qualified to work with transgender clients/patients.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	3	6	3	10	2	0	1
post-survey:	0	0	0	5	7	4	0
7. I have experience working with transgender couples and/or families.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	8	6	1	3	4	0	1
post-survey:	5	2	4	3	1	1	0
8. I have experience working with male to female transgender individuals.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	1	4	5	4	4	4	3
post-survey:	0	1	4	6	3	2	0
9. I am aware some research indicates that transgender individuals are more likely to be diagnosed with mental illnesses than are non-transgender individuals.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**

pre-survey:	0	1	2	5	6	5	6
post-survey:	0	0	0	3	2	3	8
10. A transgender person is not as psychologically stable as a non-transgender person.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	9	7	7	2	0	0	0
post-survey:	4	4	1	6	1	0	0
11. Being highly discreet about their gender identity and expression is a trait that transgender individuals should work towards.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	22	2	1	0	0	0	0
post-survey:	12	3	1	0	0	0	0
12. I have been to professional in-services, conference sessions, or workshops focusing on transgender issues.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	17	0	5	2	0	1	0
post-survey:	8	2	1	2	2	1	0
13. Prejudicial concepts about gender have permeated the health professions.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	0	3	1	4	6	4	7
post-survey:	1	0	0	5	2	4	4
14. I feel competent to assess a person who is transgender in a therapeutic setting.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	3	1	3	7	10	1	0
post-survey:	0	1	0	2	7	6	0
15. Transgender people don't need special rights (e.g., employment, marriage, housing, or legal).							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	15	5	2	1	0	0	2
post-survey:	11	3	0	0	0	0	2
16. There are different issues (i.e., psychosocial, medical) impacting male-to-female versus female-to-male transgender individuals.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	0	2	4	5	4	6	4

post-survey:	1	0	0	0	5	5	5
17. It would be best if my clients/patients viewed traditional gender expression as ideal.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	20	1	3	0	0	1	0
post-survey:	13	1	1	0	0	0	1
18. I have experience working with transgender female to male individuals.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	1	2	1	6	4	2	9
post-survey:	0	0	2	4	5	2	3
19. I am aware of institutional barriers that may inhibit transgender people from using healthcare services.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	0	2	0	6	7	7	3
post-survey:	0	1	0	1	1	3	9
20. I am aware that healthcare practitioners impose their values concerning gender upon transgender clients/patients.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	1	2	2	5	7	1	7
post-survey:	0	0	2	4	4	3	3
21. My clients/patients should accept some degree of conformity to traditional gender roles and expression.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	13	8	1	2	1	0	0
post-survey:	11	3	0	1	1	0	0
22. Currently, I do not have the skills or training to do a case presentation or consultation if my client/patient were a transgender individual.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	0	1	6	3	3	8	3
post-survey:	2	2	4	6	1	0	1
23. Transgender individuals will benefit most from a provider endorsing conventional values and norms about gender.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	17	4	1	1	0	1	0
post-survey:	14	1	0	0	0	1	0

24. Being born a non- transgender person in this society carries with it certain advantages.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	1	1	1	2	1	5	14
post-survey:	0	1	1	1	2	2	9
25. Gender identity differences between providers and clients/patients may serve as an initial barrier to effective clinical care with transgender individuals.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	0	1	1	6	6	7	3
post-survey:	0	0	0	1	3	6	6
26. I have done a training role-play involving a transgender clinical issue.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	24	1	0	0	0	0	0
post-survey:	14	2	0	0	0	0	0
27. I think being transgender is a mental disorder.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	15	7	1	1	1	0	0
post-survey:	11	2	1	1	1	0	0
28. Transgender individuals must be discreet about their gender identity and expression around children.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	17	4	1	3	0	0	0
post-survey:	11	2	1	0	1	0	1
29. When it comes to transgender individuals, I believe they are morally deviant.							
Scale:	**Not true at all**	2	3	**Somewhat true**	5	6	**Totally true**
pre-survey:	22	2	1	0	0	0	0
post-survey:	15	1	0	0	0	0	0

Table 3: Statistical Analysis of SOCCS by subscale			
	pre-test mean	post-test mean	*p*-level
Attitudinal Awareness	M=6.40	M=6.35	0.639
Cultural Knowledge	M=4.92	M=5.57	0.006
Clinical Skill	M=3.36	M=4.17	0.014