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Trans* and gender non-conforming (TGNC) young adults : self-report of access and comfort in health care systems

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Victoria L. Reiszner
Trans* and Gender Non-Conforming
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ABSTRACT

This study examined diverse trans* and gender non-conforming (TGNC) young adults' perceptions of medical and mental health providers and health care settings; and how TGNC perceptions influence or inhibit their level of comfort and willingness to access preventative and emergency services. The study aimed to extend knowledge and understanding of challenges faced by TGNC individuals and to inform health care providers on how they can become more effective in both their outreach and service provision to TGNC communities.

Much of the current literature examining individuals with gender nonconforming identities focus on discrimination, limited access to health care, major health challenges, conflicting surgical outcomes, and mental health concerns (Dovor, 2004; Lev, 2004; Zucker & Bradley, 1995). Other research focuses on pathology, discovery of trans* existence, or its proposed root causes. This view of trans* individuals by society, and clinicians' lack of knowledge and understanding about how trans* individuals experience their identity, negatively impacts clinical intervention. Unlike those studies, this study gives voice to TGNC young adults as they speak out about their needs, feelings and requirements for safe and adequate health care. The current research is significant because it openly advocates for and accepts diverse transgender and gender non-conforming (TGNC) individuals and communities as equals, and educates medical and mental health providers who likely will work with TGNC young adults during the span of their professional careers.

Eleven self-identified TGNC individuals were interviewed using structured interview questions to respond to the study's two research questions: (1) What are the positive and

negative experiences within medical and mental health care systems that diverse TGNC youth experience; and (2) What does a supportive environment, setting, and culturally sensitive provider look like for trans* and gender non-conforming young adults?

Several significant findings emerged from this study. The data showed that negative experiences with healthcare providers included providers making automatic assumptions about TGNC identities related to gender and sexuality, genitalia, and sexual health care needs. Participants in this study described purposefully withholding personal health information when they did not feel safe and accepted by health care providers. In contrast, the researcher found that positive and comforting experiences with healthcare providers and systems included explicit acknowledgement, validation, support, and open communication with TGNC clients and patients.

TRANS* AND GENDER NON-CONFORMING YOUNG ADULTS: SELF-REPORT OF ACCESS AND COMFORT IN HEALTH CARE SYSTEMS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

Transgender is an “umbrella term” that incorporates individuals whose gender identity or gender expression differs from people who identify with a gender that is traditionally and socially associated to their assigned anatomical sex, also known as cis-gender (Johnson, Mimiaga, & Bradford, 2008). The asterisk in trans* incorporates a broad range of non cis-gender people, including gender queer, gender non-conforming, transsexual, female to male (FTM), male to female (MTF), bi-gender, genderless, and pangender individuals (Johnson et al., 2008). Gender non-conformity aims to conceptualize individuals who maintain a distinct gender identity, presentation, and/or understanding of themselves that differs from societal norms and attributes that are traditionally assigned to primary and secondary sex characteristics (Coleman et al., via Institute of Medicine, 2011). The gender transition process is a uniquely individualized process (Coleman et al., 2012) and might include altering sex and binary gender that was assigned at birth to align with the preferred gender to which transgender people self-identify. There are various types of transition-related processes such as hormone replacement therapy, sex reassignment surgery and other gender confirming surgeries.

In terms of potential medical and psychological care, transition related processes may or may not include changes in gender identity, gender expression, hormone therapy, surgical procedures, voice and communication therapy, and psychotherapy (Coleman et al., 2012).

Additional options for trans* and gender non-conforming (TGNC) individuals to enhance well-being and sense of self include peer support systems, support resources for family and friends, hair removal treatments, breast binding, genital tucking, and changes in name and gender record documents (Coleman, et al., 2012). The World Professional Associate for Transgender Health (WPATH) provides countless recommendations for medical and mental health professionals who work with TGNC adolescents (Coleman et al., 2012).

TGNC individuals experience various forms of oppression and discrimination merely because they express their gender in ways that differ from United States' society's norms (Lev, 2004). This discrimination exists in numerous areas of society, including the political, social, economic, educational, medical, and mental health arenas. There is limited literature on TGNC individuals and that which does exist, often focuses on pathology, discovery of TGNC existence, or its proposed root causes. This rejection of TGNC individuals by society, and clinicians' lack of knowledge and understanding about how TGNC individuals experience their identity negatively impacts clinical intervention. The current research aimed to incorporate the intersectionality of race, ethnicity, gender, sexual orientation, and social class of diverse young adults who identify as transgender, gender non-conforming, or are questioning their gender identity.

The National Transgender Discrimination Survey, which is the most comprehensive survey of transgender discrimination ever undertaken, found that transgender Latino populations are at a greater risk of being refused medical care because of bias, and in turn often do not seek medical support (Moser, 2013). Medical institutions and practitioners who lack sensitivity or fail to understand the need for trans* inclusive services hurt and isolate trans* patients in various ways. Trans* patients may fear being "outed", mistreated, or feel as though they have to teach their provider what it means to be trans* (Moser, 2013).

The current researcher examines intersectionality related to race, ethnicity, gender, sexual orientation, and social class of young adults who identify as transgender, gender non-conforming, or are questioning their gender identity, and how this impacts health seeking behaviors. For this study these terms are defined as follows.

Intersectionality – a sociological term that aims to understand and name the complex and often-invisible collection of multiple sociocultural identities that an individual might possess; and that these identities impact individuals, groups, and larger social structures and systems ("University of California," 2011).

Race – a social construct based on past and present perceived differences in biological make up, visible appearance, and behaviors (NCBI, 2006).

Ethnicity – describes groups that share cultural values that may include language, religion, beliefs, and customs (Johnson et al., 2008).

Gender – the behavioral, cultural, or psychological traits typically associated with one's sex and sexual orientation as the inclination of an individual with respect to heterosexual, homosexual, and bisexual behavior (Merriam-Webster's Collegiate Dictionary, 11th Edition).

Individuals who identify as lesbian, gay, bisexual, or transgender (LGBT) also are susceptible to being placed at a socioeconomic disadvantage. Thus, SES is inherently related to the rights and well-being of LGBT persons. Geographic location and class also are important to study because in rural areas, trans*, gender non-conforming, and people questioning their gender identities often are unseen and afraid to access services (Moser, 2013). Many TGNC individuals who live in rural areas look for trans* inclusive providers who are far away from their home, but many of these individuals may not have access to these providers (Moser, 2013). This study focuses on TGNC young adults (18-26) and their individual past and current access and comfort in seeking medical and psychological support systems in their immediate environment.

This research is important in terms of advocating with and accepting diverse TGNC individuals and communities, and empowering medical and mental health providers who will likely work with trans*, gender non-conforming, and gender questioning young adults during the span of their professional careers. Kenagy (2005) expressed the strong need for mental health providers, including social workers to be concerned about the high rates of substance misuse, suicide, and homelessness within trans* communities. Also, mental health providers must not ignore the lack of access to culturally informed mental health and primary care providers for these communities (Kenagy, 2005). Therefore, it is inherently necessary to study diverse trans* and gender non-conforming young adult perceptions of providers, including how these perceptions influence diverse trans* and gender non-conforming young adults and their access and comfort in seeking preventative and emergency health services. It is essential to give voice to diverse young adults who are trans* and/or gender non-conforming and hear what they need in order for them to feel more comfortable, safe, and uninhibited to provide honest answers to personal health-related questions that are typically asked in medical and mental health settings. I hypothesize that increased awareness, knowledge, acceptance and “better practices” when working with trans* and gender non-conforming individuals may lead to increased honesty and comfort between diverse trans* clients and health care providers. Therefore this research is instrumental in informing providers who are unfamiliar and/or uncomfortable working with young adults who are in the process of identity development and who may or may not be questioning their sexual orientation and/or gender identity (Kenagy, 2005). Vital questions to ask are, what are the positive and negative experiences within health care systems felt by diverse trans* and gender non-conforming young adults, and what does a supportive environment, setting, and culturally sensitive provider “look like” for TGNC young adults? The results of this study will be imperative to providing TGNC young adults’ access to supportive and quality services, and in decreasing health disparities, risks, and discrimination trans* young adults frequently face in today’s society.

Throughout this research study, I ask participants to define TGNC inclusive care, knowledge, acceptance, and comfort in their own words and ideas; and what would make them feel more comfortable in accessing medical and mental health care services? Asking diverse trans* participants questions related to their past and current health care experiences begins to shape ways in which health care providers and larger care services can improve health care access and comfort for these populations.

Chapter 2 of this thesis provides both a theoretical and empirical framework for this study and includes risks related to TGNC and a discussion of the study’s limitations. Chapter 3 provides the methodology for this study’s investigation. Chapter 4 details the study’s findings. Chapter 5 provides an overview of the study and discusses the results of my interviews in relation to the objectives of this study.

CHAPTER II

Literature Review

Theoretical Review

As I began researching major theories and key concepts related to gender, identity and diverse TGNC individuals, transgender, gender, intersectionality and internalized oppression frameworks largely emerged (Elliot, 2010; Benson, 2013; Burdge, 2007; Szymanski & Gupta, 2009). De Vries (2012) focused on intersectionality and the understanding of “multiple oppression” and “racialized gender"” to define how our larger societal construction of gender is framed through a lens of whiteness, heterosexuality, and dichotomous masculine and feminine narratives. Transgender studies provide crucial understanding to misguided beliefs and expectations that dichotomize and homogenize gender and sex identities (Elliot, 2010). Transgender theory further notes the importance of trans* individuals speaking out about their own diverse identities and experiences (Elliot, 2010). The ability to learn about trans* individuals and communities directly from those who hold trans* identities allows non-trans* persons to engage in more realistic perceptions, knowledge, and ways of understanding trans* people (Elliot, 2010).

