

---

Theses, Dissertations, and Projects

---

2016

## Transfigured treatment : a comparative needs and specialized services assessment of transgender youth and gender specialist providers in the Bay Area

Lark E. Nierenberg  
*Smith College*

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social Work Commons](#)

---

### Recommended Citation

Nierenberg, Lark E., "Transfigured treatment : a comparative needs and specialized services assessment of transgender youth and gender specialist providers in the Bay Area" (2016). Masters Thesis, Smith College, Northampton, MA.

<https://scholarworks.smith.edu/theses/1746>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact [scholarworks@smith.edu](mailto:scholarworks@smith.edu).

Lark Endean Nierenberg  
Transfigured Treatment: A  
Comparative Needs and Specialized  
Services Assessment of Transgender  
Youth and Gender Specialist  
Providers in the Bay Area

## ABSTRACT

*Transfigured Treatment* is a mixed-methods study that aims to assess and improve multidisciplinary clinical care for transgender and gender expansive youth in the Bay Area. This trans-led research is a joint needs- and services-assessment of local gender-specialized care, including mental health support, access to medical care, and housing assistance. *Transfigured Treatment* is a tool with which to share histories of need and transform them into legacies of care. Participants were recruited via non-probability sampling and data were collected via an anonymous online survey. Adult participants must have/had a gender expansive identity while living in the Bay Area at some point between the ages 12-24, *or* be a clinical provider offering gender-specific care in the Bay Area to people between the ages 12-24. Data were coded and statistically tested in order to assess historical and contemporary equity in access to and delivery of care. Findings indicate multidisciplinary services are both provided for and accessed by local trans youth, predominantly care-coordination with the medical system and individual therapy. There is a need for enhanced cohesion between trans youth and clinical providers regarding care-coordination with the education system, group therapy, and family involvement in treatment. Further research on the clinical implications and impact of gender specialist providers is recommended, as is incorporating structural competency into gender-related models of care.

*Keywords:* transgender, gender expansive, youth, gender specialist, Bay Area

**TRANSFIGURED TREATMENT: A COMPARATIVE NEEDS AND SPECIALIZED  
SERVICES ASSESSMENT OF TRANSGENDER YOUTH AND GENDER SPECIALIST  
PROVIDERS IN THE BAY AREA**

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

Lark Endean Nierenberg

Smith College School for Social Work  
Northampton, Massachusetts 01063

2016

## **ACKNOWLEDGEMENTS**

Laura, thank you for both holding me steady and for encouraging me to dive deeper into theory, practice, and curiosity. Thank you for being my endless inspiration-- and now my fiancé!

My family, thank you for loving me as I am, and as I continue to be; thank you for the honor of loving you back. You know all I say.

Thank you, Diana Fuery, for advising this project and supporting it to be both meaningful and manageable.

Thank you, Marjorie Postal, for assistance with statistical analysis, even when categories inevitably became complicated.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES.....	iv
LIST OF FIGURES .....	v
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	4
III METHODOLOGY.....	30
IV FINDINGS.....	39
V DISCUSSION.....	57
REFERENCES.....	72
APPENDICES	
Appendix A: Smith College School for Social Work Human Subjects Review Application .	79
Appendix B: Human Subjects Review, Protocol Change Form.....	112

## LIST OF TABLES

### Table

1.	Table 1.1: Provider Gender Coding.....	36
2.	Table 1.2: Trans Adult Gender Coding .....	36
3.	Table 1.3: All Participants, Race Coding .....	36
4.	Table 1.4: Socio-Demographic Characteristics & Statistical Analysis .....	36
5.	Table 1.5: Research Questions & Statistical Analysis .....	37
6.	Table 1.6: Provider & Trans Recommended Services Analysis .....	37
7.	Table 2.1: Socio-Demographic Characteristics for Trans Adults & Providers .....	40
8.	Table 2.2: Clinical Services Acquired By Trans Youth, By Gender.....	43
9.	Table 2.3: Clinical Services Acquired By Trans Youth, By Race.....	43
10.	Table 2.4: Clinical Services Desired, Although Not Acquired, By Trans Youth, By Gender.....	45
11.	Table 2.5: Clinical Services Desired, Although Not Acquired, By Trans Youth, By Race .....	46
12.	Table 2.6: Who Is a Gender Specialist, By Gender.....	53
13.	Table 2.7: Who Is a Gender Specialist, By Race .....	53
14.	Table 2.8: Identified Clinical Needs, Ranked .....	56

## LIST OF FIGURES

### Figure

1. Figure 1.1: Between the Ages 12-24, Did You Receive Clinical Social Work Services? 41
2. Figure 1.2: Clinical Services Acquired by Trans Youth ..... 42
3. Figure 1.3: Figure 1.3: Between the Ages 12-24, Were You Interested In Obtaining Clinical Social Work Services?..... 44
4. Figure 1.4: Which of the Following Services Were You Interested in Obtaining? ..... 45
5. Figure 1.5: Why Were the Services You Desired Not Obtained? ..... 47
6. Figure 1.6: Barriers Encountered when Accessing Individual Therapy..... 48
7. Figure 1.7: Barriers Encountered When Accessing Care-Coordination With The Medical System ..... 49
8. Figure 1.8: Clinical Services Provided Today in the Bay Area for Transgender Youth.. 50
9. Figure 1.9: Why Are Certain Services *Most* Frequently Provided?..... 51
10. Figure 1.10: Do you consider yourself a “gender specialist”? ..... 52
11. Figure 1.11: Providers: How Needed Are the Following Clinical Services for Transgender Youth in the Bay Area? ..... 54
12. Figure 1.12: Trans Adults: What Services Do You Hope Are Available for Transgender Youth Today? ..... 55

## CHAPTER 1

### Introduction

*Transfigured Treatment* was a transgender-led joint needs- and services-assessment of multidiscipline gender-specialized clinical care in the Bay Area. The research aimed to assess and improve care for transgender and gender-creative youth. The anonymous data collected from study participants endeavored to help this research become a tool with which to share histories of need and transform them into legacies of care.

The study utilized mixed-methods data collection via an original online survey instrument designed to assess the local clinical needs of Bay Area transgender and gender-expansive youth. The study further compared such needs to the services provided by local multidisciplinary clinicians, some of whom consider themselves to be “gender specialists.” This research aimed to fill a void in clinical care for transgender young people, an underserved population which consistently presents with lower mental, physical, and social health scores than peer populations (American Progress, 2010; GLSEN, 2013; Grant et al., 2011; Haas et al., 2011; Institute of Medicine, 2011; National Center for Transgender Equality, 2011). To this point, in 2011, the National Transgender Discrimination Survey (NTDS), a study including almost 6,450 transgender and gender-variant people across the U.S. reported that “it is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the workplace and health care settings, every day (Grant et al., 2011, p.7).” This research addressed discriminatory conventions in clinical care, and worked to remedy them through new empirical knowledge.



## TRANSFIGURED TREATMENT

In 2011, the Institute of Medicine designated transgender-specific health needs a “priority research area” (p.6), a designation from which this study’s population, methodology, and goals stemmed. *Transfigured Treatment* aimed to remedy chronic marginalization, both out-of- and in-clinic, by conducting a simultaneous needs and services assessment. Few studies speak to both client and clinician, yet this research maintained that clinical services are foundationally dyadic and systemic, and as such studies aimed at assessing and improving care must consider perspectives from each angle of the clinical paradigm.

Understanding the clinical climate in the Bay Area in this way created the potential to illustrate both gaps in clinical care and to highlight successful models of intervention. The results aimed to aide in the creation of clinical services that most successfully benefit their target populations, while simultaneously supplying providers with clarity and direction in their work.

In order to assess clinical needs of and services for transgender youth in the Bay Area, this study analyzed the results of 50 completed mixed-methods online surveys. The research sample was divided into two study groups: multidisciplinary clinical providers who worked with transgender youth in the Bay Area and offered at least one gender-specific service; and adults who reported having a transgender identity between the ages of 12 and 24 while living in the Bay Area. For the clinical provider study group, research questions and analyses focused on: which clinical services were provided for trans youth, and why; definition of and identification with the term “gender specialist;” and identified clinical needs among local transgender youth today. For the trans adult study group, research questions and analyses focused on: clinical services acquired when participants were between the ages of 12 and 24; clinical services desired, although not obtained, when participants were between the ages of 12 and 24; barriers to care encountered whether or not services were obtained; and identified clinical needs among local

## TRANSFIGURED TREATMENT

transgender youth today. For both study groups, socio-demographic characteristics were analyzed and identified needs among trans youth were compared.

Following this initial chapter are four subsequent sections. Chapter II reviews the current and relevant literature to this research. Chapter III further details the methodology and intended statistical analyses of this study. Chapter IV presents the findings of both the needs- and services-assessment tracks of the survey. Finally, Chapter V discusses the study results within the framework of current literature, including the minority stress model and structural competency, as well as explores the implications of the findings on clinical practice and future research with transgender youth.

## CHAPTER 2

### Literature Review

Transgender and gender expansive youth and adults are oft unrepresented in medical and social sciences literature. "Whereas there is a paucity of health literature about lesbian, gay, bisexual (LGB) youth, transgender youth are almost nonexistent in this literature" (Stieglitz, 2010, p.193). Even obtaining an accurate population count proves difficult. Typically cited is an analysis completed by the Williams Institute from a recent Gallup poll measuring the lesbian, gay, bisexual, and transgender (LGBT) population in the United States. From their approximation, "0.3% of the U.S population is transgender" (National Health Care for the Homeless, 2014, p.2). Indeed "no general population-based survey of the adolescent or adult U.S. population has attempted to measure transgender identity" (Haas et al., 2011, p. 14-15). In the Centers for Disease Control and Prevention's (CDC) 2013 Youth Risk Behavior Surveillance report, "Transgender" or "LGBT" is not written once.; "sexual minority" is used only once, for a non-statistical and non-representative purpose (CDC, 2013). Whereas the community strengths or interpersonal identity of trans youth are not often represented in empirical literature, community crisis, structural stigma, and institutional oppression are.

#### I. Language and Definitions

This research aligns with the linguistic stance set forth by David Valentine (2007), anthropologist and author of *Imagining Transgender: An Ethnography of a Category*, such that language is of utmost importance, and that it "shapes how we make sense of our worlds" and, fundamentally, of ourselves (p.31). Furthermore, the "meanings, values, and investments of

## TRANSFIGURED TREATMENT

naming and labeling...do not simply describe discrete histories but rather are productive of the very phenomena they seem to describe” (Valentine, 2007, p.30). It matters not as much what a word *means* as what a word *does*.

Usage of language is a productive process, whether the words are in use, being withheld, or inconsistently defined. It is not only the dearth of research aforementioned that negatively impacts empirical understanding of transgender and gender expansive identities and lives, but so too do inconsistent definitions. Transgender youth are among the most severely impacted by the scarcity of research and inconsistency in definition (Haas et al., 2011). This research aims to support transgender and gender expansive youth, and to affirm their lives through language. Thus a description of relevant definitions follows.

The World Professional Association for Transgender Health (WPATH), “an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health” offers the following definition of *sex*: “sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex” (Coleman et al., 2012, p.97). Typical sex development is variable, and there are numerous disorders of sex development, some resulting in intersex anatomy. For many people, gender identity and gender expression are consistent with the social norms assigned to the sex they were assigned at birth (Coleman et al., 2012).

Often assumed to be naturally rooted in ones sex rather than historically, socially, and politically mediated, *gender role or gender expression* are “the manner in which a person represents or expresses gender to others, often through their behavior, clothing, hairstyles,

## TRANSFIGURED TREATMENT

activities, voice, and mannerisms (Hussey, 2015, p.4). WPATH expands:

“Gender role or expression [refers to] characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly masculine or feminine gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Coleman et al., 2012, p.96).

*Gender identity* is a term of utmost importance in this research, as it is of utmost importance in the lives of transgender youth. Like gender expression, it is often assumed to be aligned with one’s sex, such that people assigned female at birth identify as women, and people assigned male at birth identify as men. However, the possibilities inherent in this term are not limited to an alignment with one’s sex assigned at birth, nor binary confines such as man/woman. It refers to the internalized, although not always embodied, understanding of *self* in terms of *gender* (Hussey, 2015). This identity “is not an entirely fixed characteristic, and many transgender people move fluidly between identities over time, often without any specific labels (Haas et al., 2011, p.14).

Culture, anatomy, and history each influence the language we use for our bodies, our social positions, and ourselves. *Transgender* as a term comes with many definitions, influenced from many positions, and all as varied as the bodies who claim this identity. According to the American Psychological Association (2015), "Transgender" is an umbrella term for persons

## TRANSFIGURED TREATMENT

whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth. WPATH defines it as an “adjective to describe a diverse group of individuals who cross or transcend culturally defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Coleman et al., 2012, p.97). Finally, the National Health Care for the Homeless Council (2014) writes that the term “refers to persons whose gender identity and/or gender expression is different from the sex they were assigned at birth and the expected gender role of that sex” (p.1). “Trans” is an abbreviation for “transgender.”