World Professional Association for Transgender Health (WPATH) urges healthcare professionals and systems to de-psychopathologize trans* and gender non-conformity (Coleman et al., 2012). "This statement noted that 'the expression of gender characteristics, including identities, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative'"(Coleman et al., 2012).

Benson (2013) and Burdge (2007) articulated the importance of affirming client gender identity and preferred pronouns. Although Benson (2013) and Burdge (2007) easily speak to the fluidity of gender, gender and trans* oppression, gender and queer theoretical frames in therapy contexts, and trans* affirmative care, these frameworks focus on a white, working and middle class theoretical interpretation of trans* inclusive care. While such research has strengths, further research is needed for diverse trans* communities because current and recent historical implications for practice focus primarily on white trans* men and women. Benson's work is significant to this study. She constructed a process model that reflected how people come to understand and develop a stance of advocacy toward trans* people; and identified core categories and properties that influenced these behaviors (Benson, 2013). This model included: personal characteristics (personality, values, gender expression, and attraction), sociocultural context (religion, family, coming out, regional context, and safety), campus/environmental climate (affirming, non-affirming, and neutral), learning about trans* people (modes of learning and content of learning), and their personal experiences. Understanding and developing a stance of advocacy was conceptualized as resulting in expressions of advocacy (attitudes and behaviors). These notions have a sensitive relationship with gender theory because gender is a characteristic not only of individuals, but also of social interaction and social structure (Risman, 2004). Hence, gender interactions may be more or less gendered based upon its relevance during the course of one's interaction; and social structures are more or less gendered depending upon the extent to which routinized patterns of interaction are organized around gender, which draws heavily on the sensitizing concepts of gender theory.

Burdge (2007) acknowledged that queer theory is instrumental in understanding and conceptualizing sex and gender fluidity. Queer theory deconstructs sex, sexuality, and gender in an attempt to recognize and challenge binary divides that ultimately exclude people who do not meet social conventions of female and male behavior and focuses on how these categorizations are inadequate and further exclude and alienate transgender persons. Burdge (2007) stated that most information about transgender people is "anecdotal evidence" because there are not many studies available on transgender individuals, and because trans* persons do not readily come forward makes it difficult to do research. She admits, even her own research is somewhat limited in this area.

Benson (2013) and Burdge (2007) did not incorporate a diverse sample of trans* individuals from various racial, ethnic, socioeconomic, and geographic backgrounds; and in turn, narratives of trans* individuals of color and diversity with intersectional identities were largely invisible. Burdge (2007) articulated the incongruence between the “gender” assigned at birth, and the “gender” incongruence for trans* populations. Burdge’s (2007) research is limited by her framework of “gender”, which she uses to equate anatomical make-up to the social construction of gender. Burdge (2007) might inadvertently minimize and misinform her readers in terms of the spectrum and social construction of gender and gender oppression, and how this construct is distinct from biological makeup. She does however advance a critical analysis of the dominant gender paradigm by using two alternative theoretical perspectives on gender-queer theory and social constructionism.

This study increases understanding of maintaining a collection of non-privileged identities, and the oppression and impact trans* individuals face when they occupy additional marginalized identities. While exploring the complexities of multiple oppressions, it is crucial to incorporate the concept of internalized oppression as an integral part of this framework. Szymanski and Gupta (2009) explained that internalized oppression involves an individual knowingly or unknowingly supporting conceptualizations of the self that are rooted in distorted perceptions of populations who meet characterization(s) of the larger oppressed community. In order to more thoroughly understand the scope and comprehensiveness of oppressive forces, it is imperative to understand identities that are privileged in United States society including, but not limited to white, cisgender, heterosexual, and middle class men (De Vries, 2012).

Empirical Literature Review

There are several socio-cultural risk factors within diverse transgender and gender non-conforming (TGNC) communities.

Suicide. Relatively little attention has been given to the problem of suicidal behavior in trans* individuals, despite reports of elevated risk (Kenagy, 2005; Haas et al., 2011; Clements-Nolle, Marx, & Katz, 2006). Increased knowledge on how to reduce risk and prevent suicidal behavior in this group is needed. Studies have consistently revealed that an overwhelming percentage of TGNC individuals attempt suicide at least once in their lifetime (Kenagy, 2005; Haas et al., 2011; Clements-Nolle et al., 2006). Further, Kenagy (2005) found that out of the forty-nine participants who stated they had attempted suicide, approximately two-thirds of these individuals contributed such attempts to their transgender identity. Clements-Nolle et al., (2006), like Haas et al., (2001) and Kenagy (2005), found that over thirty percent of trans* individuals had previous suicide attempts, and that variables independently associated with higher rates of attempted suicide included transgender individuals who were younger in age, those diagnosed with depression, trans* individuals with past substance abuse, trans* survivors of sexual abuse, and those who were victimized because of their gender identity. According to the Transgender

Discrimination Survey, those who were at an increased risk of suicide were young adults, and those who were harassed and victimized at school. Risk of suicide increased significantly when teachers were the perpetrators of this abuse (Grant et al., 2011).

These researchers found that although African American and Latino/a communities generally display lower suicide rates overall, the Transgender Discrimination Survey found that these groups of people had significantly higher risk for suicidality (Grant et al., 2011). In addition, seventy-five percent of male-to-female MTF) transgender individuals and roughly fifty-three percent of female-to-male (FTM) transgender individuals stated that they tried to commit suicide because of their transgender identity (Kenagy, 2005). Transgender individuals who were victims of sexual abuse also showed increase risks of suicidality (Grant et al., 2011).

Sexual/Physical/Verbal Abuse. Many transgender people reported frequent physical and verbal abuse perpetrated against them in public settings because of their TGNC identities (Grant et al., 2011; Selelius, 2012). In addition to increased risk of suicide for TGNC who hold additional non-privileged identities, researchers have consistently found that trans* women face increased physical and sexual abuse compared to trans men (Kenagy, 2005; Sevelius, 2012). Further, Trans Women of Color (TWOC) have experienced and continue to experience significantly larger amounts of physical and sexual abuse (Kenagy, 2005; Sevelius, 2012; Bockting, Miner, Romine, Hamilton, & Coleman, 2013).

TWOC have to face the compounding forces of racism, sexism, transphobia and additional oppressive factors (Sevelius, 2012; Bockting et al., 2013). TWOC are exceedingly marginalized and have overwhelmingly less access to consistent housing and sufficient income, and in turn, are frequently forced into sex work in order to get their basic needs for food and housing met (Sevelius, 2012; Bockting et al., 2013).

Overall Mental Health and Substance Abuse. Previous research consistently shows that TGNC communities are often rejected by caregivers and other support systems, and have less access to social support due to their gender identity (Sevelius, 2012; Grossman D'Augelli's, 2006). Low social support and acceptance of TGNC people is likely related to disproportionately high rates of mental health related symptoms including anxiety, depression, shame and low self-esteem (Clements-Noelle, Marx, Guzman, & Katz 2001; Sevelius, 2012; Bockting, et al., 2013). In addition, negative mental health outcomes were more common among trans* women (Sevelius, 2012; Bockting et al., 2013).

Research also has described high rates of risk behaviors, including alcohol and drug use and abuse within TGNC communities. Researchers believe that these dramatic increases in substance abuse are often related to minimal social support and acceptance of their TGNC identities (Clements-Nolle et al., 2006; Grant et al., 2011; Sevelius, 2012).

Sexual Health/HIV. Research has shown that TGNC individuals and communities engage in unsafe sex practices and are at greater risk of contracting sexually transmitted infections (Clements-Noelle et al., 2001). TGNC communities are at an increased risk of HIV infection in comparison to the general population (Grant et al., 2011; Clements-Noelle et al., 2001; Sevelius, 2012;). Further, research has consistently shown that Black and African American trans* women are at an increased risk of unsafe sex practices and HIV infection (Clements-Noelle et al., 2001; Sevelius, 2012). TWOC overwhelmingly report having to engage in sex work for food, money, and shelter, and also report that sex is one of the ways in which TWOC affirm their identity as a woman (Sevelius, 2012).

Risk Factors in Medical and Mental Health Care Systems. Research has shown the complex social and environmental risk factors that TGNC communities face over time (Kenagy, 2005; Sevelius, 2012; Grant et al., 2011). Recent and current research has started to expand understanding of structural and systemic barriers related to access of inclusive and affirmative care for TGNC communities, in addition to interpersonal factors that further isolate TGNC people in these healthcare settings (Grant et al., 2011). The Transgender Discrimination Survey consistently finds that TGNC individuals face significant injustice when accessing health care systems, including refusal of care, harassment, violence, criticism, assault, neglect, and lack of provider knowledge (Grant, et al., 2011). Grant et al., (2011) found that barriers across health systems included preventative, routine, emergency, and transition related medical environments.

Trans* women and Latino/a communities in particular reported a higher rate of treatment refusal and discrimination in medical settings (Grant et al., 2011). Trans* people of color reported higher levels of refusal of care because of their transgender or gender non-conforming identities (Grant et al., 2011). These findings align with studies that acknowledge the deficiency of training for medical professionals about TGNC affirmative and inclusive care (Kitts, 2010; Bauer et al., 2009). Further, Kitts (2010) found that physicians were less likely to routinely discuss gender identity than sexual orientation and attraction while taking a sexual history.