In addition to transgender, there are many, many more identity labels to describe an individual’s gender. For example, WPATH defines *gender nonconforming or GNC* as, an “adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period. (Coleman et al., 2012, p.96). Hussey (2015) elaborates, and writes that GNC is:

“A broad description that may include people whose gender expression or gender identity is neither masculine nor feminine or is different from traditional or stereotypical gender expectations. Some individuals prefer the terms gender variant or gender expansive. Gender-nonconforming youth may or may not identify as transgender or as lesbian, gay, or bisexual (p.4)”

Another gender-based identity term, this one politically and theoretically rooted, is *genderqueer*. According to WPATH, this term may be defined as an “identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Coleman et al., 2012, p.96). Genderqueer stems from one of the most historically dynamic terms in this

## TRANSFIGURED TREATMENT

research, as well as one of the most variable: *queer*. The Gender Equity Resource Center (2013) offers four definitions, all of which are used contemporarily in queer communities:

“An umbrella term to refer to all LGBTIQ people; a political statement, as well as a sexual orientation, which advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid; a simple label to explain a complex set of sexual behaviors and desires...; many older LGBT people feel the word has been hatefully used against them for too long and are reluctant to embrace it.”

*Gender expansive* is another contemporarily commonly used gender-based term, especially among youth and among adults writing about youth. It indicates an existence through and beyond culturally constructed gender expressions and/or roles assigned at birth. Also expanding beyond binary gender is the term *two spirit*, or an identity for indigenous North Americans “who have attributes and both men and women, have distinct social and gender roles in their tribes, and are often involved with mystical rituals” (Gender Equity Resource Center, 2013).

This research will include a term cited from previously published literature. In those pieces, *sexual minority* refers to individuals and communities with diverse gender identities and expressions. According to the Gender Equity Resource Center (2013), it also “refers to members of sexual orientations or who engage in sexual activities that are not part of the mainstream.” The term also “refers to members of sex groups that do not fall into the majority categories of male or female, such as intersexuals and transsexuals” (Gender Equity Resource Center, 2013). The use of the term “sexual minority” to refer to gender diverse populations is contested within transgender communities, as it creates yet

## TRANSFIGURED TREATMENT

another binary (minority/majority) in the realm of gender, and further dismisses the importance of variety and expansiveness among *all genders*.

Although this research emphasizes the lives of transgender folks, *cisgender* is a critical term with which to be familiar; it is defined as “a person whose gender identity matches their assigned sex at birth” (Hussey, 2015, p.4). It is important to recognize that gender identity labels are not restricted to those with expansive identities. Rather those whose gender identities align with their assigned sex at birth also embody a historically, politically, and socially mediated term.

The language above, the bodies they describe, and the lives they embody have fought battles—national, familial, intrapsychic—for recognition, not to mention for justice. These battles are waged against *Transphobia*, which is defined by The Gender Equity Resource Center (2013) at University of California, Berkeley, as “fear or hatred of transgender people; transphobia is manifested in a number of ways, including violence, harassment and discrimination.” The prevalence and effects of transphobia are subsequently detailed.

## **II. Structural Marginalization, Oppression, and Violence**

In 2011, The National Gay and Lesbian Task Force and the National Center for Transgender Equality released the findings from the National Transgender Discrimination Survey (NTDS), a study including almost 6,450 transgender and gender-variant people across the U.S. (Grant et al.). The NTDS revealed that “it is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the workplace



## TRANSFIGURED TREATMENT

and health care settings, every day (Grant et al., 2011, p.7).” The NTDS claims that the structures and institutions commonly thought of as providing and ensuring safety, such as health systems, schools, families, and police departments, as are actually “failing daily in [their] obligation to serve transgender and gender non-conforming people” (Grant et al., 2011, p.7). According to the Institute of Medicine (2011), “LGBT youth report experiencing elevated levels of violence, victimization, and harassment compared with heterosexual and non-gender-variant youth (p.4). To that end, the Institute of Medicine (2011) has designated transgender-specific health needs a “priority research area” (p.6). Much of the extant research on transgender-specific health needs has reflected the violence, discrimination, and structural oppression experienced throughout this population in varied setting and institutions.

School is a site of widespread discrimination for trans youth. Findings from the NTDS and The Gay, Lesbian and Straight Education Network’s (GLSEN) 2013 National School Climate Survey report, which surveyed 295 transgender 6<sup>th</sup> through 12<sup>th</sup> graders around the U.S., reveal a violent reality at schools around the country for gender expansive and transgender youth. 82% of LGBT students feel “unsafe at school because of who they are (National Center for Transgender Equality, 2011, p.2). Nearly half (44%) of transgender students report physical assault, including being punched or injured with a weapon, and over three-quarters (76%) “reported that they had experienced unwanted sexual remarks or touching from peers” (National Center for Transgender Equality, 2011, p.2). Abuse at school does not come solely from peers. Abuse by teachers and school staff was also oft reported by students: “harassment (31%), physical assault (5%) and sexual assault (3%)” (National Center for Transgender Equality, 2011, p. 6). In addition to assault, transgender students are often denied opportunities based on their

## TRANSFIGURED TREATMENT

identities. “59% of trans students have been denied access to restrooms consistent with their gender identity,” and others are denied opportunities to participate on sports teams consistent with their gender identity (National Center for Transgender Equality, 2015).

Despite the reality that transgender students encounter violent barriers to equitable access to education, and although the levels of victimization correlate positively with the degree to which they were public with their gender expansive identities, being “out” at school may also function as a protective factor (GLSEN, 2013). The National School Climate Survey showed that “LGBT students who were out to more of their peers and/ or school staff reported higher levels of self-esteem than students who were less out at school” (GLSEN, 2013, p.77). Moreover, perhaps the protective factor of accepting community functions longitudinally. Compared to just 7% of the general population aged 25-44 currently in school, 22% of that transgender adults in that age range are currently in school (Grant et al., 2011). Of course there is another possible interpretation of that statistic: that transgender students are unable to complete educational milestones along with the general population and must account for educational and earning gaps later in their life.

Society is rapidly digitizing, and discrimination is following suit, finding roots online from which to foster intimidation, violence, and fear. According to the Human Rights Campaign (HRC) (2015), more than 9 out of 10 (92%) LGBT youth report exposure to “negative messages about being LGBT,” citing the Internet as one of the top sources of such messages. Despite the localization of negative messages, nearly 3 out of 4 (73%) of “LGBT youth say they are more honest about themselves online than in the real world” (HRC, 2015, p.1). For transgender youth, openness about identity is often followed by harassment and abuse. Thus it follows that when

## TRANSFIGURED TREATMENT

such a large percentage of trans youth are honest about themselves online, the majority (62%) also reports cyberbullying (National Center for Transgender Equality, 2011).

Transgender youth are experiencing homelessness at rates significantly higher than the general population, and are finding themselves without adequate financial or structural support. Of the federal government's \$42 billion budget for homeless-assistance programs, only \$195 million are targeted toward homeless youth, or 0.5% (American Progress, 2010). There are currently 1.6 million - 2.8 million homeless youth in the U.S. (American Progress, 2010). Of the homeless youth population, 20-40% are LGBT, compared to only 5-10% LGBT in the general population (American Progress, 2010). Among the entire transgender population, National Healthcare for the Homeless (2014) estimates that 20% "have unstable housing, or are at risk or in need of shelter services" (p.1). That figure aligns with the 19% of respondents to the NTDS who experienced homelessness; that figure is 2.5 times the rate of the general population. (National Healthcare for the Homeless, 2014, p.1).

Once trans youth are experiencing homelessness, their safety diminishes. According to a report by American Progress (2010), nearly 9 out of 10 (88%) professional staffers in out-of-home placements claim that LGBT youth are not safe in group-home environments. When in group homes, on the streets, or other out-of-home environments, LGBT youth's safety is compromised. According to American Progress (2010), "44% [of] homeless LGBT youth reported being asked by someone on the street to exchange sex for money, food, drugs, shelter, or clothes;" this rate is "compared to 26% [of] straight homeless youth." Here "LGBT" and "straight" appear contradictory terms, when in fact someone may very well be trans and straight. The overall significance of the statistic and those that follow is the compounding effect that a

## TRANSFIGURED TREATMENT

sexually or gender expansive identity has on one's safety. American Progress (2010) also reports that "58% homeless LGBT youth have been sexually assaulted" compared to 33% heterosexual. Homeless trans youth experience harassment and abuse from strangers on the street, their peers, and too the adults whom they are told they may trust. According to the NTDS, "the majority of those trying to access a homeless shelter were harassed by shelter staff or residents (55%), 29% were turned away altogether, and 22% were sexually assaulted by residents or staff (Grant et al., 2011, p.4). Increasing numbers of transgender youth are homeless (Hussey, 2015).

The National Association for the Advancement of Colored People (2015) writes, "3.2 percent of the population is under some form of correctional control." Among those under correctional control and otherwise involved in the criminal justice system, transgender individuals are significantly more likely, in fact 3.32 times more likely, than their cisgender counterparts to experience police violence (National Healthcare for the Homeless, 2014). Nearly one-fifth (22%) of respondents to the NTDS who had interacted with police reported harassment (Grant et al., 2011, p.5). Of the NTDS respondents who had been to jail or prison, "16%...reported being physically assaulted and 15% reported being sexually assaulted (Grant et al., 2011, p.5). The U.S. Bureau of Justice Statistics put these trends into perspective against the general incarcerated population: "35% of transgender prisoners report experiencing sexual abuse in the last twelve months, compared to 4% of all prisoners (Movement Advancement Project, 2015b, p.14).

According to The Trevor Project (2015), "suicide is the 2nd leading cause of death among young people ages 10 to 24." Further, each experience of harassment and abuse due to

## TRANSFIGURED TREATMENT

one's sexual and/or gender identity “increases the likelihood of self-harming behavior by 2.5 times” (The Trevor Project, 2015). Given the interaction of victimization and self-harming behavior such as suicide, the rate of suicide attempts by transgender individuals (41%) is substantially greater than LGB adults (10-20%) and the general population (1.6%) (Movement Advancement Project, 2015b; Haas et al., 2014).

Of the 41% of respondents to the NTDS who had reported attempting suicide, structural factors appear to significantly influence attempts, as rates rose for those “who lost a job due to bias (55%), were harassed/bullied in school (51%)...or were the victim of physical assault (61%) or sexual assault (64%) (Grant et al., 2011, p.2). Additionally, age, racial, familial, community and health disparities led to rates of attempts higher than the study's average, including: those who are 18-24 years old (45%); those who are multiracial (54%); those who are American Indian or Alaska Native (56%); those who completed high school or less (48-49%); those who are earn less than 10k/year (54%); those who are HIV positive (51%); those with disabilities (55-56%); those with a mental health condition that substantially affects a major life activity (65%). Those whose family chose not to speak or spend time with them 57%; those who were harassed or bullied at school (any level) (50-54%); those who experienced discrimination or harassment at work (50-59%); those whose doctor or health care provider refused to treat them (60%); those who were disrespected or harassed by law enforcement officers (57-61%); those who suffered physical or sexual violence by law enforcement officers (60-70%); and those who experienced homelessness (69%) (Haas et al., 2014). These blunt statistics illuminate the crisis of transgender suicide, and they allow research and intervention to consider the relationships between structural oppression and self-harming behavior for transgender individuals.

## TRANSFIGURED TREATMENT

Families are among the institutions failing to adequately protect transgender and gender expansive youth. According to the NTDS, over half (57%) of the respondents experienced significant family rejection (Grant et al., 2011). Family rejection is significantly correlated with a number of dangerous outcomes. If LGBT youth are rejected by their families in adolescence, they are 8.4 times more likely to attempt suicide, 5.9 times as likely to have experienced depression, and 3.4 times as likely to have used illicit drugs, and 3.4 times as likely to have had unprotected sex (American Progress, 2010). However, strong family relationships appear to be a protective factor: “a lower than average prevalence of lifetime suicide attempts (33%) was found among respondents who said their family relationships had remained strong after coming out (Haas et al., 2014, p.12).

Results from the NTDS indicated that the transgender population is consistently, structurally oppressed in the workplace and financial sphere. 4% of the general population represents a household income of less than \$10,000/year; however, 15% of NTDS respondents indicated this financial burden (Grant et al., 2011; Movement Advancement Project, 2015a). 67% of the general population owns their own home, while only 32% of NTDS respondents do (Grant et al., 2011). Rates of unemployment were twice that of the general population, and the rates elevated to four times that of the general population for transgender people of color (Grant et al., 2011). And when they did secure employment, nearly half (47%) reported experiencing “an adverse job outcome, such as being fired, not hired or denied a promotion because of being transgender or gender non-conforming (Grant et al., 2011, p.3). The respondents who reported being fired because of being trans experienced “ruinous consequences,” compared to those who were not fired for being trans, “such as four times the rate of homelessness, 70% more current

## TRANSFIGURED TREATMENT

drinking or misuse of drugs to cope with mistreatment, 50% more incarceration, more than double the rate working in the underground economy, and more than double the HIV infection rate” (Grant et al., 2011, p.3). These findings clearly indicate systemic economic marginalization of transgender people.