Many studies show that an overwhelming percentage of TGNC populations would delay or refuse preventative and emergency related medical care due to discrimination, feeling uncomfortable with a physical examination, or inability to access medical services (Grant et al., 2011; Rachlin, Green and Lombardi, 2008; Sevelius, 2012; Clements-Noelle et al., 2001). Studies have shown that TWOC in particular do not have access to trans* medical care, and use illegal and dangerous hormones and additional means in order to feminize their bodies (Sevelius, 2012).

TGNC individuals often report that they had to teach medical providers about transgender identity and basic transgender terms in order to receive more appropriate care (Grant et al., 2011). In addition, Grant et al., (2011) found that trans* individuals whose medical providers knew of their trans* identity were more likely to exhibit discrimination toward trans* patients.

TGNC individuals and communities face similar challenges in mental health care settings. Research reveals that TGNC individuals report insufficient mental health provider competency of trans* inclusive care and common trans* related issues (Bess & Stabbs, 2009; Benson, 2013). Research also suggests that mental health providers often pathologize gender identity and make assumptions that TGNC people access mental health care because of their gender identity (Bess & Stabbs, 2009; Benson, 2013). TGNC individuals held beliefs that mental health clinicians were uninformed or inaccurately informed about trans* communities, and that clinicians would require education about their gender identity directly from TGNC individuals (Benson, 2013).

Medical and Mental Health Suggestions and Positive Outcomes. Trans* standards of care express the importance of long term primary health care for all TGNC individuals and communities for overall health related prevention and intervention (Coleman et al., 2011). Researchers articulated the need for TGNC education opportunities and training for mental health and medical providers, in addition to further research related to trans* inclusive healthcare (Grossman and D’Augelli, 2006; Coleman et al., 2011). WPATH standards of care recommend that mental health providers should not enforce a binary conceptualization of gender, and that it is essential for agencies to provide advocacy, education, information and referrals for young adults who do not conform to socially driven binary gender roles and expectations and their families (Coleman et. al., 2011; Feldman & Goldberg, 2006). Grossman and D’Augelli (2006)

Coleman et al., (2011) and Feldman & Goldberg (2006) reiterated the importance for all health care providers to accept and recognize the existence of TGNC people, and to refrain from avoidance or the expression of negativity toward clients and patients who disclose non-cisgender identities (Coleman et. al., 2011). Further, Coleman et al., (2011) and Feldman & Goldberg (2006) articulated the necessity for providers to view non-cisgender identities through a lens of diversity rather than pathological.

Grossman and D'Augelli (2006) and Coleman et al., (2011) stated that agencies and organizations must work to provide trans* individuals and communities with appropriate and culturally sensitive resources in terms of medical, mental health, school, employment and housing opportunities. Grossman and D'Augelli (2006) and Coleman et al., (2011) advocate for service programs and clinicians to work toward collective understanding and acceptance for trans* communities in an effort to increase safe environments for transgender and gender non-conforming people. In addition, researchers advocate for teaching providers and youth about gender constructs, oppression, and advocacy to better understand and work toward progressive changes in our society (Grossman and D'Augelli, 2006).

Kitts (2010), Clements-Nolle et al., (2006) and Kenagy (2005) agreed that medical and mental health providers must better address issues related to depression, substance abuse, and sexual abuse within the transgender community in an effort to reduce suicidal behaviors within this marginalized population. Further, Kitts suggests (2010) that physicians should discuss gender identity when interacting with adolescents who present with depressed mood or suicidal thoughts. Haas et al. (2011) reported the need for increased research, interventions and suicide prevention strategies to be implemented for trans* communities. Haas et al. (2011) articulates that research also should include extending trans* issues to include other sociocultural factors such as age, race, ethnic background, and various geographic groups. Researchers recommend that healthcare options should be developed for diverse TGNC populations across geographic locations (Haas et al. 2011; Rachlin et al., 2008).

Kenagy (2005) addressed the need to reduce obstacles and barriers to inclusive and culturally appropriate health care for transgender communities, and particularly transgender communities of color. Haas et al., (2011) supports increased research and funding for high-risk LGBT populations including youth, homeless and incarcerated individuals and groups. WPATH advocated for exploration and openness to possible adaptation(s) of standards of care for mental health providers based on client's cultural differences and reified psychotherapy as an option for trans* individuals who are experiencing emotional distress (Coleman et al., 2011).

TGNC Community Voices: Affirmative Approaches and Treatment Considerations.

Bockting, Robinson, & Scheltema (2004) evaluated trans* individuals' satisfaction with transgender health care services. Bockting et al., (2004) found that transgender patients reported higher levels of satisfaction and an increased ability to handle their problems after seeking mental health therapy for their challenges. Grossman and D'Augelli (2006) found a significant amount of youth in their study communicated feelings of being and knowing they were transgender at or before puberty, which would likely be crucial in terms of providing TGNC inclusive healthcare for youth and young adult communities. Recent studies have communicated that it is imperative for TGNC young adults to feel safe and comfortable with their healthcare providers (Hoffman, Freeman & Sawnn, 2009; Benson & Stabbs, 2009). TGNC people have shared that the qualities they often require from their provider in order to feel comfortable include honesty, respect, and nonjudgmental listening skills (Hoffman et al., 2009). Similarly, Bess & Stabbs, (2009) found that TGNC communities communicated that honesty and trust between client and clinician was a crucial factor in their own beneficial mental health outcomes. Experience providing mental heath therapy for TGNC communities, having knowledge about these communities, and celebrating diverse gender identities was related to healthy and honest relationships between clients and their clinicians (Bess & Stabbs, 2009; Benson, 2013).

Research and Limitations in Studies. The research that Kenagy (2005) conducted provides information that is relevant for future trans* studies and is pertinent in interpreting large statistical differences in gender and racial discrimination, particularly against women and racially marginalized communities. Kenagy (2005) collected data from two sources and approximately two hundred transgender individuals, including the Needs Assessment for the Transgender Communities in the Philadelphia Region, and the Delaware Valley Transgender Survey. He used snowball sampling to obtain participants in this study. Eight trained transgender interviewers collected data through face-to-face interviews that lasted up to an hour each. Close to seventy percent of the participants in this study identified as African American, Multi-Racial, Bi-Racial, Latino, and “Other”, while Caucasian Americans made up roughly thirty percent of the individuals surveyed. The age range of those in Kenagy’s study was seventeen to sixty-eight years old. This study was strengthened by its large sample size, diversity and important findings. However its limitations were in the use of non-probability sampling methods, which made it difficult to generalize study findings; and the language of trans* related identities may not be recognized, or may be unfamiliar to various racially and ethnically diverse populations.

Clements-Nolle et al., (2006) used target sampling and agency referrals to recruit trans* participants for their study and chose individuals who self-identified as transgender, were eighteen years or older, were in the San Francisco area, and spoke English, Spanish, Vietnamese, Tagalog, or American Sign Language. The inclusion of intersectional identities was a significant strength of this study. However, a significant limitation of this study was its cross-sectional study design, which limited the researchers' ability to establish causality and to determine whether suicide attempts by individuals in the study occurred before, during, or after their transgender identity emerged.

Grossman and D'Augelli (2006) identified strengths and limitations of their research, with a significant limitation being the use of a small convenience sample that consisted of focus groups with trans* identified individuals who were between the ages of fifteen to twenty years. Parental consent for participants under 18 was not noted in the study report. Grossman and D'Augelli (2006) gleamed new discoveries of trans* information related to youth experiences by asking the youth questions related to their experiences with vulnerability, risk, discrimination, marginalization, and access to supports and resources.

In his 2011 article, Haas et al., (2011) reported that much of the research available mainly focused on sub-group transgender individuals who seek medical treatment such as hormone therapy or surgical procedures. This was mainly due to researchers having greater access to medical institutions, which produced small quantities of research on transgender and gender non-conforming communities. These studies likely do not equitably include transgender and gender non-conforming individuals with lower socio-economic status, those who are not 'out' as being transgender, transgender youth, and any other transgender, questioning, or gender non-conforming person who does not want or cannot access hormone or other medical procedures, especially trans* people of color and differing ethnic groups.

De Vries (2012) conducted research that included strengths such as ability to share diverse trans* narratives, themes, and experiences related to theories of intersectionality. A significant limitation of this study was the gap between the findings and theory, and suggestions and implications for providers to learn about working within an intersectional framework. De Vries (2012) used his “insider” role in terms of sharing a trans* identity and being an active member in various online trans* community groups and local trans* organizations, which can be considered a strength and a limitation of this study. He used snowball sampling to recruit participants at conferences, online groups, and word of mouth. He aggressively sought trans* people of color by being extremely clear in terms of his white trans* working class identity and articulated why he was interested in learning about experiences of trans* youth of color.

His research was well received and he was able to collect qualitative research through interviews with thirty-one diverse trans* individuals with a range of intersectional identities in terms of race, ethnicity, gender identity, class, sexuality, education, age, years “out”, medical treatment and occupation (De Vries, 2012). He used in depth, open-ended, semi-structured interviews and participant observations via conferences, social activities, online groups, and planning committees (De Vries, 2012). Interview spaces were chosen by the participant and lasted one-to-three-and-a-half hours. De Vries (2012) used open coding to identify common themes and issues, and was able to pull out quotes related to significant themes.