Transgender individuals face many barriers when attempting to access medical and mental health care. According to the NTDS, nearly half (48%) are unable to afford care, while nearly 1 out of 5 (19%) “reported being refused medical care due to their transgender or gender non-conforming status, with even higher numbers among people of color in the survey” (Grant et al., 2011, p.5). NTDS respondents also indicated that over half (60%) of those who were refused care due to their identity had attempted suicide (Haas et al., 2014). When trans patients were seen for care, over half (51%) reported needing to teach their provider about their bodies, lives, and experiences in order to receive appropriate care (Haas et al., 2014). These upstream access barriers have detrimental downstream effects, for instance that trans individuals report over four times the national average of HIV infection (Grant et al., 2011).

Trans folks experience barriers to mental health care in addition to medical care, although a need for care is clear. Many states have complicated and expensive processes by which an individual may change their gender marker on their official documents. In the NTDS, 41% reported living “without ID that matches their gender identity” (Grant et al., 2011, p.5). When presenting an ID that was not consistent with their gender, 40% of NTDS respondents reported being harassed (Grant et al., 2011). The dysphoria experienced through that disconnect is not one of individual pathology, but rather societal structure.

Trans individuals report depression at a rate (44-54%) 6-8 times higher than the general

## TRANSFIGURED TREATMENT

population (6.4%) (National Healthcare for the Homeless, 2014). Many hold little hope of happiness, resilience, or safety due to pervasive bias against their identity. The NTDS used the prompt: “Because I am Trans/GNC, life in general is...,” and the responses offer a bleak picture: “the same (31%), somewhat improved (37%), much improved (39%); somewhat worse (42%), much worse (56%), some ways better, some ways worse (45%) (Haas et al., 2014, p.14). Among those respondents, many indicated they received mental health support (44%), while others indicated they may someday be interested support (39%). Still, given the bleakness of the responses above, it appears the current mental health support is not adequately meeting the needs of trans communities.

The Institute of Medicine (2011) defines intersectionality as the “examin[ation of] an individual’s multiple identities and the ways in which they interact,” and identifies intersectional examination as a need in order to deliver adequate care to any population (p.2). For transgender folks, marginalized identities appear to have a compounding factor within reports of assault, violence, and poverty.

A marginalized racial identity elevates the risk of violence for trans folks. In the NTDS, people of color report significantly greater abuses and oppressions than white participants; among respondents of color, African American respondents reported worse outcomes in most categories (Grant et al., 2011). Trans youth of color experience elevated levels of abuse at schools; NSCS results indicated: “harassment by teachers or staff was highest among Latino/Latina (35%) and multiracial (42%) respondents;” “physical assault was highest among American Indian and multiracial respondents (6%);” and “sexual assault by teachers or staff was highest among African American respondents (7%)” (National Center for Transgender Equality, 2011, p.6).



## TRANSFIGURED TREATMENT

Racism extends beyond the school. 16% of trans folks have been incarcerated, but that rate jumps to 47% for Black transgender folks (Movement Advancement Project, 2015b). Additionally, Black and Hispanic youth are two times more likely to attempt suicide than White youth (Trevor Project, 2015). Moreover, the interaction of racism and transphobia is economically insidious. “Asian and Pacific Islander (API) transgender people were six times as likely to report extremely low incomes compared to other API people, while 34% of black transgender respondents reported incomes at this level, compared to 9% percent of all African Americans” (Movement Advancement Project, 2015b, p.7). Compounding marginalization is violently detrimental to trans folks’ lives.

Misogyny and transphobia, also known as transmisogyny, is a pervasive factor in structural oppression, too. According to the NSCS, “transgender girls were twice as likely to have been physically or sexually assaulted by teachers or staff while in school as transgender boys” (National Center for Transgender Equality, 2011, p.6). Additionally, although only 16% of trans folks have been incarcerated, 21% of trans women have. Trans women are at elevated risk for experiencing police brutality than their cisgender or non-feminine trans peers (Movement Advancement Project, 2015b). Finally, “in 2013, transgender women of color comprised more than half of all LGBT homicide victims” (Movement Advancement Project, 2015b, p.12). Transmisogyny violently oppresses, and kills, transwomen and transwomen of color.

Additionally, gender-based oppression and poverty have detrimental outcomes to trans folks’ medical safety. The National Healthcare for the Homeless (2014) reports that “the HIV rate for those that had a history of homelessness was 7.12% compared to a rate of 1.97% of those who did not (p.3). Moreover, among the respondents of the NTDS who indicated having

## TRANSFIGURED TREATMENT

attempted suicide, 69% had experienced homelessness (National Healthcare for the Homeless (2014). Taking into account the rates at which trans folks access mental health and medical care, those statistics represents intersectional marginalization at every turn.

Finally, Miller and Grollman (2015), report that “gender nonconforming trans adults reported more events of major and everyday transphobic discrimination than their gender conforming counterparts” (p.826). The fact that GNC individuals are at greater risk of abuse, harassment, and health disparity due to their gender expression and/or identity, reveals the inherent bias against bodies and lives that expand beyond cultural norms regulating gender.

### **III. Minority Stress Model**

This research is contextualized within the minority stress model, a framework that explains how “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems” (Meyer, 2003b, p.1). When originally developed, this model took into account gay, lesbian, and bisexual individuals and communities who were not necessarily transgender. Since the model aims to document “the impact of institutional stressors...via assessments of differences in population parameters...at the group rather than the individual level, it has been commonly applied to the trans population as a method of understanding compounding structural stressors and their consequences on the mental health of the population (Meyer, 2003a, p.263).

The Institute of Medicine (IOM) (2011), reports that “sexual and gender minorities are subjected to chronic stress as a result of their stigmatization as a minority group” (p.314). The IOM identifies subsets of structural stress processes which influence trans folks’ health. The report the processes “are both proximal (subjective) and distal (objective)”; they are also external

## TRANSFIGURED TREATMENT

(enacted stigma) and internal (felt stigma, self-stigma) (IOM, 2011, p.314). The dynamic processes between subjective and objective marginalization, compounded by multiple manifestations of stigma, exert sweeping control over the mental well-being of trans communities, and thus the IOM (2011) recommends that minority stress and stigma be understood as central to overall *health* and an integral focus in research with this marginalized population.

### **IV. Stigma, Post-Structuralism, and the Limits of Being**

The Institute of Medicine, a contemporary empirical health sciences institution, draws heavily in its research discourse on mid-century social theory. The origin of *stigma* entering the discursive lexicon may be attributed to Erving Goffman, an influential pioneer of sociology. Goffman (1963) identifies stigma as a relational process wherein there occurs a social discrediting of an individual identity, thus resulting in the “spoil[ing of their] social identity” (p.19). The IOM draws from Goffman’s foundation and identifies subsets of stigma relevant to empirical research on the phenomenon’s effect on stigmatized populations. These subsets include: enacted stigma, or “explicit behaviors that express stigma;” felt stigma, or “awareness of the possibility that stigma will be enacted in particular situations;” internalized stigma, or “accepting the legitimacy of society’s negative regard for the stigmatized group;” and structural sexual stigma, which “disadvantages and restricts the opportunities of sexual and gender minorities by perpetuating their lower status and power relative to non-gender-variant heterosexuals” (IOM, 2011, p.62-65). Each subset of stigma may be experienced by trans individuals, likely due to the discrediting processes inherent in the formation of gender as an embodied identity.

## TRANSFIGURED TREATMENT

As Judith Butler (1993) writes, “the construction of gender operates through *exclusionary* means,” such that social processes that *allow some* gender identities to come into being only do so by *refusing others* “cultural articulation” (p.8). Butler (1993) theorizes that the seemingly fixed syllables of cultural articulation that separate bodies, separate genders, and separate identities may not actually be located as a “site [n]or surface, but [rather as] *a process of materialization that stabilizes over time to produce the effect of boundary*” (p.9). Furthermore, the embodied syllables of cultural articulation, perpetually in discursive process, may “bound a thing only through enforcing a certain criterion, a principle of selectivity” (Butler, 1993, p.11). Butler’s (1993) theoretical paradigm reflects the afore detailed violent reality for transgender individuals, such that she writes the *process* of intelligibility, gender or otherwise, “will have some normative force and, indeed, some violence, for it can construct only through erasing” (p.11). The violent erasure of identities- of bodies- recalls Valentine’s (2007) paradigm of language, such that it matters less what a word *means* than what a word *does*.

Valentine (2007) explains that the processes by which categorizations of identities, such as gender, are made “are never neutral” (p.5). Butler (1993) also dismisses the possibility of neutrality in categories of self, such as gender, by claiming that “the acquisition of being [occurs through] the citing of power, a citing that establishes an originary complicity with power in the formation of the “I”” (p.15). The power to which Butler (1993) refers is also cited by Foucault (1977) as that which “produces domains of objects and rituals of truth” (p.194). For transgender individuals, embodying gender, or embodying theoretical *object* and *truth*, manifests as being “caught in a system of signification, power, and meaning over which [you] have little control” (Valentine, 2007, p.13).

Stigma and power interact, and their interaction may be understood as “intersectionality.”

## TRANSFIGURED TREATMENT

According to Patricia Hill Collins (2000), a Black feminist theorist, “intersectional paradigms remind us that oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice” (p.21). Maintaining a critical theoretical and empirical focus on intersectionality is essential to producing research and knowledge that justly reflects the breadth of bodies caught in Valentine’s (2007) system of power. Black feminist poet Audre Lorde (1982) articulates the necessity of this critical gaze when she claims, “in order to survive, those of us for whom oppression is as American as apple pie have always had to be watchers” (p.114). For those whose nation is represented by chronic structural oppression, support must manifest by maintaining a critical eye toward language, categorization, and power.

### **V. The Role of Mental Health Providers and Services**

Mental health practitioners may draw upon their understanding of human development in order to support the varied needs throughout the lifespan of trans individuals (Moe et al., 2014). Regardless of gender identity, “striving for balance, learning to cope, questioning, and eventually becoming comfortable with one's gender identity and sexual orientation are of paramount importance for healthy growth and development” (Stieglitz, 2010, p.192). Perhaps it is this developmental current that keeps youth optimistic, despite the widespread oppression detailed above. Notwithstanding the likelihood that they will experience some form of abuse, violence, or rejection, “77% LGBT youth say they know things will get better” (HRC, 2015, p.3). In fact a study by Birkett et al. (2015) utilized a longitudinal design which spanned over 3.5 years to ask a racially diverse sample of 231 LGBTQ folks ages 16-20: Does it get better? Indeed, Birkett et al. (2015) found that it may indeed “get better” for the youth, so long as they encounter fewer instances of victimization. These findings suggest that early prevention and intervention for trans

## TRANSFIGURED TREATMENT

youth may lead to substantial health benefits years later.

Knowing that services may support youth is only part of the solution, however. We must also know which services, provided by whom and where, would most benefit trans youth.

Hoffman, Freeman, and Swann (2009) conducted a cross-sectional Internet-based survey in order to assess service preferences among trans youth. 733 respondents ages 13-21 years and older living in the U.S. or Canada responded to their survey. Youth indicated what was most important to them in the context of care, and also what was least: most important was “competence overall and specifically in issues unique to taking care of youth and LGBTQ persons, as well as being respected and treated by providers the same as other youth;” least important was “the provider’s gender and sexual orientation” (Hoffman, Freeman, and Swann, 2009, p.222). These findings indicate that although clinical knowledge of trans-specific care is a priority for youth, providers need not be trans or gender-expansive. With adequate clinical training, any provider could provide competent care.

Another Internet-based survey conducted by Wells et al. (2013) surveyed 544 domestic sexual minority youth, ages 14-19, about their clinical needs and clinical preferences. Responses varied depending on youths’ racial identity and how certain youth were of their gender identity. For instance, “African American youth were more likely than others to prefer services offered in a place of worship,” despite the finding that “the majority preferred to receive services at an agency specifically designated for LGBTQ youth” (Wells et al., 2013, p.312-318). Additionally, those who were questioning their gender identity “expressed stronger interest than others in services to address stress, family issues, and self-defense, and in receiving support and guidance from LGBTQ adults” (Wells et al., 2013, p.312). Thus despite Hoffman, Freeman, and Swann’s (2009) findings, perhaps for those questioning their identity, receiving care from an LGBTQ

## TRANSFIGURED TREATMENT

provider would actually act as a protective factor. This is a discrepancy in findings worth further study.

Trans youth's needs were also analyzed by Davis et al. (2009) from two separate needs assessments at LGBT youth centers, one in Ohio and one in Massachusetts. Davis et al. (2009) found "youth in both regions described frustrations with difficulties in accessing knowledgeable professionals," and that many youth had to "educate" the mental health providers in order to receive adequate care (Davis et al., 2009, p.1039). These data underscore a trend in youth reports: trans-specific provider knowledge is essential for productive care.

Rachlin (2002) assessed trans patients' experiences of psychotherapy in Baltimore, MD, and her findings echo those reported by youth above. Results of the 93 participants who encountered 150 psychotherapists indicate that "provider experience in working with the gender issues was associated with a higher number of positive changes, higher patient satisfaction with progress in both general personal growth, and gender related issues (Rachlin, 2002, p.1).

At a University of Minnesota health clinic, Bockting et al. (2004) compared psychotherapeutic, psychiatric, and sexual medicine services satisfaction scores between 180 trans adults and 837 other non-trans patients. Their study reports two relevant findings. First, that trans patients attend significantly fewer (mean of 10) sessions when accessing care in order to fulfill a mandated requirement for gender affirming medical intervention compared to those seeking broader, growth-oriented mental health services (mean of 52) (Bockting et al., 2004). Secondly, transgender patients reported equal satisfaction with fees compared to non-trans patients, but the researchers still suggest "limits on the reimbursement for transgender-specific health care is a major and growing barrier for access" (Bockting et al., 2004, p.290). These findings provide a snapshot into the barriers to care many trans patients face: the necessity of

## TRANSFIGURED TREATMENT

passing through mental health's gatekeeping role en route to medical intervention, as well as encountering a financial barrier to receiving desired care.

Needs assessments, like those referenced above, are helpful tools with which to access individual experience and overall community need. Mental health support is a dyadic process, though, and provider perspective is likewise important to consider when trying to understand the experiences of any clinical population. Mental health providers play a critical role in the holistic care of trans clients. Their responsibilities "include assessment, individualized treatment, advocacy, and aftercare" (Bockting, 2008, p.215). Each one of those tasks requires community attunement, clinical experience, and empirical grounding. Through each clinical duty, therapists may support "individuals in addressing the impact of stigma, confronting internalized transphobia, exploring their gender identity and sexuality, and achieving comfort and fulfillment" (Bockting, 2008, p.218).

The literature shows that mental health service providers struggle to meet the complex needs of trans youth. According to service providers throughout the U.S. who work with homeless youth, "nearly six in ten respondents (58%) report that transgender homeless youth have worse physical and mental overall health" (Durso and Gates, 2012, p.10). It is impractical that one provider, or even one agency, could reverse and heal "overall health." Providers in Toronto have expressed frustration about just that. The Toronto Teen Survey received reports from 80 providers in 55 agencies across the city (Travers et al., 2010). The providers indicated they encounter "both a sea of misinformation in addition to a lack of evidence-based information to guide them" (Travers et al., 2010, p.196). Due to providers' concerns about the lack of knowledge and the extent of need observed, many providers in Toronto "described the ongoing



## TRANSFIGURED TREATMENT

reliance on hidden referral networks of trusted LGBT staff and allies in other agencies” (Travers et al., 2010, p.195). It is not uncommon for providers to utilize referrals for enhanced care for their patients. However, the reliance on “hidden” networks suggests trans-specific care to be a mysterious, if not insidious, presence in mental health care systems.

One strategy to bring referrals and wrap-around care to light is to start multidisciplinary clinics, such as those launched by The Hospital for Sick Children in Toronto and University of California, San Francisco (Cross, 2014). Each hospital offers a team consisting of physicians, endocrinologists, nurses, and social workers who “provide youth and their families with the resources and care they need while allowing for better continuity of care” (Cross, 2014, p.1). Each clinic prides itself on being “driven by the youth’s needs” and offering cooperative, interdisciplinary services to meet whatever needs arise.

Another strategy to improving care may be to implement treatment sooner in the lives of trans youth requesting support. Olson-Kennedy writes in *JAMA Pediatrics* (2016), “the scientific and professional provider community still remains largely uncertain about the complex nature of transgender experience, especially in regard to youth” (E1). Yet we know from a recent study published in *PEDIATRICS* by Olson et al. (2015) that socially transitioned, prepubescent (ages 3-12) transgender children who are supported in their gender identity “showed typical rates of depression and only slightly elevated rates of anxiety symptoms compared with population averages” (p.5). These results suggest that, although the clinical community may be “uncertain” about the trans experience, there is no uncertainty about the mental health benefits of supporting prepubescent transgender youth to socially transition. Olson et al. (2015) illustrate a lesson that is imperative for the clinical community to learn: “These data suggest at least the possibility that being transgender is not synonymous with, nor the direct result of, psychopathology in

## TRANSFIGURED TREATMENT

childhood” (p.7). Olson-Kennedy (2016) writes, “The entire framework of transgender health care would benefit from a restructuring to meet the needs of patients and clients, as well as acknowledging pragmatic limitations of available professionals” (E2). Perhaps one such restructuring tactic would be to systematically reevaluate the age at and methods with which transgender youth are clinically supported.

### **VI. Embodying Transgender in the Bay Area**

Although the Institute of Medicine (2011) has identified transgender-specific health as a “priority research area” (p.6), most research to date has focused on need and risk within the population, rather than service delivery and satisfaction ratings within the population. A community needs assessment, such as the one utilized in this research, is one method through which to examine needs, existing delivery systems, and service preferences simultaneously (Craig, 2011). Following are summaries of two studies, one reporting risk, the other reporting needs, specifically of trans youth in the Bay Area. However, neither addresses existing delivery systems or the satisfaction ratings of those delivery systems.

Toomey et al. (2010) examined school victimization and its subsequent mental health presentation among 245 gender nonconforming (GNC) students in the Bay Area. The authors found that the presentation of depression in GNC students could be fully accounted for by levels of identity-based victimization, experienced as “distal stigma,” at school (Toomey et al., 2010, p.2). Toomey et al. (2010) also identify an association between identity-based school victimization and young adult presentation of depression, anxiety, and lower life satisfaction, among other adjustment problems. These results suggest early intervention in identity-based victimization could radically decrease later adjustment difficulty.

## TRANSFIGURED TREATMENT

Another Bay Area, ethnographic study assessed the needs of 43 trans youth and adults of color in San Francisco (Bith-Melander, 2010). Participants identified a number of barriers encountered due to their gender identity. Their responses, localized to San Francisco, reflect the national trends detailed above. Barriers to care included a lack of health insurance, fear of not accessing a competent provider, lack of knowledge about available or free services, and lack of transportation to reach services. Additionally, youth reported “they struggled with being accepted by their families and lacked direction or resources to pursue their interests” (Bith-Melander, 2010, p.217). Finally, youth stated main areas of concern are employment opportunities and stable housing (Bith-Melander, 2010). Altogether, the needs reflected in this small, ethnographic Bay Area study reflect the national trends of numerous, varied, and far-reaching opportunities to support transgender youth.

### **VII. Contributions and Limitations**

This study will attempt to capture transgender youth’s perspective through a retrospective needs assessment and service satisfaction survey of trans adults. Youth’s voices are too oft left out of empirical efforts, and unfortunately this report will also lack their direct insight. However, most trans adults were trans youth at one point, and this survey offers an opportunity to tend to younger generations and contribute truth and power to the trans population as a whole.

Secondly, this study will be localized and it will be current. It will assess the needs and services in the Bay Area *today*. The rate at which transgender clients are appearing on caseloads is rapidly rising, and a current empirical measure of needs, services, and satisfaction is necessary in order to clinically cope with the needs of the population (Durso and Gates, 2012).

Thirdly, this research will integrate client *and* clinician responses. It will assess the

## TRANSFIGURED TREATMENT

present needs of the community, and it will also assess the present services delivered by providers committed to competent trans care. No other report has yet compared the two data sets in order to assess for gaps, recommendations, or models.

Lastly, clinical social work is a profession with few boundaries. The data in this research will represent the many components of care social workers provide. Rather than focusing solely on interventions for youth experiencing homelessness or barriers to HIV care, this research will take the temperature of overall community needs and compare it to overall clinical services. It will paint a broad picture of the Bay Area trans youth community, one which will reflect the dynamic lives and needs of the participants.

In addition to contributions, this research also retains two significant limitations. The survey for trans adults will be retrospective, while the survey for clinicians will be current. Thus, the two data sets may not be analyzed as if they represent the same clinical and community environment. Thus the surveys will be compared and analyzed against each other, but with the caveat that they are not representative of the same point in time.

Finally, the survey will not be a representative sample of Bay Area transgender youth. Data will be collected via convenience and snowball sampling, and thus the data will not be a stringently representative sample of the population it aims to measure. Despite these limitations, the study will contribute new knowledge to the field and may serve as a reference for service recommendation and creation.

## CHAPTER 3

### Methodology

#### I. Research Formulation

This research was largely founded upon the critical findings of the National Transgender Discrimination Survey (NTDS), conducted in 2011 by the National LGBTQ Task Force and the National Center for Transgender Equality. The NTDS, a study including almost 6,450 transgender and gender-variant people across the U.S., revealed that “it is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the workplace and health care settings, every day (Grant et al., 2011, p.7).” Additionally, this study responded to the Institute of Medicine’s (IOM) (2011) designation of transgender-specific health needs as a “priority research area” (p.6). The findings from the NTDS and the IOM’s priority research designation follow an empirical trend, such that much of the extant research on transgender-specific livelihood has reflected violence, discrimination, and structural oppression throughout a national population rather than conducted an assessment of needs and interventions in a local, specific population. This study aimed to bridge the widespread calls to action with localized empirical methodology.

The community needs and specialized services assessment presented here utilized mixed-methods, that are both qualitative and quantitative, data collection and analysis. Through these methods, this study compared the clinical social work needs of transgender youth in the Bay Area with the services provided by local gender specialist clinicians. This study investigated

## TRANSFIGURED TREATMENT

whether a historically and chronically marginalized population's local needs were met by available, specialized services.

Language was an important factor throughout this research, for both statistical and ethical intentions. The relevant meanings of terms used throughout this study may be found in the preceding Literature Review chapter. Throughout this study, the term “transgender” was oft and critically employed. In a sample of 100, this term may well be defined 100 different ways; such a term is historical, personal, and evolving. For the methodological purposes of this research, the National Center for Transgender Equality’s definition of “transgender” was used: “A term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth.” It is important to note that a single definition, such as the one used here, still leaves room for multiple possibilities of embodiment and identity.

## **II. Research Sample**

This eight-month study included both quantitative and qualitative survey responses from 50 participants. Participants were members of two study groups:

The first group consisted of residents of the Bay Area, delineated by nine California Counties: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma. Participants were 18 years or older, and were able to consent to participation independently. At the time of study, participants must have reported having a gender-expansive identity (e.g., transgender, genderqueer, aggressive/AG) when they were 24 years or younger.

The second study group consisted of mental health, medical, and social service providers (e.g., MSWs, LCSWs, MFTs, MDs, PhDs, etc.) who practiced in the Bay Area at time of study. Participants were 18 years or older, and were able to consent to participation independently.

## TRANSFIGURED TREATMENT

Participants in this group must have identified one or more of their services as specialized to the needs of transgender and gender-expansive youth.

Participants of both study groups were recruited using non-probability "snowball sampling" and received one of two participant recruitment messages, attached in the study's appendices. Recruitment messages provided potential participants with the purpose of the research, study sample requirements, and this researcher's contact information. The first recruitment message was posted to and shared on Facebook via: this researcher's personal profile; Smith College School for Social Work Class of 2016's group page; Smith Social Workers Speakeasy group page; and Smithies in the Bay group page. It was also shared on Reddit, via the subreddits: r/socialwork, r/transgender, r/asktransgender, r/trans, r/queer, r/lgbt, r/radicalqueers, r/genderqueer, r/bayarea, r/research, and r/socialscience. Additionally, it was further shared among social media users who encountered the recruitment message via contacts or one of the original posting pages.

The second recruitment message was distributed by email to a list of local clinicians, organizations, and institutions providing clinical social work services to transgender and gender-expansive youth. The list of organizations contacted is included in the appendices. The local organizations were identified by this researcher via colleague recommendation and through Dimensions Clinic's *The Little Black Book 2*, an index of local trans-affirming services. Two of the organizations contacted, San Francisco AIDS Foundation and the Trans Thrive Drop-In Center at Asian & Pacific Islander Wellness Center, invited this researcher to recruit participants in-person. This recruitment measure was particularly beneficial for offering the study to participants who might not otherwise have access to the Internet, as the researcher brought a personal computer to the spaces for participants' use.

## TRANSFIGURED TREATMENT

The organizations contacted serve clients with varied socio-economic statuses, gender identities, racial identities, diagnoses, insurance coverage statuses, and clinical needs. Although many of the organizations also serve clients who are not literate in English, the recruitment messages for this study, as well as the study itself, were only distributed and available in English. Additionally, this study's survey was only available online, so participants needed access to the Internet. Methodology including an online-only study with an English literacy recruitment is presumed to have limited participant population and access; this barrier is a significant limitation to the generalizability of this research.