Bockting et al., (2004) compared satisfaction data for transgender individuals against those who did not identify as transgender using satisfaction surveys from five sequential surveys that were conducted between 1993 and 2002 in an outpatient sexual health clinic setting during a two-week period. They used a Likert rating scale to measure overall healthcare satisfaction, perceived problem improvement, satisfaction with their therapist and office staff, and whether or not they would recommend services to a friend or family member (Bockting et al., 2004).

They also left space for answers to open-ended questions about the most significant positive and negative experiences in this clinic setting (Bockting et al., 2004). Independent researchers unaffiliated with the setting interpreted content and found themes for those respondents who identified as transgender (Bockting et al., 2004). A significant limitation of this study relates to the possible bias associated with researchers providing refreshments and decorating the office space to encourage patients to complete surveys, which may have led to painting the clinic setting to be more welcoming. Another limitation of this study included the lack of generalizability of the findings in terms of the differences in a university-based sexual health clinic compared to health care settings outside of a college or university (Bockting et al., 2004). Another potential bias to consider is whether transgender individuals had minimal expectations in their sexual health care opportunities prior to receiving services in this setting.

Rachlin, Green, and Lombardi (2008) conducted a study using quantitative measures to ask one hundred and twenty-two female-to-male (FTM) transgender individuals about their medical care. The majority of trans* individuals were taking testosterone and approximately half of the participants had trans* related surgical procedures (Rachlin et al., 2008). Approximately seventy percent of participants considered their overall healthcare to be in the “good” or “excellent” range. Of particular notation is that among this sample, employment rate, knowledge of medical care, and access to providers were all significantly increased when compared to research involving male-to-female (MTF) transgender individuals. A significant limitation of Rachlin et al., (2008) study included the specific FTM trans* communities and the trans* affirming geographic and conference location where the majority of surveys were collected. Of particular consideration for Rachlin et al., (2008) study was that the participants largely had access to various supports, and how their identity as men contributed to their increased privileges and services was overlooked. Also sociocultural factors such as race, ethnicity and socioeconomic diversity were not explicitly researched within this study.

Kenagy (2005) used snowball sampling to obtain participants in their study; and non-probability sampling methods to collect data through face-to-face interviews that lasted up to an hour each, which were conducted by eight transgender interviewers who were trained on how to administer the needs assessment. Clements-Nolle et al., (2006) used target sampling and a cross-sectional study design through agency referrals to recruit trans* participants who were eligible if they self-identified as transgender, eighteen years or older, were in the San Francisco area, and spoke English, Spanish, Vietnamese, Tagalog, or American Sign Language.

Grossman and D'Augelli (2006) used convenience-sampling methods, and their study consisted of focus groups. De Vries (2012) used snowball sampling to recruit participants at conferences, online groups, and word of mouth. De Vries (2012) was able to collect qualitative research through interviews with thirty-one diverse trans* individuals with a range of intersectional identities in terms of race, ethnicity, gender identity, class, sexuality, education, age, years "out", medical treatment and occupation. He used in-depth, open-ended, semi-structured interviews and participant observations via conferences, social activities, online groups, and planning committees. Based upon the analysis of previous research, the current researcher chose to use an intensive structured interviewing qualitative method. This research method was particularly helpful given the exploratory nature of this project, in addition to discovering in depth thought processes and actions related to social identities and structures.

Synopsis of the Literature. Literature related to trans* and gender non-conforming medical and mental health care offer prominent themes of overwhelmingly high behavioral and psychosocial risk factors for these communities (Benson, 2013; Burdge, 2007; Clements-Nolle et al., 2006; De Vries, 2012; Grossman, 2006; Haas, 2011; Kenagy, 2005; Rachlin, 2008)**;** and reinforce the need for increased investigation with trans* communities who are marginalized by race, ethnicity, gender, age, and socioeconomic status (Benson, 2013; Burdge, 2007; Clements-Nolle et al., 2006; De Vries, 2012; Grossman, 2006; Haas, 2011; Kenagy, 2005). Existing literature increasingly states the need for awareness and inclusion of trans* individuals, with attention to community, societal and institutional systems (Benson, 2013; Burdge, 2007; Clements-Nolle et al., 2006; De Vries, 2012; Grossman, 2006; Haas, 2011; Kenagy, 2005). Research also highlights the sparse amount of research with trans* individuals of color, specifically trans* women of color, and their experiences of medical and mental health services (Clements-Nolle et al., 2006; De Vries, 2012; Grossman, 2006; Haas, 2011; Kenagy, 2005). The current study largely draws upon non-probability sampling methods. In non-probability sampling, there is an assumption that there is an even distribution of characteristics within the population, leading the researcher to believe that any sample would be representative and that results will be accurate. Studies also show that suicide attempts are more likely among transgender youth populations (Grossman, 2006; Eisenberg & Resnick, 2006; Haas et al., 2011; Ryan et al. 2009), and that there is a strong need to increase knowledge and prevention strategies for transgender and gender non-conforming individuals.

CHAPTER III

Methodology

Research Design

This study identified the experiences of diverse TGNC young adults and was intended to increase understanding of TGNC inclusive and non-inclusive care in medical and mental health care settings. Two research questions guided this study: (1) What are the positive and negative experiences within medical and mental health care systems that diverse TGNC youth experience, and (2) What does a supportive environment, setting, and culturally sensitive provider look like for trans* and gender non-conforming young adults? The research questions were intended to provide insight into how healthcare experiences influence TGNC young adults feelings related to safety and comfort when accessing health care support systems.

I chose an intensive semi-structured qualitative format to interview participants; and believed these methods were imperative for the study considering gaps in existing literature for this study population. Open-ended questions were used to facilitate participant-centered explanations and recollections of past experiences. I maintained rapport throughout the initial telephone interview; quickly responded to email inquiries by answering questions; and expressed gratitude for all responses. Furthermore, I attempted to maintain rapport throughout the interviews by thanking the participants, reiterating confidentiality, and communicating to each participant that they had a choice in responding or not responding to any question asked of them. I mirrored language and used my knowledge of TGNC-inclusive language.

Data Analysis

Data from this qualitative study was interpreted through thematic analysis. Thematic analysis is a search for themes that emerge as important to the description or response to a phenomenon. I identified the themes in participant responses by carefully reading and re-reading their responses, and searched for patterns within the responses. These themes became my focus for analysis and understanding my using inductive coding.

Questions related to this research covered several areas: TGNC experiences with medical and mental health providers; awareness of how ones TGNC and other important personal identities impact service delivery access; past experiences with medical and mental health care professionals; and how care providers and health care systems can more effectively support diverse trans* and gender non-conforming individuals and communities. Patterns of information surfaced from these questions that allowed me to interpret participant data.

Recruitment and Procedures

During preliminary investigations for the current study, I posted virtual and hard copies of recruitment flyers on blog and other social media sites, mental health agency bulletin boards, and in one coffee shop. I also sent out emails to contact persons in mental health fields in Massachusetts and Georgia. The TGNC "blogs" included websites related to trans* health, FTM, MTF, trans* people of color, and gender queer people.

Flyers contained the study’s selection criteria and a brief description of the study, and included my name, phone number, and school email address for interested participants. I also offered phone, video, and in-person interview options (when the participant and researcher were driving distance apart). Upon receiving participation inquires via email and telephone, I then provided a copy of the informed consent through email, and asked potential participants to review the form before confirming their participation. Upon receiving a response that stated interest, I then sent participants two copies of the informed consent form; one for them to keep, and the other for them to sign and send back to me in a pre-stamped, addressed envelope, or deliver in person if face-to-face interviews were used. Eleven interviews were via video web chat and one interview was done via web-based audio due to technical difficulties with video interactions.

This research was reviewed and approved by Smith College Human Subjects Review Board prior to implementation. All research materials including audio recordings, transcriptions, analyses, field notes, and consent documents are stored in a protected location for up to three years and only I have access to these materials. Consent forms are kept separately from other research materials to further ensure participants' confidentiality. All names and identifying information were removed from research materials and reported in aggregate form. All data is password protected and locked in a safe place until the electronic documents are deleted.

Interviews lasted 45 – 60 minutes in length and occurred in a safe, confidential space agreed upon by both the participant and me. These settings included web-based video and telephone contact, where both the participant and I were in a private space. All interviews were recorded using audiotape (via Quicktime Audio Player). Field notes were taken during and after the interview to assist in highlighting certain content areas and in remembering selected content. All participants were informed of these actions and permission was confirmed prior to beginning the interview.

These recruitment methods were intended to solicit diverse participants who had differing types of social support, used social media or accessed trans* affirming agency services in order to make meaning and reporting of their trans* experiences and identities.

Participants

Demographic data included gender identity, race, ethnicity, sexual orientation, social class, age, employment and educational background. The study population consisted of 11 transgender, gender non-conforming, and gender queer young adults ages 18 – 26 years old who voluntarily participated in qualitative interviews and who had access to video calls. Exclusionary criteria were individuals who self-identified as “cisgender”, specifically those who understood their biological sex, body, and gender identity to be “aligned”. This study focused on diverse trans* individuals who also disclosed a range of sociocultural identities, including but not limited to race, ethnicity, sexual orientation and social class.

Limitations of this Study

One limitation of this study is that these TGNC participants may not represent the “whole” TGNC and gender questioning populations in the United States who are between the ages of 18 – 26, but specific only to this study. Another limitation is the reality that the majority of the participants in the present study were TGNC individuals who accessed and posted about their trans* identity and transition experiences on the Internet. There may have been other eligible participants who did not post about their trans* identities through social media, or were not social media users.