### **III. Data Collection**

This study utilizes an original survey instrument, attached in the appendices, created by the researcher with the support of their advisor. The study asks all participants demographic information, including age, race, gender identity, household income, housing status, health insurance coverage status, and religious or spiritual affiliation. The survey then branches to account for the two study groups. Those who self-reported having a transgender identity while 24 years old or younger were asked a series of questions about their experiences, or lack thereof, with clinical services, including housing support, mental healthcare, medical care, and legal support. Those who self-identified as being a gender specialist provider were asked a series of questions about the services they do, and do not, provide for local transgender youth. Demographic and service-specific questions were inspired by and/or modeled after those in the NTDS and the NTDS' creator's most recent national study, the 2015 U.S. Trans Survey, whose results have not yet been released and in which this researcher personally participated. This survey utilized mixed-methods data collection primarily as an ethical safeguard. Given that the



## TRANSFIGURED TREATMENT

experiences of trans folks and clinicians are so varied and expansive, many survey questions included an additional write-in space for respondents to clarify, expand upon, or challenge the given question if so desired.

Before data collection began, this study was approved by the Human Subjects Review (HSR) committee at Smith College School for Social Work. Upon HSR approval, participant recruitment methods, detailed above, were employed. Once participants encountered the recruitment message via social media, professional listservs, email, in-person, and/or word-of-mouth, they accessed the survey instrument, hosted by Qualtrics, online. Survey respondents consented to participation digitally, following the Consent Form attached in the appendices. Respondents then completed the survey, a time requirement of approximately 5-15 minutes. After completing the survey, participants were shown a list of three local medical and mental health clinics available should they have experienced distress linked to study participation; this same local service list was included in participants' initial consent form. Study participation ceased once the survey was completed.

Most participants accessed the survey online, independent of direct interaction with the researcher. Those who did interact directly with the researcher did so at San Francisco AIDS Foundation or Trans Thrive, or due to questions sent online or queried in-person about study participation. All survey responses, regardless of researcher-interaction, remained anonymous.

### **IV. Data Analysis**

Survey data were accessed by the researcher via personal computer, which was both password-protected and encrypted. It was also shared with Dr. Diana Fuery, advisor to this study, and Marjorie Postal, data analyst at Smith College School for Social Work. All who accessed

## TRANSFIGURED TREATMENT

data did so following the protection protocols outlined by Smith College School for Social Work, such that "all research materials including recordings, transcriptions, analyses and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period."

Qualitative data were coded and organized using Excel. This type of analysis was primarily required in order to define and describe what respondents reported about being a "gender specialist" provider. Data indicating professional training, clinical guidelines, and professional support were thematically coded and categorized using a matrix form. Categorical data were then bundled to define participants' roles and experiences as Gender Specialists, and are presented in the subsequent Findings chapter.

Quantitative data were likewise coded and organized using Excel. Some demographic variables were coded to condense categories for statistical analysis. For the providers, gender was coded into two variables, based on self-report responses to National Center for Transgender Equality's definition of "transgender," detailed below in *Table 1.1*. For transgender non-provider respondents, gender was coded into three variables: trans-feminine, trans-masculine, and gender expansive, as detailed in *Table 1.2*. If a participant fell into two or more gender groups, they were coded as "gender expansive." Race was also coded to reflect participants, as detailed in *Table 1.3*. Socio-demographic characteristics were assessed using cross tabulations, t-tests and chi-squares, detailed in *Table 1.4*. *Table 1.5* further details the study's research questions and corresponding tests. Finally, this study's overarching purpose was to assess whether gender specialists are meeting trans-specific, trans-identified needs. In order to analyze this, frequency

## TRANSFIGURED TREATMENT

reports were compared for each clinical service in three distinct pairing paradigms, as depicted in *Table 1.6*.

<b>Table 1.1: Provider Gender Coding</b>	
Transgender	<i>According to the National Center for Transgender Equality's definition of "transgender," are you transgender? YES</i>
Not Transgender	<i>According to the National Center for Transgender Equality's definition of "transgender," are you transgender? NO</i>

<b>Table 1.2: Trans Adult Gender Coding</b>	
Trans-Feminine	<i>Femme MTF/M2F Transwoman Trans Woman (Other) Woman</i>
Trans-Feminine	<i>FTM/F2M Man Transman</i>
Gender Expansive	<i>Agender Gender Diverse Gender Fluid Gender Non-Conforming Genderqueer Intergender Queer Other</i>

<b>Table 1.3: All Participants, Race Coding</b>	
Black or African American	<i>Black or African American selected</i>
Hispanic or Latin@	<i>Hispanic or Latin@ selected</i>
American Indian or Alaska Native	<i>American Indian or Alaska Native selected</i>
Asian	<i>Asian selected</i>
White	<i>White selected</i>
Mixed Race	<i>&gt;1 race selected; Afro-Latin</i>

<b>Table 1.4: Socio-Demographic Characteristics &amp; Statistical Analysis</b>	
Gender	<i>Cross tabulation by trans adult / provider</i>
Age	<i>Two-tailed t-test by trans adult / provider</i>

## TRANSFIGURED TREATMENT

Race	<i>Cross tabulation by trans adult / provider</i>
Health Insurance	<i>Cross tabulation by trans adult / provider</i>
Dental Insurance	<i>Cross tabulation by trans adult / provider</i>
Rent Home	<i>Chi-square</i>
Own Home	<i>Chi-square</i>
Household Income	<i>Two-tailed t-test by trans adult / provider</i>

<b>Table 1.5: Research Questions &amp; Statistical Analysis</b>	
What percentage of trans respondents accessed clinical services as youth?	<i>Frequency report</i>
Which clinical services were obtained?	<i>Cross tabulations for gender, race, and poverty line</i>
For those who wanted, but did not obtain services, which services were desired?	<i>Cross tabulations for gender, race, and poverty line</i>
For those who wanted, but did not obtain services, which barriers to care were cited?	<i>Cross tabulations for gender, race, and poverty line</i>
For those who did obtain services, which barriers to care were still identified?	<i>Cross tabulations for gender, race, and poverty line</i>
What services do trans adults hope are available to trans youth today?	<i>Frequency report</i>
Which clinical services are provided today to transgender youth?	<i>Frequency report</i>
Who considers themselves to be a “gender specialist”?	<i>Cross tabulations for gender and race</i>
Why are some services more often provided to trans youth?	<i>Frequency report</i>
Why are some services less frequently provided to trans youth?	<i>Frequency report</i>
Which services do gender specialists believe are needed for trans youth today?	<i>Frequency report</i>

<b>Table 1.6: Provider &amp; Trans Recommended Services Analysis</b>		
Services hoped for by trans respondents	Services currently provided by gender specialists	<i>Frequency report</i>
Services currently provided by gender specialists	Services identified as needed by gender specialists	<i>Frequency report</i>
Services hoped for by trans respondents	Services identified as needed by gender specialists	<i>Frequency report</i>

### **V. Study Limitations and Benefits**

This methodology included limitations. As mentioned above, the survey track for trans adults asked about needs *in the past*, while the survey track for clinicians asked about services *provided today*. Additionally, data did not reflect a representative sample of Bay Area transgender youth or gender specialist providers, as they required English literacy and online access, and were collected via non-probability, convenience sampling methods.

Despite these limitations, the study's findings may serve as a reference for service modification, recommendation, and creation. Conducting a needs assessment and comparing it directly to a service assessment might produce valuable insight into the alignment of a population (trans youth) and a profession (clinical gender specialization). Understanding the clinical climate in the Bay in this way allows for the potential to illustrate gaps in clinical care and to highlight successful models of intervention. This study's empirical findings may help distill and create systems of clinical services that most successfully benefit target populations, while simultaneously imparting providers with enhanced clarity and direction in their work.

## CHAPTER 4

### Findings

#### I. Socio-Demographic Characteristics of Study Participants

This study includes data from two groups of adults: adults who identified as having a transgender identity between the ages of 12 and 24 while living in the Bay Area; and those who are clinical providers currently offering gender-specialized care in the Bay Area. The socio-demographic characteristics of the entire study sample are presented in Table 2.1. The study sample included 30 transgender adults and 20 clinical providers. The study group was predominantly white (74%), and predominantly transgender (71.2%). Among the clinical providers, 35% were transgender according to the National Center for Transgender Equality's definition of the term, and 65% were not transgender. Among adults who identified as transgender between the ages of 12 and 24, 34.1% were trans-feminine, 18.2% were trans-masculine, and 47.7% were gender expansive. There was a statistically significant difference in the mean age of the two study groups, such that the transgender adults were significantly younger (mean age=26.52 years) than the providers (mean age=44.35 years) ( $t(37.91)=5.458$ ,  $p=.000$ , two-tailed).

There were also significant economic differences between the two study groups. Among the providers, 50% owned their home compared to 17.9% of the trans adult group (chi square(1,48)=4.214,  $p=.040$ , continuity corrected). Additionally, a significant difference was found in household income between the two study groups, such that the trans adults had a significantly lower household income than the providers ( $t(43.312)=2.744$ ,  $p=.009$ , two-tailed). Such economic indicators point to household demographics, rather than individual

## TRANSFIGURED TREATMENT

demographics, and thus interpretation and extrapolation from such data points must be mediated by consideration of other social, familial, and economic constraints, such as the history of marriage legislation, gender-based employment discrimination, and/or the mean age of the study groups. When analyzed with the Federal Poverty Line, which takes into account household income and number of people per household, 23% of the transgender adults were found to be living beneath the Federal Poverty Line compared to 5% of the clinical providers.

<b>Table 2.1: Socio-Demographic Characteristics for Trans Adults &amp; Providers</b>		
	<i>Transgender Adults (n=30)</i>	<i>Clinical Providers (n=20)</i>
Gender, %		
Transgender		65
Not Transgender		35
Trans-Feminine	34.1	
Trans-Masculine	18.2	
Gender Expansive	47.7	
Mean Age, y	26.5	44.4
Race/Ethnicity, %		
Black or African American	0.05	--
Hispanic or Latin@	0.15	--
Asian	0.2	--
White	0.9	0.95
Mixed Race	0.2	0.05
Has Health Insurance, %	96.6	100.0
Has Dental Insurance, %	79.3	90.0
Owns Home, %	17.9	50.0
Annual Household Income, %		
≤\$11,770	22.2	5.0
\$11,770-\$15,930	7.4	--
\$15,930-\$20,090	3.7	--
\$20,090-\$24,250	--	--
\$24,250-\$28,410	3.7	--
\$28,410-\$32,570	--	--
\$32,570-\$36,730	3.7	5.0
\$36,730-\$40,890	--	--
\$40,890-\$75,100	18.5	25.0

## TRANSFIGURED TREATMENT

\$75,100-\$100,000	7.4	--
\$100,000-\$150,000	14.8	35.0
\$150,000-\$200,000	3.7	10.0
≥\$200,000	14.8	20.0
Below Federal Poverty Line, %	0.23	0.05

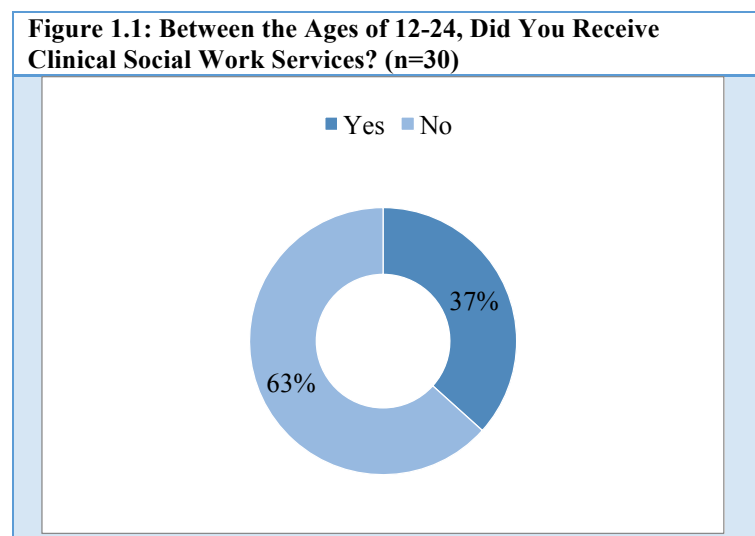
## II. Clinical Services Acquired and Desired by Transgender Youth

The transgender adult study group was asked whether or not they received clinical services in the Bay Area between the ages of 12 and 24. If they accessed services as youth, they were asked a series of questions about such service acquisition. If they had not accessed services, they were asked whether or not they were interested in obtaining services, and, if so, which services they were interested in obtaining as transgender youth.

Among the study group (n=30), 36.67% of individuals accessed clinical services as youth (n=11), whereas 63.33% did not (n=19), as illustrated in Figure 1.1.