Additional limitations include number of participants, access to diverse trans* young adults, and limited validity and generalization to larger diverse trans* young adults communities. I also had special concern for my ability to ask youth who were eighteen and older about their private experiences in various health care systems. These concerns centered on whether the topics were too “triggering” for particular participants; and I wondered how to create a study with diverse trans* young adult participants sufficient enough to maximize future benefits and acceptance of diverse trans* young adults in healthcare agencies. Of last concern was the issue of how my own whiteness and androgynous presentation would affect the answers of participants when conducing in-person interviews with trans* youth. I remained critically aware of the limitations of the specific recruitment of TGNC individuals who were able to access and feel comfortable posting about their trans* identity and transition experiences on the web, as opposed to those who may not be comfortable with this reporting. I believe however that these methods resulted in the recruitment of participants who had increased or differing types of social support in comparison to those who did not use social media or access trans* affirming agency services to make meaning and expression for their trans* experiences and identities.

I anticipated that my white racial identity and androgynous appearance may have affected some participants and their willingness to participate, their openness and honesty in answering questions, and in turn the skewed participant population access. My own TGNC affirmative stance may have bias in the way I asked questions and the possible follow up questions asked of participants. To address this issue, I tried be consistent in the questions I asked participants during all interviews.

Validity

It was important to interview a diverse participant pool in order to increase awareness and understanding of differences within trans* and gender non-conforming communities. It also was important to include individuals who regularly sought medical and mental health care as well as those who did not seek consistent care.

I was transparent and clearly asked the same question of all participants. I also encouraged clarifying questions when the participant did not fully understand a question during the course of the interview. I acknowledge that the results of this study may be difficult to replicate due to the various variables and contextual complexities in the study, in addition to qualitative methods and its small sample size of 11 participants. I further used member checking by summarizing participant answers to questions multiple times during each interview to increase validity.

Participant Rights

There were minimal risks anticipated during and after the interview process. Participants were told that they could skip questions without judgment. I reiterated that if participants found the study or questions to become too upsetting, that they could stop the interview at any time and that any information obtained up to that point would be deleted and shredded. Each participant also was given a list of free mental health resources in their immediate environment as well as a free, twenty-four hour hotline number to call if they were in distress.

CHAPTER IV

Findings

In this chapter the data gathered from eleven in-depth, semi-structured interviews with diverse TGNC young adults is presented. Study participants were informed of the purpose of the study and completed consent forms prior to beginning the interview. Participants also were assured that all the data they provided would be used for the purpose of the research and that their identities would remain confidential. The purpose of this research was to determine the experiences of TGNC young adults who seek services from medical and mental health care systems, and to obtain descriptors that reflect a supportive, culturally sensitive setting in which TGNC youth can go without feeling judged or afraid to self-disclose and to receive services.

This chapter provides a detailed account of the demographic profile of the participants and their responses to the research questions. It was assumed that the attributes of the participants influenced their behavior and answers to the interview questions. Of particular significance to the findings of this study is that findings are based solely on the voice of TGNC participants.

Demographic Profiles

The study was comprised of eleven trans* and gender non-conforming young adults who self-identified in terms of gender, age, race, sexual orientation, and DSM-IV diagnosis. Five (n = 45%) participants identified as transmen; one (n = 10%) as transmasculine; three (n = 27%) as gender queer; and two (n = 18%) as gender non-binary. The age range of participants in this study was nineteen to twenty-five years old; and all participants resided in the United States. Two (n = 18%) participants identified as multiracial (one participant identified as Black and White, while the other participant identified as Asian, Native American and White). Two (n = 18%) of the participants identified as Latino(a). Eight (n = 73%) of the eleven participants reported having a non-heterosexual sexual orientation or identity. Three (n = 27%) participants identified as coming from a working class and working poor socioeconomic background. Three (n = 27%) participants were considered to have a mental health diagnosis (two participants articulated PTSD and one participant had an Asperger's Syndrome diagnosis). There was one participant who identified as being part of the Deaf community.

Participants were asked to describe their interactions with health care providers and to give specific examples. Their responses are reported by negative interactions and positive interactions, with examples.

Negative Interactions with Medical and Mental Health Providers

Eight (n = 73%) of the eleven participants described having one or more adverse interactions with medical providers. Negative interactions were commonly described as medical providers making automatic assumptions about their identities related to gender and sexuality, genitalia, and sexual health care needs, as reflected in the following response by Cam (name changed to protect confidentiality).

> "I pass really well now, visually speaking, most folks assume I'm cis. They clearly haven't even read my chart, and then I have to drop that bomb… and their reaction is like, 'Whaaaat'? Or it's like, 'Oh my God you look so good'. Um… and then they assume that I date women, which is not true. I date other masculine of center folks…. I've had partners where they assume we don't really need to get

> tested for HIV because we are both female-bodied… Um … or then we, you know, I don't know. They don't necessarily extend the right … what's the word for this … reproductive care. Like, you know, in situations where I am talking about my intimate health… and they should be offering me a pap smear and I know it, and they are just not."

Participants also reported that they often felt unsafe in their interactions with providers, and purposefully withheld relevant personal health information during interactions with health providers. Some participants talked about withholding personal information about gender, sexuality, sexual histories, current mental health concerns, and trauma when they did not feel safe and accepted by health care providers. Some of the reasons participants offered for not fully disclosing personal information included: fear of judgment; wanting to avoid having to teach or educate providers; feeling silenced by the un-inclusive and gendered language providers used; and concerns related to patient and provider confidentiality.

In addition, over half of the participants described either having had experienced or feared medical providers pathologizing their gender identity by automatically attributing their identity to mental health related challenges, previous sexual trauma, and disability status, as indicated by the following responses.

> "The guy that I saw in Washington, that I saw before I was with the person I'm with now, was really not cool – and like every single time I brought up anything about being trans – he'd be like … 'well you should see a behavioral therapist for this' … and he wouldn't even help at all".

Another participant responded:

> "Um, so I developed my PTSD, you know after I was raped. And … and I just kind of started throwing up a lot, and so the doctor, you know, I mean they were asking stuff all the time relating to sexuality and I wouldn't tell them anything – I would just lie. But I eventually told them and then the doctor said, 'Okay, do you think that your stress … and that … because of what happened to you, uh, you know, and do you think, yeah, so do you think that you're just deciding this, deciding to be this, like, go against this man that raped you'. And I mean, that was horrible, like no. You know, like first of all, you're making horrible assumptions about my identity, and like, medicalizing my sexuality is really uncomfortable".

One participant acknowledged the possibility that providers might conceptualize a relationship between his identity and mental health issues, but did not view it as a presenting concern. He reported that, "I haven't encountered this, but I assume that it's out there – that my transness or queerness could be a part of my mental health issues even though they are the most stabilizing force in my life." Another participant who is deaf stated the following.

> "There was this one time I was seeing a psychiatrist but I didn't want to tell him I was trans. Psychiatrists are usually the worst about that in my experience. They think that being trans affects way more than it does. So I just told him I had some hormone imbalance. He [the doctor] then asked me, 'is that why you are deaf'"?

Another participant stated that:

> "Because when you walk in with a service dog, it's obviously, well not obviously

> – but when you say it's [your need for help] is not for something physical, and it's a mental disability, um, I worry that they are going to say 'oh, well you're not ready to move on because you need to work past this other thing'. Definitely something that's always in my mind whenever I – like I just had to meet with a new psychiatrist for surgery a couple of weeks ago and I was really nervous about walking in there. I was worried she was going to say, 'No, you can't have surgery. Obviously there's some other mental things to take care of'… but everyone's been great."

This participant went on to say:

> "Yeah, like I said with the service dog thing. It's always good to keep in mind that it's [gender identity] always going to put a block in front of getting the kind of help or anything that you need… like you don't want to tell them, 'oh well I've got this kind of problem" or "being depressed lately' or you know, just things you don't want to get in the way of getting hormones or… or a referral for surgery or a name change or something like that so I think that in the past, I avoided talking about that kind of thing with my doctor, just because I was afraid of that, … but I didn't need to because my doctors are really great. Definitely in terms of partners or sexual health – I really don't visit with doctors outside of the two that I have just because I don't want to have that happen. I had to go in to a doctor one time… I definitely avoided – I was worried because I had to go to the doctor because I had some "downstairs problem", you know?"

TGNC participants who identified as racially and ethnically diverse discussed feeling uncomfortable while meeting with medical providers who were cisgender white men. Further, these participants communicated feeling as though their medical providers did not acknowledge and sometimes even pathologized their cultural background. One participant reported:

> "I just… it's something about how interacting with a cis male that doesn't understand what it's like 'down there' for people like me, and I just don't feel comfortable talking to them about it or, you know, worse, them being 'down there'. I don't have a lot of experience with POC as providers, which is really unfortunate. As far as white providers go, I think there is a tendency to claim color blindness, which can be pretty detrimental, you know? Recognition that there are other people, other cultures, other paths of transitioning – it would just be good."

Seven (n = 64%) out of eleven participants experienced one or more negative interactions with mental health care providers. These interactions largely included not feeling believed and validated after disclosing their gender identities; being avoided by clinicians soon after disclosing their gender identities; and feeling as though they needed to defend or argue their own identity. When disclosing their gender identities, two (n =18%) participants were told by their providers that although they were not knowledgeable about trans and gender non-conforming communities, they would make an effort to do independent research between therapy sessions. Participants then disclosed that their providers did not make any effort to learn about gender identity. One participant talked about his therapist treating him differently after he disclosed to her that he identified as transgender.

> "I mean, I don't know. She made me feel comfortable in the initial session, but the initial session was all we got. She was like 'yeah, I will definitely be willing to work with you and I will do some research on it and I'll just ask you questions and…' I don't know. But I mean like, when she cancelled, she always had her secretary do it for me. Where as before, she would email me. It was weird … so… The fact that she didn't want to pass along the info herself or try to reschedule herself… Because in the past, I could just email her and set up and an appointment… but she was telling me to go through the secretary – it was a hassle."

Another participant responded:

> "Because her [the therapist] attitude towards – her body language – kind of the way she presented herself. She kind of like, was very critical. It could have also been, in fairness, that she didn't know, had no prior experience with what I was talking about. She did not seem to present herself as though she was at ease with the situation or talking about the situation. After awhile … Well I mean after that, she had never brought it up again. She just kind of let it drop as something it never… at any point in any discussion – even when it probably could have been relevant, said (never said) – she never did any research on it; I know that for a fact. Because when it came up afterwards, I believe, one time, she refused to pursue that line of questioning, picked something up entirely and still looked confused. She hadn't done any research."

Positive Interactions with Medical Providers

Seven (n = 64%) participants reported one or more positive interactions with medical providers. Participants found it helpful when medical providers would acknowledge, validate, and support their gender identities. In response to discussions about gender identity, participants found it helpful when providers would acknowledge and affirm their disclosure without asking multiple follow up questions or making any assumptions about their transition processes. Participants also found it helpful when their providers would use gender inclusive language when communicating with them in medical settings. Further, TGNC individuals were more likely to provide honest personal information to providers when they felt as though their medical providers were supportive and respectful of their gender identity.

Furthermore, participants found it comforting when their medical provider explicitly disclosed their personal affirmation and respect for TGNC communities, their own LGBTQ identities, and previous interactions with patients who have similar gender identities. Additionally, TGNC individuals in this research study found it comforting when medical providers would provide them with clear and realistic communication about medical procedures and precautions. These participants found it helpful when providers would ask permission and demonstrate comfort about certain medical procedures.

Descriptors that Reflect a Supportive, Culturally Sensitive Setting

A number of participants described the absence of visible markers in their medical healthcare settings that would articulate TGNC inclusiveness. Most participants experienced healthcare settings that did not incorporate signs representing a "safe space", gender inclusive language on medical forms, or gender-neutral restrooms. TGNC individuals articulated that not having these visible markers were often related to feeling unsafe or unsure about how they might be treated or perceived in that particular environment, and by their health provider.

Some participants did report noticeable markers to communicate inclusion of TGNC individuals and communities in some mental health care systems, and that these types of explicit markers were more present in mental health care settings than in medical settings. College mental health settings also were reported to have visible TGNC inclusive markers indicating visibility and awareness of various gender identities. These markers included LGBTQ* related pamphlets, indicators of "Safe Space" training and signage, forms with gender inclusive options and space to write in their own gender identities and sexual orientations. The following participant described his experience in an LGBTQ* inclusive mental health setting.

> "Well, let's use this as an example. I just started therapy at a queer center so they deal with gender non-conforming people, anyway… but their form was quite thorough. They tried to provide a nice list of say, gender identities and also just left a blank space… so you can write in what you want. It's as simple as that, you know?"

TGNC individuals also described barriers related to healthcare including in-access to healthcare insurance and coverage, financial challenges, and geographic location. Most participants reported avoiding care after experiencing negative interactions in healthcare systems.

Suggestions for Inclusive Medical and Mental Health Providers and Systems

TGNC individuals in this study described the importance of TGNC education and training for medical and mental health providers; and that such education should include basic education about gender identity, sensitivity training for working with TGNC communities, and providers having the willingness to do their own independent research when working within these communities. When asked about what type of information participants would include in TGNC inclusive training for providers or what they would want providers to know about their identities, they discussed the significance of TGNC awareness and education around individualized, complex and numerous transition processes. Similarly, they discussed the importance for providers to not make assumptions about their identities and health care needs as TGNC individuals. They want providers to know the differences between sex, gender, and sexuality. Participants stated it would be helpful if providers maintained a list of TGNC inclusive medical and mental health resources and referrals if they did not feel adequately prepared to work with these communities.

TGNC participants in this study felt that it is crucial for providers to increase their awareness of cultural considerations during clinical interactions and treatment processes. Some TGNC participants articulated that it would be beneficial for providers to gain a greater understanding of how medical and mental health professionals should acknowledge racially and ethnically diverse TGNC communities and recognize how paths of transitioning might be different for TGNC POC.

Further, TGNC participants asserted the need for providers to listen and affirm their identities and to be supportive of their needs and experiences. In terms of responding to disclosing TGNC identities, participants in this study stated that they wanted to feel heard and believed, yet did not want their provider to focus too heavily on their disclosure. They wanted to be respected as people and did not want their gender identity to be viewed as pathology. Participants also stated that they did not want to feel pressured into disclosing their gender identities to providers and would only want to do so if and when they felt comfortable in these relationships.

The majority of participants stated that it would be highly important and comforting for providers to inquire about their preferred pronouns and ask about gender identity in an inclusive way. TGNC participants suggested that providers should verbally ask their patients and clients about gender pronoun use, create gender inclusive forms, and using gender-neutral language when describing healthcare options and processes. Participants discussed the benefits of these types of interactions. These advantages included feeling more comfortable communicating with healthcare providers and in relevant settings, feeling as though their providers are aware or at least open to learning and understanding their TGNC identities. One participant used an analogy to describe the importance of gender inclusive forms.

> "…And actually that's one thing that makes me really antsy is when I'm signing up for stuff and they don't have the unspecified option, it's like which one do I pick? It's like a banana picking between an apple and an orange."

Specifically, TGNC participants in this study suggested that all provider settings should include gender inclusive options on their forms. Ideally, these forms would include multiple boxes for gender and an additional place where clients and patients would be able to "write in" their own unique gender identities.

Summary

This chapter articulated TGNC participants' responses to services from medical and mental health care systems and described markers that would reflect support, cultural sensitivity, and inclusion of diverse gender identities. The majority of participants in this study reported shortcomings on behalf of healthcare professionals who deliver services to TGNC persons. Lack of sensitivity, lack of education and awareness and lack of outreach and effective communication in service delivery were major concerns. Participants in this study reported the need for specific training in gender identities and that healthcare providers should be knowledgeable of the transition processes, resources and programs available to TGNC persons. Participants also reported the need for visible markers such as "Safe Space" stickers and signs paired with TGNC trainings, signs that are gender neutral, gender-neutral restrooms, and visible community-based and sexual health resources.

CHAPTER V

Discussion

This study sought to explore the positive and negative experiences felt by diverse trans* and gender non-conforming young adults within health care systems. Participants in the study were asked to define qualities that form a supportive environment and setting, and to describe what a culturally sensitive provider would “look like” for trans* and gender non-conforming young adults. This innovative study gave voice to diverse young adults who self-identified as TGNC and reported on their unique needs and wants specific to increased comfort, safety, and willingness to disclose personal information with medical and mental health providers in health related settings. This research adds to knowledge and understanding of the challenges faced by TGNC individuals and informs health care providers on how they can become more effective in both their outreach and service provision to TGNC communities. Negative experiences with healthcare providers and within systems included providers making automatic assumptions about TGNC* identities related to gender and sexuality, genitalia, and sexual health care needs. Participants also described purposefully withholding personal health information when they did not feel safe and accepted by health care providers. In contrast, the researcher found that positive and comforting experiences with healthcare providers and within systems included explicit acknowledgement, validation, support, and open communication with TGNC* clients and patients, and inviting environments in which TGNC* clients and patients would observe markers and other office media materials to show awareness, including intake forms that allowed TGNC* to self-identify or choose how they wanted to be addressed. This final chapter discusses the findings from this study and is divided in four sections: (1) Inaccessibility of TGNC* Affirmative Health Care; (2) TGNC Conceptualizations of Gender Inclusive Providers and Settings; (3) Clinical Relevance of Findings; and (4) Implications for Future Research

Inaccessibility of TGNC Affirmative Healthcare

Consistent with previous research conducted by Grant et al., (2011), my study confirmed excessive interpersonal and environmental factors that prevent access to affirmative healthcare for TGNC communities. Similar to findings found in the Transgender Discrimination Survey that indicated TGNC had experienced harassment, violence, criticism, assault, neglect, and lack of provider knowledge within healthcare systems, my study revealed that TGNC individuals often felt unsafe, silenced by gender binary language, and experienced or feared that providers would pathologize their gender identity by automatically attributing their identity to mental health related challenges, previous sexual trauma, and disability status.

Previous research had indicated that an overwhelming percentage of TGNC populations would delay or refuse preventative and emergency related medical care due to discrimination, feeling uncomfortable with a physical examination, or inability to access medical services (Grant et al., 2011; Rachlin, Green and Lombardi, 2008; Sevelius, 2012; Clements-Noelle et al., 2001). Similar to findings discovered in the Transgender Discrimination Survey, my findings indicated that TGNC individuals who disclosed their gender identity to medical and mental health care providers were met with discrimination and questions rooted in assumptions about gender and sexuality, genitalia, and sexual health care needs. Further, these assumptions were related to feeling unsafe, unsupported, and un-acknowledged by providers and often led to non-disclosure of personal health information on behalf of the TGNC patient and client.