Among the services obtained as youth, respondents reported most-commonly accessing individual

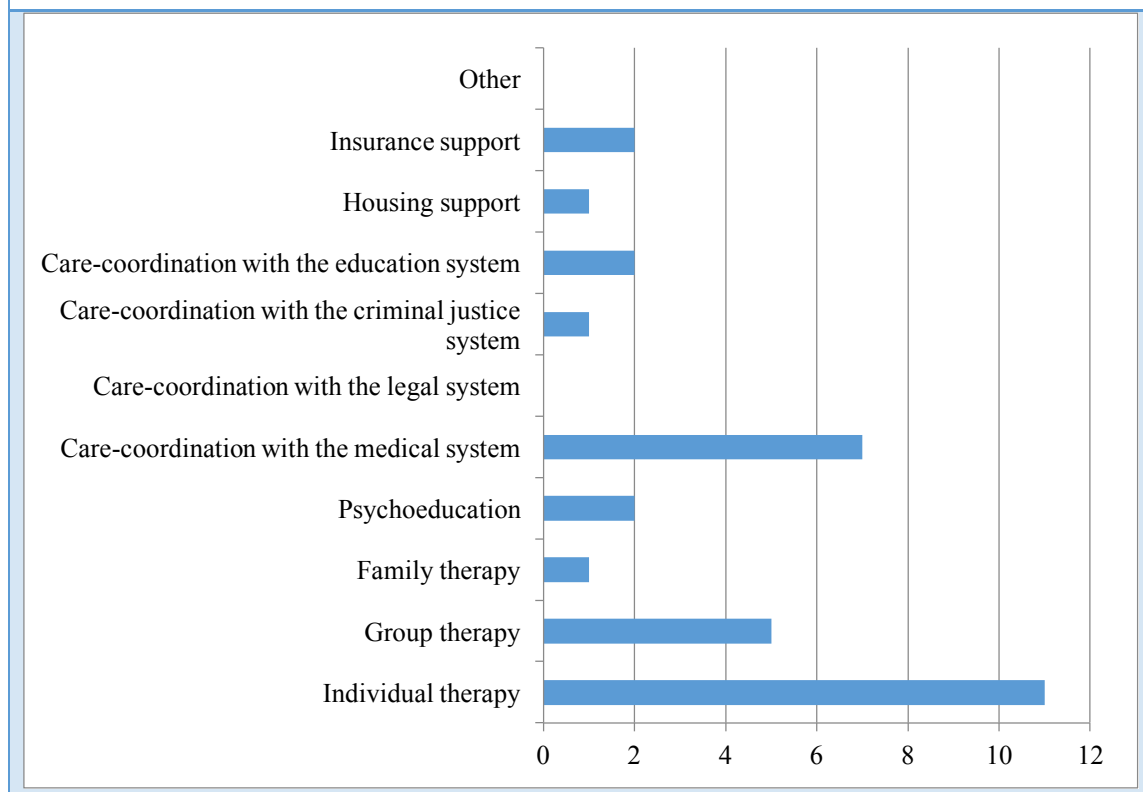
therapy, care-coordination with the medical system, and group therapy. All clinical services reportedly accessed by trans youth are presented in Figure 1.2.





## TRANSFIGURED TREATMENT

**Figure 1.2: Clinical Services Acquired by Trans Youth (n=11)**



Clinical services acquired by transgender youth, presented along gender categories (i.e., trans-feminine, trans-masculine, and gender expansive), are reported in Table 2.2. Of note, not a single trans-masculine respondent reported accessing services as a youth. Due to the small number of respondents who accessed services, it was not possible to assess for a statistical difference between the service acquisition of trans-feminine and gender expansive respondents. Clinical services acquired are presented along race identification in Table 2.3, and another stark trend is apparent: not a single Black or African American, nor American Indian or Alaska Native, respondent reported accessing clinical services as a transgender youth. Again, due to the small number of respondents who accessed services, it was not possible to test for statistical difference between service acquisition and race of youth.

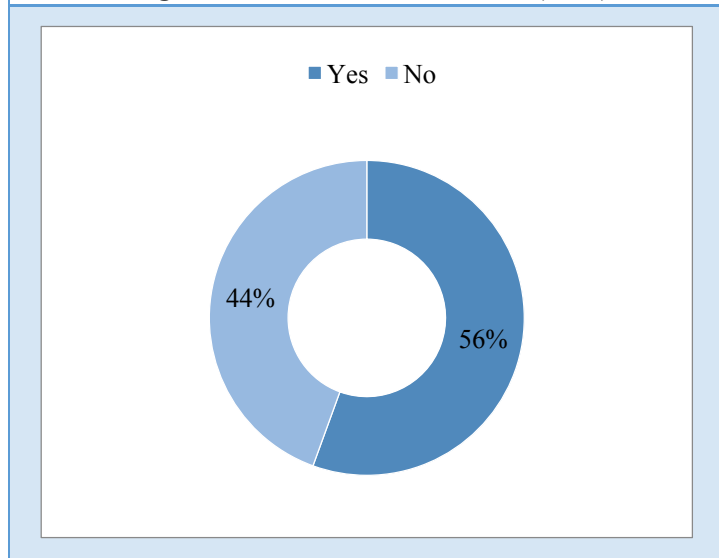
## TRANSFIGURED TREATMENT

	<i>Trans-Feminine</i>	<i>Trans-Masculine</i>	<i>Gender Expansive</i>
Individual Therapy, % (n)	63.6 (7)	--	36.4 (4)
Group Therapy	60.0 (3)	--	40.0 (2)
Family Therapy	--	--	100.0 (1)
Psychoeducation	--	--	100.0 (2)
Care-Coordination with Medical System	42.9 (3)	--	57.1 (4)
Care-Coordination with Legal System	--	--	--
Care-Coordination with Criminal Justice System	100.0 (1)	--	--
Care-Coordination with Education System	--	--	100.0 (2)
Housing Support	--	--	100.0 (1)
Insurance Support	--	--	100.0 (2)

	<i>Black or African American</i>	<i>Hispanic or Latin@</i>	<i>American Indian or Alaska Native</i>	<i>Asian</i>	<i>White</i>	<i>Mixed Race</i>
Individual Therapy, % (n)	--	18.2 (2)	--	27.3 (3)	45.5 (5)	9.1 (1)
Group Therapy	--	20.0 (1)	--	20.0 (1)	40.0 (2)	20.0 (1)
Family Therapy	--	--	--	100.0 (1)	--	--
Psychoeducation	--	--	--	100.0 (2)	--	--
Care-Coordination with Medical System	--	14.3 (1)	--	28.6 (2)	42.9 (3)	14.3 (1)
Care-Coordination with Legal System	--	--	--	--	--	--
Care-Coordination with Criminal Justice System	--	--	--	--	100.0 (1)	--
Care-Coordination with Education System	--	--	--	100.0 (2)	--	--
Housing Support	--	--	--	--	--	100.0 (1)
Insurance Support	--	--	--	50.0 (1)	--	50.0 (1)

More transgender youth did not access services (n=19) than did access them (n=11). Of those who did not access services, more respondents were interested in obtaining services (n=10) than those who were not interested in obtaining them (n=8), as illustrated in Figure 1.3.

**Figure 1.3: Between the Ages of 12-24, Were You Interested In Obtaining Clinical Social Work Services? (n=18)**

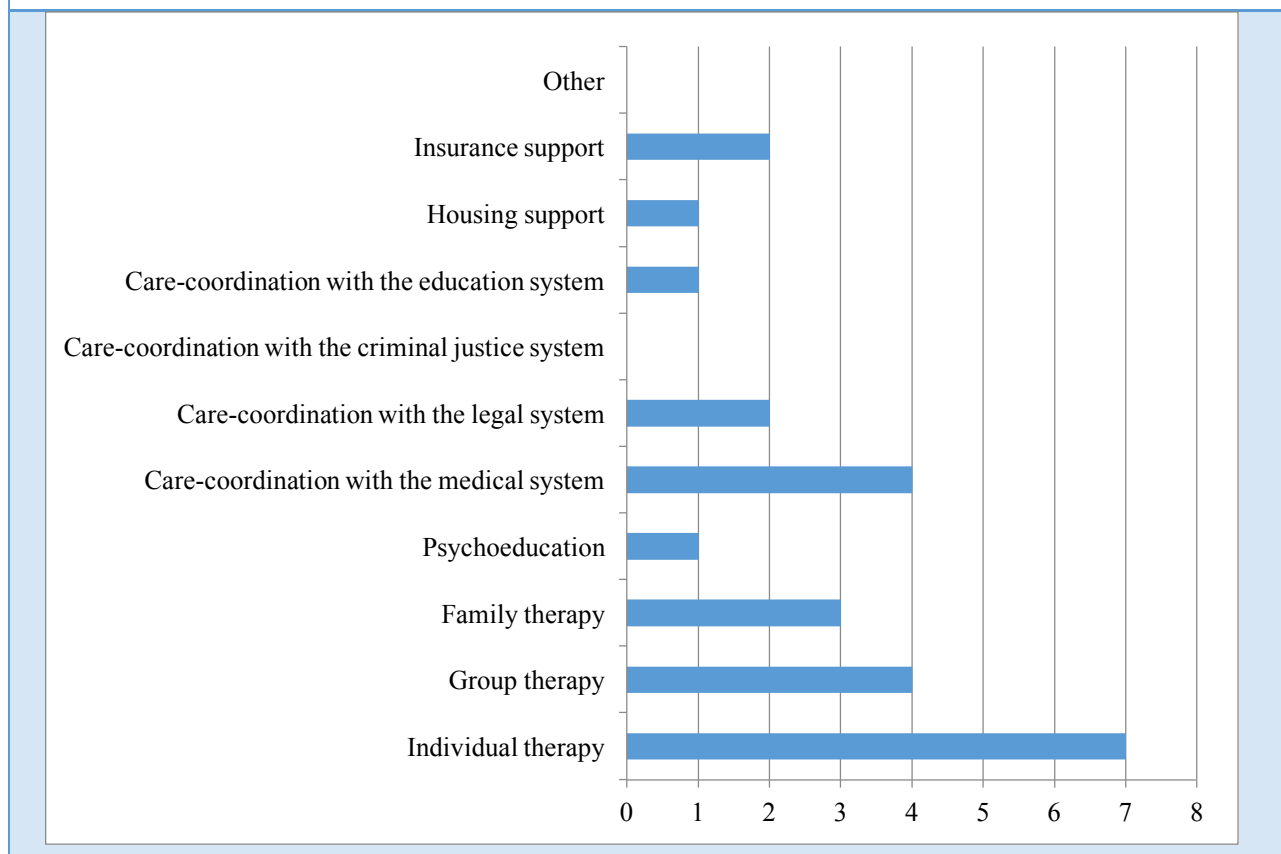


The three most reportedly desired services among transgender youth were individual therapy (n=7), care-coordination with the medical system (n=4), and group therapy (n=4). Of note, these three most-desired services were the same as the three most-accessed services. Whereas no trans-masculine folks reported accessing

services as youth, trans-masculine folks did indeed report desiring services, such as care-coordination with the medical system (n=2), care-coordination with the education system (n=1), and housing support (n=1), as presented in Table 2.4. Additionally, although Black or African American respondents did not report obtaining services as youth, they did report desiring services, such as care-coordination with the medical system (n=1) and housing support (n=1), as presented in Table 2.5.

## TRANSFIGURED TREATMENT

**Figure 1.4: Which of the Following Services Were You Interested in Obtaining? (n=10)**



**Table 2.4: Clinical Services Desired, Although Not Acquired, By Trans Youth, By Gender (n=10)**

	<i>Trans-Feminine</i>	<i>Trans-Masculine</i>	<i>Gender Expansive</i>
Individual Therapy, % (n)	14.3 (1)	14.3 (1)	71.4 (5)
Group Therapy	50.0 (2)	--	50.0 (2)
Family Therapy	33.3 (1)	--	66.7 (2)
Psychoeducation	--	100.0 (1)	--
Care-Coordination with Medical System	50.0 (2)	50.0 (2)	--
Care-Coordination with Legal System	100.0 (2)	--	--
Care-Coordination with Criminal Justice System	100.0 (1)	--	--
Care-Coordination with Education System	--	100.0 (1)	--
Housing Support	--	100.0 (1)	--
Insurance Support	--	50.0 (1)	50.0 (1)