TGNC Conceptualizations of Gender Inclusive Providers and Settings

Recent studies have communicated the important need for TGNC young adults to feel safe and comfortable with their healthcare providers (Hoffman, Freeman & Sawnn, 2009; Benson & Stabbs, 2009). My research aligns with and expands upon these findings and indicates that clients and patients that report concerns around personal safety and acceptance of their gender identity by healthcare providers results in lack of disclosure and non-disclosure of essential personal health information. My study identified consistent ways in which TGNC individuals determine whether or not their provider and overall healthcare systems were welcoming of their TGNC identity; and in turn, determined how this translates into comfortable and inclusive interactions and safety in their larger healthcare environments. For example, healthcare providers that are accepting of TGNC communities will communicate openly. The healthcare provider can create a positive experience by simply demonstrating a supportive approach during the intake assessment by asking what name the client would like to be called, even if their name is listed on the paperwork. Then ask what gender pronoun they use and how they identify their own gender. My study suggests that only through open, attentive, and safe care, TGNC individuals are likely to have positive health care experiences.

Similar to suggestions made by the WPATH standards of care for mental health professionals that stated the importance for mental health care providers to not implement binary conceptualizations of gender, my study found that TGNC individuals felt and would feel supported when providers disclosed personal affirmation and respect for TGNC individuals and communities. TGNC individuals also communicated feeling safe and supported with providers who would "check in" and "ask permission" with and from their clients and patients about their individualized treatment processes. My study aligns with previous findings that indicate that physicians were less likely to routinely discuss gender identity than sexual orientation and attraction while taking a sexual history (Kitts, 2010). In addition to similar findings of providers more likely asking about sexual orientation than gender identity, my study found that TGNC young adults thought it would be helpful for providers to ask them about their preferred gender pronoun, and articulated that this inquiry would signify awareness of TGNC communities.

Consistent with Grossman and D’Augelli (2006) and Coleman et al., (2011) who discussed the significance of providing TGNC individuals and communities with appropriate and culturally sensitive resources in medical and mental health settings, my research suggests that visible TGNC inclusive markers are extremely crucial in terms of comfort and safety in healthcare settings. TGNC individuals articulated the importance of gender inclusive medical and mental health forms, "Safe Space" signage, gender-neutral bathrooms, and other indicators of the existence and acceptance of gender non-binary individuals and communities. TGNC young adults in this study acknowledged the absence of visible gender inclusive markers in both medical and mental health care settings, and not having explicit markers were often related to feeling unsafe or unsure about how they might be treated or perceived by a healthcare provider or within the relevant setting.

Consistent with numerous previous findings that indicate the absence of TGNC inclusive training for medical and mental health professionals, my findings indicate that TGNC would overwhelmingly conclude that their providers did not receive any type of gender inclusive training (Kitts, 2010; Bauer et al., 2009; Grossman and D’Augelli, 2006; Coleman et al., 2011). In addition, my study found that racially and ethnically diverse TGNC individuals felt as though their providers were not inclusive and sensitive to their backgrounds. Further, my study indicates that TGNC would find it extremely comforting and helpful to know that their provider(s) have some type of education and awareness about TGNC individuals and communities.

Clinical Relevance of Findings

There are multiple ways in which my research findings are beneficial to the social work profession and related healthcare fields. My study adds to previous literature about TGNC individuals. It also gives voice to diverse TGNC young adults and substantiates the need for communities and healthcare providers to enable TGNC individuals to feel more comfortable, safe, and uninhibited in healthcare settings, which enables them to provide honest answers to personal health-related questions typically asked in medical and mental health settings. It is crucial to study TGNC young adult perceptions of providers and how these perceptions influence accessibility and personal health disclosure in healthcare systems. These findings provide helpful ways in which healthcare providers and systems might seek to interact with TGNC clients and patients. My research findings reiterate and expand upon ideas to create increasingly TGNC inclusive interactions and spaces in a variety of healthcare systems, including displaying visible markers that will likely increase TGNC young adults access and comfort to inclusive, supportive and quality services. Similarly, I believe that if TGNC young adults feel accepted and affirmed by providers and within relevant settings that these communities might be more willing to disclose pertinent personal health information that might lead to increased access to appropriate care. This, in turn, can lead to decreased health disparities, risks, and discrimination that TGNC young adults continue to encounter.

Implication for Future Research

Future research might expand upon understanding the significance of honest, comfortable, and health relationships between TGNC individuals and their healthcare providers.

Further, it may be beneficial for researchers to evaluate the effectiveness of TGNC inclusive models that are already in place and determine whether these strategies are helpful in increasing health, wellness, and accessibility to appropriate and inclusive care. In addition to these suggestions, future research should seek to include perspectives of diverse TGNC young adults in terms of race, ethnicity, gender, sexual orientation, ability, social class, and additional personal and societal factors and identities to more accurately and representatively assess the needs of larger TGNC communities.

Because very little research exists in this area, additional studies and research is warranted to further understanding and awareness in healthcare professions. The current study also can be expanded to include more participants of a greater age range, from other cultural and ethnic backgrounds and geographical areas. It may also be useful to explore the experiences of health care providers who care for or have cared for transgender patients to increase improved services and to identify various types of training needed to further effective treatment. Such a study also will address the needs of healthcare providers and hone in on the type of training, resources and information they need in order to become more effective and efficient service providers to TGNC persons.

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APPENDIX A

HSR Approval letter

Smith College School for Social Work

November 4, 2013

Victoria Reiszner

Dear Vicki,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

APPENDIX B

Informed Consent Form

Smith College School for Social Work, Northampton, MA

……………………………………………………………………………….

Title of Study: Diverse Trans* and Gender Non-conforming Young Adults: Access and Comfort in Health Care Systems

Investigator(s):

Victoria Reiszner
Smith College School for Social Work
(XXX) XXX-XXXX

……………………………………………………………………………….

Introduction

You are being asked to be in a research study that aims to explore the lives of diverse transgender (trans* is used to represent inclusivity of the transgender community) and gender non-conforming young adults between the ages of eighteen and twenty six and their experiences with medical and mental health care professionals and services. You were selected as a possible participant because you identify yourself as a trans* and/or gender non-conforming person who has other non-privileged identities. These additional identities might include your race, ethnicity, sexual orientation, religion, socioeconomic background, and/or any other important factors that are included in how you identify and view yourself. You are also being asked to be part of this study because you are between the ages of eighteen and twenty six years old. You do not have to currently be “out” to others as trans* and/or “out” as any other identity that you might have to be in this study. You do not have to have any experience getting medical and/or mental health care to be interviewed in this study. I ask that you carefully read this form and ask any questions that you may have before agreeing to be in this study. My contact information is located at the end of the consent form.

Purpose of Study

Although there is some research out there that focuses on trans* and gender non-conforming experiences in medical and mental health care settings, there is not a whole lot of research related to what diverse trans* and gender non-conforming individuals would like to experience in their medical and/or mental health services. This study is intended to give voice to diverse trans* and gender non-conforming young adults and gain knowledge of current issues and suggestions that you might have to help support and respect diverse trans* and gender non-conforming individuals who may or may not feel comfortable going to the doctor or seeing a therapist or counselor.

The findings from this study are intended to provide new knowledge for care professionals about ways to interact with and explore different needs of diverse trans* communities. In addition, I hope to learn from you about your experiences regarding: 1) How often, if applicable, you meet with medical and/or mental health providers; 2) how your trans* and other important personal identities impact your access and comfort in seeking support from providers; 3) how your past experiences with care professionals shape your current interactions, if applicable; and 4) how care providers and health care systems can better provide a supportive environment for diverse trans* and gender non-conforming individuals and communities. This study is being conducted as a thesis requirement for my master's in social work degree. Ultimately, this research may be published and presented at professional conferences.

Description of the Study Procedures

If you agree to participate in this study, you will be asked to meet with the researcher in person, via Skype, conference call, or by telephone and in a safe, convenient and confidential space that you and the researcher both agree upon. The interview will be about one hour long and will include questions about your identities and experiences with care providers and health care systems, if applicable. There are no right or wrong answers in this research study. You have the option to skip any or all questions, or you may decide to stop the interview at any time. If you are within a half hour drive, I will make every effort to travel to you. If you are further than a half hour drive, you will be asked to interview via Skype or Conference Call. I will start by asking you questions about gender identity, age, race, ethnicity, religion, sexual orientation, socioeconomic status, and how often you go to medical and/or mental health care visits. I will ask you questions about your gender identity and how/when you started to understand your gender. There will be questions that I ask about your experiences as a trans* and/or gender non-conforming young adult in a medical and/or mental health care setting, any negative and/or positive experiences within these settings. These questions might be related to your identities, what experiences or ideas might make you comfortable or uncomfortable seeking care support, and whether or not you have talked about your gender identity with providers, and why? If you do not understand any of the questions I ask, I will try to word questions in a different way. I will audio record your answers if you agree to that. Your name and other personal information will be removed from the recordings to ensure your confidentiality and the information you tell me. I may ask you how you are feeling during the interview. Please take as much time as you need to think about each question before you answer.

Risks/Discomforts of Being in this Study

There are minimal risks anticipated during and after this interview process. You might experience distress and feelings of being uncomfortable when you are thinking about possible past experiences related to your identities, or your experiences with medical and/or mental health care providers and settings. You are allowed to skip, not answer, or end the interview at any time leading up to and during the interview. I will provide a listing of free referrals should you feel the need to speak with a professional following your participation in this research.

Benefits of Being in the Study

By participating in this research, you may gain new insight and understanding about who you are, your understanding of health care providers through the lens of your own personal identities, and learning about how other diverse trans* and gender non-conforming individuals have similar or different experiences and ideas as you (Upon your request, I will forward you the results from this study). A second benefit to your participation in this study is your ability to share your experiences and messages with other trans* and gender non-conforming young adults; and have such experiences presented to medical and/or mental health care professionals. An additional benefit of your participation is the opportunity to add to research about trans* experiences and community strengths, challenges, and needs. I'm sorry that I won't be able to pay you for your participation in this research study.

The potential benefits for me as the researcher include, but are not limited to increasing my own understanding of the various experiences diverse trans* and gender non conforming young adults face in medical and mental health settings; learning from those who experience discrimination and oppression resulting from their trans* and/or gender non-conforming identities; and understanding trans* experiences through their own experiences. This research will increase my ability to advocate with and for trans* and gender non-conforming clients' access to and comfort in medical and mental health care settings and interactions. Lastly, this research allows me to more accurately talk about cultural considerations for diverse trans* communities.

The potential benefits to clinical social work and society are expanding knowledge of the spectrum of gender and gender identity, fund development, visibility, and acknowledging common negative and positive experiences that diverse trans* young adults continue to face. By giving voice to the people who live as trans* and gender non-conforming individuals in our society, the field of social work will work toward increasing awareness, understanding of complexity, and appreciating the uniqueness of working with diverse trans* individuals and communities. Benefits to the social work field also include increased ability to think critically about the strengths and weaknesses in current medical and mental health care settings, specifically working with diverse trans* communities.

Confidentiality

Tangible research records and notes will be kept in a locked environment, and all electronic information will be coded and secured using a password-protected file for three years. Audio files also will be held in a locked space, and only I will have access to these files and records. I will keep data and interview notes in separate spaces to further ensure confidentiality and keeping all of your information private. I will not include any information that would identify you as a participant in any report that I may publish. The data will be kept for at least three years according to Federal regulations. Data may be kept longer if still needed for research. After the three years, or whenever the data are no longer being used, all data will be destroyed. The audiotape will be listened to and transcribed by me, the researcher, and possibly another transcriber. If an additional transcriber is used, that individual will sign a confidentiality statement before they have access and begin to transcribe the data. This individual will not have access to your consent form and will not be able to identify who you are. I/we will listen to the tapes in a private room in order to protect all of your information. I will use field notes to record key issues, questions, emotions, and ideas during the interview process. Any other notes I take might also be used as part of this study. I will transcribe and analyze the data after each individual interview.

Payments/gift

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
The decision to participate in this study is entirely up to you. Your participation in this study is voluntary and you can choose not to participate. You will have up to five days after your interview to withdraw your data without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone within five days from the date of our interview. After that date, your information will become part of my thesis. If using the web for the research interview and we lose connection, I will try to reconnect and finish the study (you will still be able to withdraw during the loss of connection or throughout the remainder of the interview after web reconnection). I will provide you with a list of nearby and hotline mental health resources along with my email address for any and all questions, comments, or concerns about the study before and/or after the interview.

Right to Ask Questions and Report Concerns
You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, [*Victoria Reiszner*] at [*vreiszner@smith.edu*] or by telephone at [*(XXX) XXX - XXXX*]. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

……………………………………………………………………………………

Name of Participant (print): ____

Signature of Participant: _________________________________ Date: _____________

Signature of Researcher(s): ______________________________ Date: _____________

……………………………………………………………………………………

[If using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): ____

Signature of Participant: _____________________________ Date: ____________

Signature of Researcher(s): ___________________________ Date: ____________

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): ____

Signature of Participant: _____________________________ Date: ____________

Signature of Researcher(s): ___________________________ Date: ____________

Researcher's Contact:

Victoria Reiszner
Address
Telephone Number
E-Mail

APPENDIX C

Qualitative Interview Questions

Interview Questions:

1. Do you/how often do you meet with primary care providers? Are you currently seeing a primary care provider? If yes, how often do you meet with your PCP? If no, have you ever met with a PCP?

2. Has your provider asked you about your gender identity? If so, how did you respond? How did the PCP respond to your gender identity?

3. Are you out as [insert personal gender identity] to providers? If so, could you talk a bit about your experience? Did you feel comfortable telling your providers about your gender identity? If so, what made you feel comfortable? If not, what made you feel uncomfortable? Does [insert another identity factor] play a role in your experience as a trans* person?
4. If you did tell your provider about your gender identity, did he/she ask follow-up questions, i.e., judgment, questioning, probing, etc.? How did that feel? Did it make you wish that you had not disclosed in the first place?

5. If you are not out to your provider, what leads to this decision? Is there anything or multiple things that would make you want to tell your provider about your gender identity? If so, what? If not, how come?

6. Does [insert another identity factor] have anything to do with your decision to “come out” or not “come out” as trans*?

7. Do you feel as though your providers know what being [insert personal gender identity] means to you? If so, how do they “show you” that they know what being trans* means?

8. Have you ever given your provider an incorrect answer because you were afraid or unsure about telling them something about you? If so, how often and about what? In the moment, what made you not tell them your actual thoughts or what was going on with you? Or – what held you back from disclosing your thoughts?

9. Do you remember seeing anything in the healthcare office or building that made it clear to you that the providers were trans* friendly? Would this have helped if you saw something that made it clear they were trans inclusive? If so, what would it look like?

10. Do you remember your doctor asking you any questions that made it seem they were trans* inclusive or trans* friendly? What could they have said/ or asked that would make them seem trans* inclusive? What do people around you do to show they are trans* inclusive?

11. Do you remember anything on the provider forms that would make you believe the services are trans* inclusive?
12. If you could change one thing about your health care as a trans* person, what would it be and why?

APPENDIX D

Recruitment Flyer

Do you identify as trans*, gender non-conforming, gender queer, or non-cisgender?

Yes ☑

Are you between the ages of 18-26?

Yes ☑

Do you also hold another diverse identity in terms of race, ethnicity, class, or sexual orientation?

Yes ☑

I am currently completing my master's thesis in Clinical Social Work. I would like to learn about your experiences with health care systems and providers. In person or Skype interviews are available.

If you would like to be a participant in my research study or have any questions, please contact me at vreiszner@smith.edu or call (XXX) XXX - XXXX

APPENDIX E

Recruitment Emails

Recruitment via trans* community social media websites, including written and video blogs:

My name is Victoria Reiszner, and I am a clinical social work graduate student at Smith College School for Social Work. As part of my degree requirement, I am required to complete a research study. I am interested in interviewing trans* and gender non-conforming young adults (ages 18-26) and their experiences and thoughts about medical and/or mental health providers and services. I want to learn more about your good, bad, or anything in between experiences of going (or not going) to the doctor's office, emergency room, youth groups or therapy appointment.

→Do you identify as gender queer, gender fluid, pan gender, bi gender, gender questioning or any trans* and/or gender non-conforming identity? Do you have a gender expression that does not "match" your biological sex?

→If so, do you also have another diverse identity related to race, ethnicity, gender, sexual orientation, or socioeconomic status?

→For example, do you identify as a Transgender Woman? Are you Gender Queer and African American? Are you Trans* and Pansexual? Do you identify as Gender Fluid and Jewish?

I am committed to gaining direct knowledge from these individuals and what they want and need in order to feel more comfortable in accessing medical settings and services in their environment. Previous research on diverse trans* and gender non-conforming young adults and their perceptions and experiences of health care providers and settings is sparse. With this research, I hope to give voice to individuals who are often silenced and marginalized in numerous ways. In addition, I wish to help increase medical and mental health awareness, knowledge, acceptance, and cultural considerations, particularly with clients and patients who are diverse trans* and gender non-conforming young adults.

If you identify within the trans* and/or gender non-conforming umbrella AND hold another identity that is often marginalized, please consider being part of this research study. Please pass this on to those you know who might be interested.
If you would like to learn more or have any questions about my research, please feel free to email me at vreiszner@smith.edu or call (XXX) XXX – XXXX.

Recruitment via trans* inclusive providers and agencies:

My name is Victoria Reiszner, and I am a clinical social work graduate student at Smith College School for Social Work. As part of my degree requirement, I am required to complete a research study. I am interested in interviewing trans* and gender non-conforming young adults (ages 18-26) and their experiences and thoughts about medical and/or mental health providers and

services. I am particularly interested in interviewing trans* folks who also have an additional marginalized identity in terms of race, ethnicity, sexual orientation, or socioeconomic status.
I am committed to gaining direct knowledge from these individuals and what they want and need in order to feel more comfortable in accessing medical settings and services in their environment. Previous research on diverse trans* and gender non-conforming young adults and their perceptions and experiences of health care providers and settings is sparse. With this research, I hope to give voice to individuals who are often silenced and marginalized in numerous ways. In addition, I wish to help increase medical and mental health awareness, knowledge, acceptance, and cultural considerations, particularly with clients and patients who are diverse trans* and gender non-conforming young adults.

If you happen to know or work with any young adults who happen to fit this description, please consider passing on my information and I will be able to provide them with more details.
If you would like to learn more or have any questions about my research, please feel free to email me at vreiszner@smith.edu or call (XXX) XXX – XXXX.