## TRANSFIGURED TREATMENT

**Table 2.5: Clinical Services Desired, Although Not Acquired, By Trans Youth, By Race (n=10)**

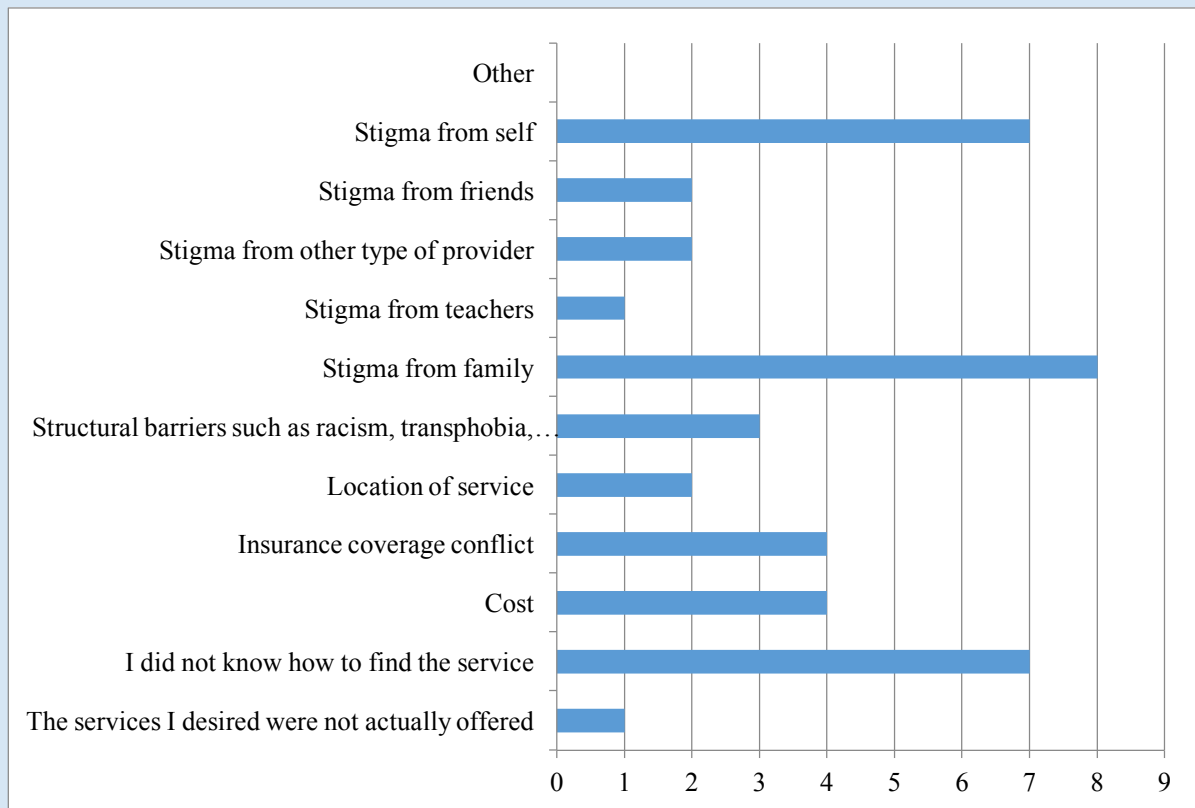
	<i>Black or African American</i>	<i>Hispanic or Latin@</i>	<i>American Indian or Alaska Native</i>	<i>Asian</i>	<i>White</i>	<i>Mixed Race</i>
Individual Therapy, % (n)	--	--	--	14.3 (1)	71.4 (5)	14.3 (1)
Group Therapy	--	25.0 (1)	--	25.0 (1)	50.0 (2)	--
Family Therapy	--	33.3 (1)	--	--	66.7 (2)	--
Psychoeducation	--	--	--	--	100.0 (1)	--
Care-Coordination with Medical System	25.0 (1)	--	--	--	50.0 (2)	25.0 (1)
Care-Coordination with Legal System	--	--	--	--	50.0 (1)	50.0 (1)
Care-Coordination with Criminal Justice System	--	--	--	--	100.0 (1)	--
Care-Coordination with Education System	--	--	--	--	100.0 (1)	--
Housing Support	100.0 (1)	--	--	--	--	--
Insurance Support	--	--	--	--	50.0 (1)	50.0 (1)

### III. Barriers Encountered to Service Acquisition

Study participants reported encountering numerous barriers to accessing clinical services as transgender youth. Among such barriers, stigma from family (n=8), stigma from self (n=7), and not knowing how to find the desired service (n=7) were most commonly reported. Among only 10 respondents interested in obtaining services, there were 41 counts of barriers, as represented in Figure 1.4. In other words, there were 41 separate instances of stigma, insurance conflict, structural barriers such as racism and transphobia, etc. that prevented the community of transgender youth in this study from accessing the clinical care they sought.

## TRANSFIGURED TREATMENT

**Figure 1.5: Why Were the Services You Desired Not Obtained? (n=10)**

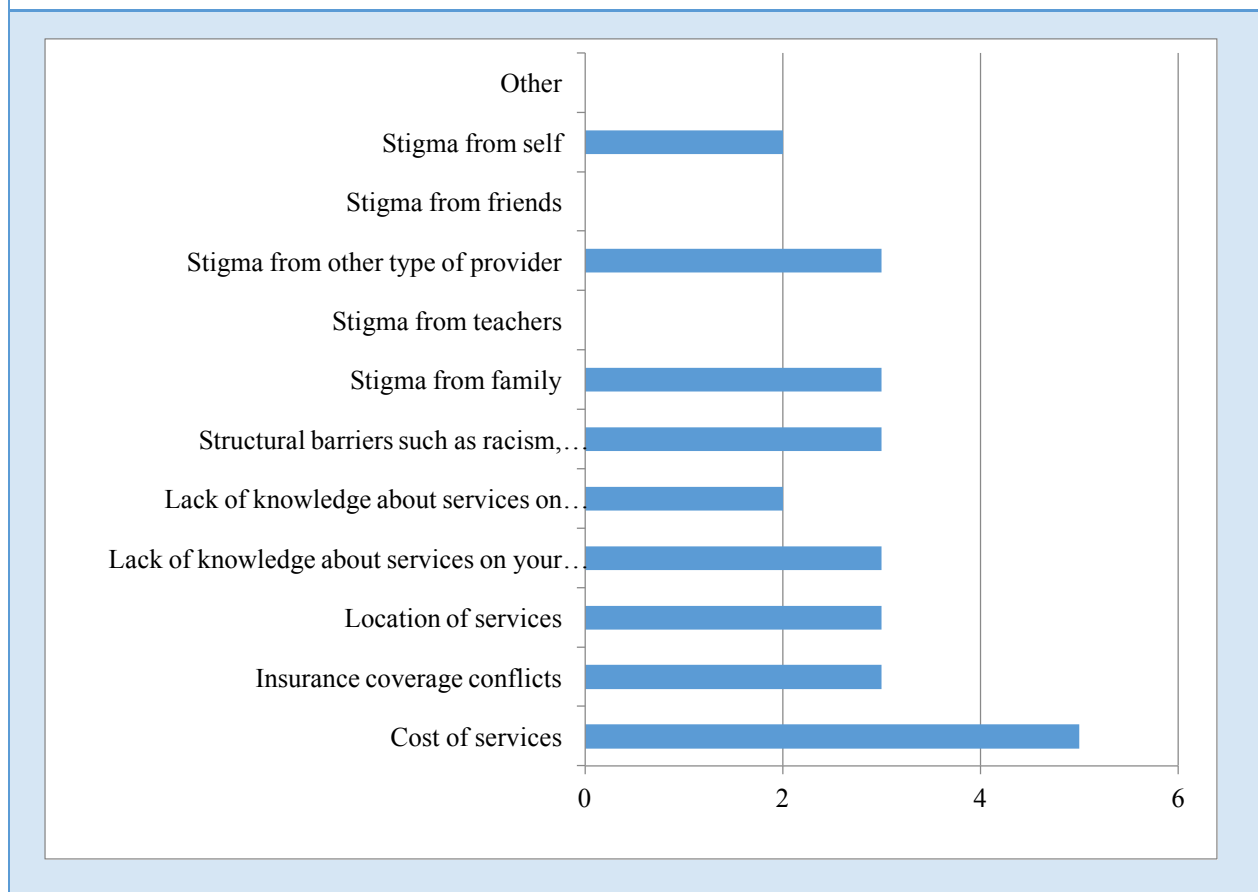


Even for those respondents who did access clinical care as youth, barriers to such services were identified. For instance, as illustrated in Figure 1.5, when accessing individual therapy, respondents cited the following as barriers to accessing care: cost of services (n=5); insurance coverage conflicts (n=3); location of services (n=3); lack of knowledge about services on the client's behalf (n=3); structural barriers such as racism and transphobia (n=3); stigma from another type of provider (n=3); and stigma from family (n=3). Similarly, as shown in Figure 1.6, when accessing care-coordination with the medical system, a service highly-sought among transgender youth, respondents reported encountering the following barriers: cost of services (n=2); insurance coverage conflicts (n=2); location of services (n=2); lack of knowledge

## TRANSFIGURED TREATMENT

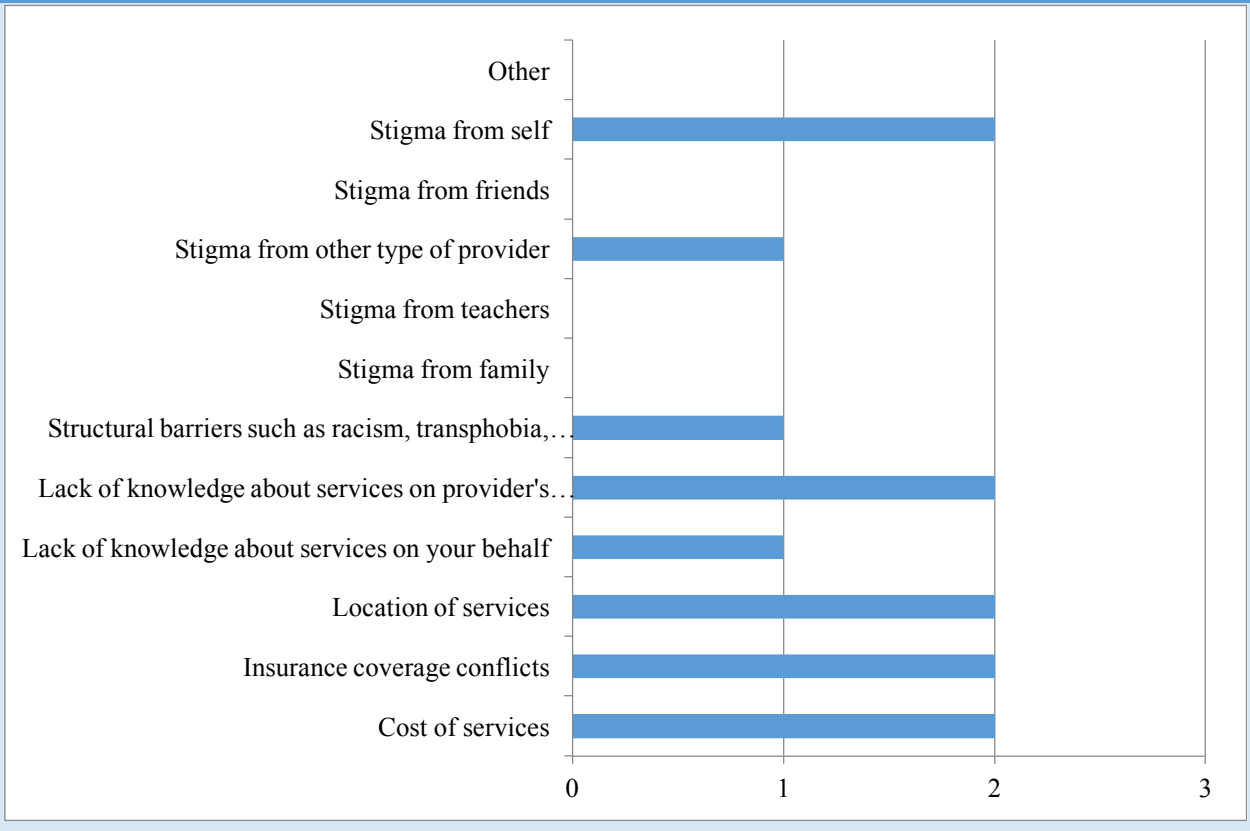
about service on provider's behalf (n=2); and stigma from self (n=2). Other reported barriers encountered when accessing services such as group therapy and family therapy included many counts of stigma: from self, from family, and from other clinical providers. Multi-pronged stigma, as well as economic concerns such as cost of services and insurance coverage, provides barriers to clinical care even for those who eventually access services.

**Figure 1.6: Barriers Encountered when Accessing Individual Therapy (n=9)**



TRANSFIGURED TREATMENT

**Figure 1.7: Barriers Encountered When Accessing Care-Coordination With The Medical System (n=4)**



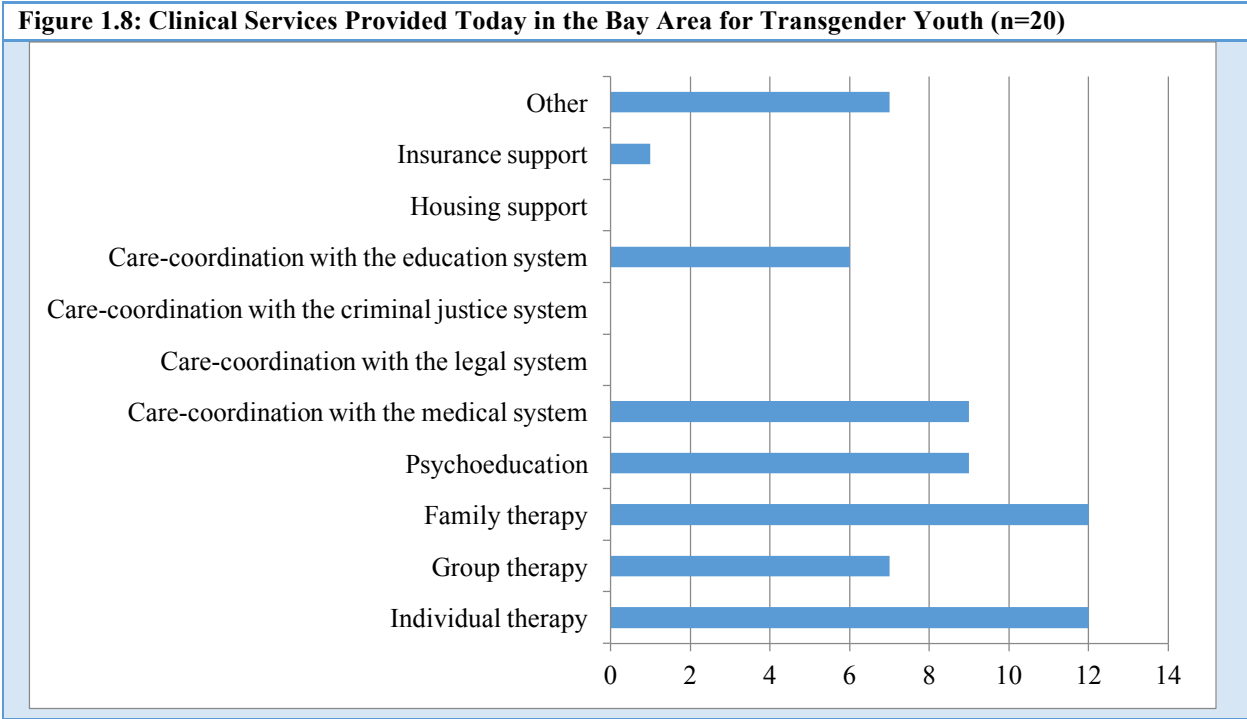
**IV. Clinical Services Provided Today to Transgender Youth**

Multidisciplinary gender-specific care is provided throughout the Bay Area. Among clinician respondents, the most frequently provided services included individual therapy (n=12), family therapy (n=12), psychoeducation (n=9), and care-coordination with the medical system (n=9). In addition to the clinical services presented in Figure 1.7, respondents also reported providing: psychiatry; resource and referrals; medical services; intakes; sexual health care; and hormone replacement therapy injections, primary care, and assistance with gender and name change forms. Responses were collected from 20 clinicians who reported a total of 69 counts of service provision. Bay Area gender-specific clinicians appear to provide more than one, if not



TRANSFIGURED TREATMENT

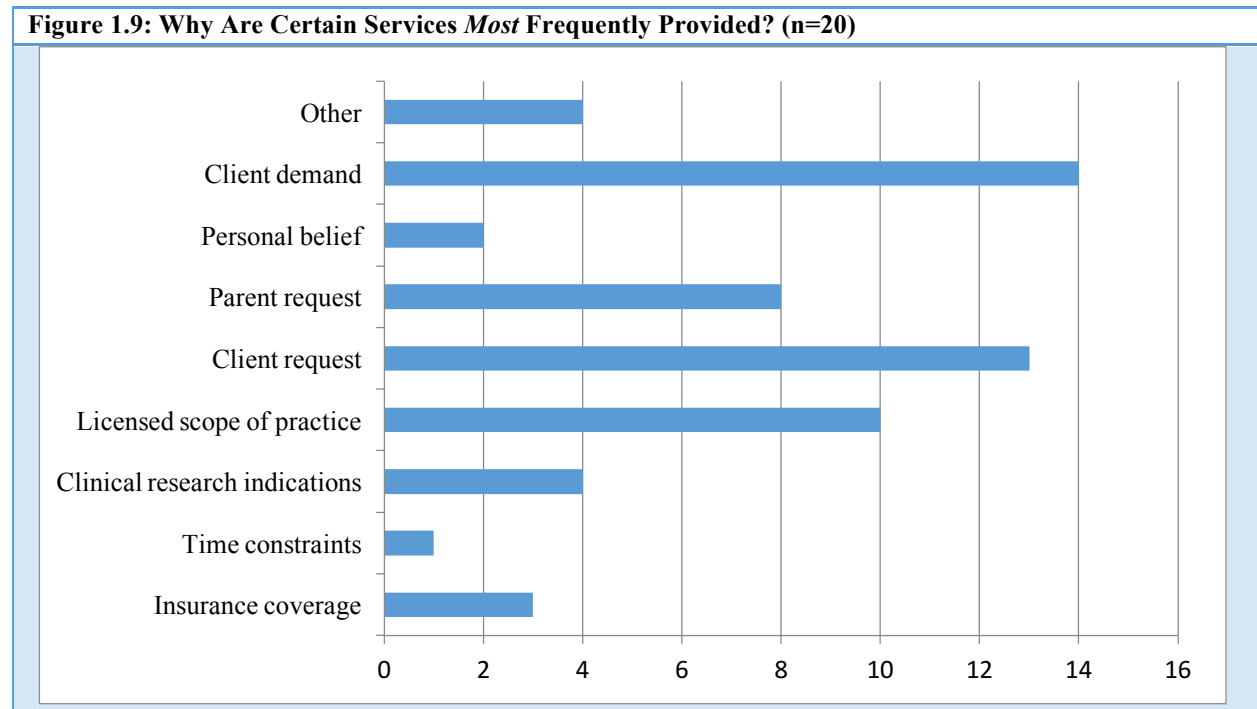
many, clinical services tailored to their clientele, yet there are gaps in entire subsets of care. No clinicians reported providing housing support, care-coordination with the criminal justice system, nor care-coordination with the legal system, each of which were reported as obtained or sought by trans youth.



Clinicians were asked how they decide which services for transgender youth to provide more or less frequently, as reported in Figure 1.8. They reported client demand (n=14), client request (n=13), licensed scope of practice (n=10), and parent request (n=8) as influential factors when deciding to offer services more frequently. Clinicians reported providing certain services less frequently when they believed they did not practice in the best clinical space from which to coordinate other services, although they did not indicate which factors signify an appropriate clinical space from which to expand coordination of care. Additionally, clinicians indicate client

## TRANSFIGURED TREATMENT

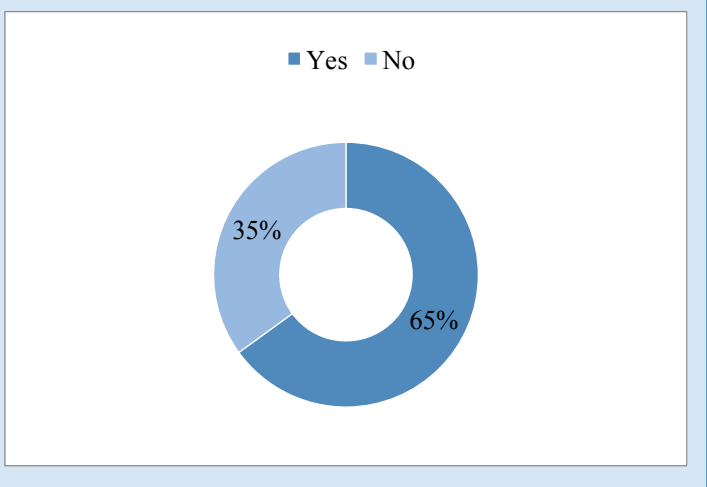
(trans youth) request and parent request as nearly equally influential when deciding which services to offer.



### V. Gender Specialists

“Gender specialist” is an unregulated and inconsistently defined term that many clients and providers alike interpret as a professional, clinical qualification. All provider participants in this study self-reported practicing with youth and providing at least one gender-specific service. However, not all provider participants considered themselves to be gender specialists. Figure 1.9 shows that 65% (n=13) consider themselves to be gender specialists, and although the remaining 35% (n=7) provide at least one gender-specific service, they do not consider themselves a gender specialist.

**Figure 1.10: Do You Consider Yourself a “Gender Specialist”?** (n=20)



Respondents who did not consider themselves to be gender specialists included additional, optional comments, including: “I don’t use that label for myself, but I am comfortable with it;” I’m not super fond of the term but I certainly have proficiency working with trans\* and

expansive people, especially youth;” and “I think primary care needs to incorporate unbiased care across genders. Even the notion of a physician needing to be a gender specialist is a little off-putting frankly.” The implications of respondents’ additional comments will be further explored in the subsequent Discussion chapter.

Among those who considered themselves gender specialists, one’s identity as transgender or not transgender did not appear to significantly impact one’s claim to gender specialty, as presented in Table 2.6. The clinicians in this study were predominantly white, and as such the relationship between a provider’s race(s) and self-report as a gender specialist could not be adequately analyzed, although the data recorded are presented in Table 2.7. Among white clinicians, 63.1% reported being gender specialists, and the only non-white clinician, who was mixed race, also reported being a gender specialist.

TRANSFIGURED TREATMENT

<b>Table 2.6: Who Is a Gender Specialist, By Gender (n=20)</b>		
	<i>Transgender</i>	<i>Not Transgender</i>
Gender Specialist, % (n)	46.2 (6)	53.8 (7)
Not a Gender Specialist	14.3 (1)	85.7 (6)

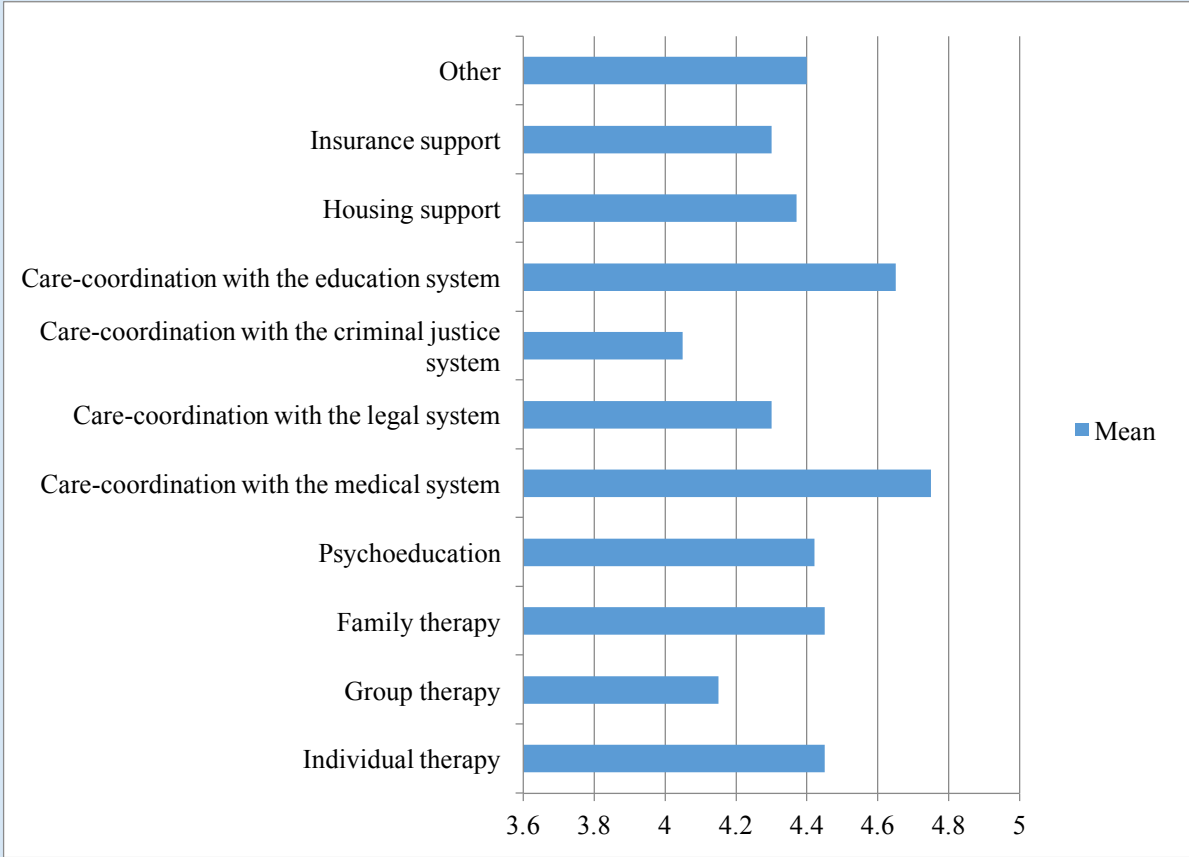
<b>Table 2.7: Who Is a Gender Specialist, By Race (n=20)</b>		
	<i>White</i>	<i>Mixed Race</i>
Gender Specialist, % (n)	92.3 (12)	7.7 (1)
Not a Gender Specialist	100.0 (7)	--

**VI. Alignment of Transgender Clients’ Reported and Clinical Providers’ Projected Needs**

Clinical providers were asked to identify which clinical services they thought were needed for transgender youth in the Bay Area, ranking them from 1 to 5, where 1 was not needed and 5 was most needed; the results are presented in Figure 1.10. Of note, all services received a score of 4 or higher, indicating that the providers surveyed believed all services were very needed among transgender youth today. In addition to scoring the list provided, respondents also wrote in other needed services. Three clinicians suggested community-based peer support groups were of great need, and another provider wrote that mentoring for trans youth from young adults who have previously transitioned would also be beneficial in the clinical care paradigm. Providers identified the following clinical services as most needed among transgender youth, in order from most to least needed: care-coordination with the medical system; care-coordination with the education system; individual therapy; family therapy; psychoeducation; housing support; insurance support; care-coordination with the legal system; group therapy; and care-coordination with the criminal justice system.

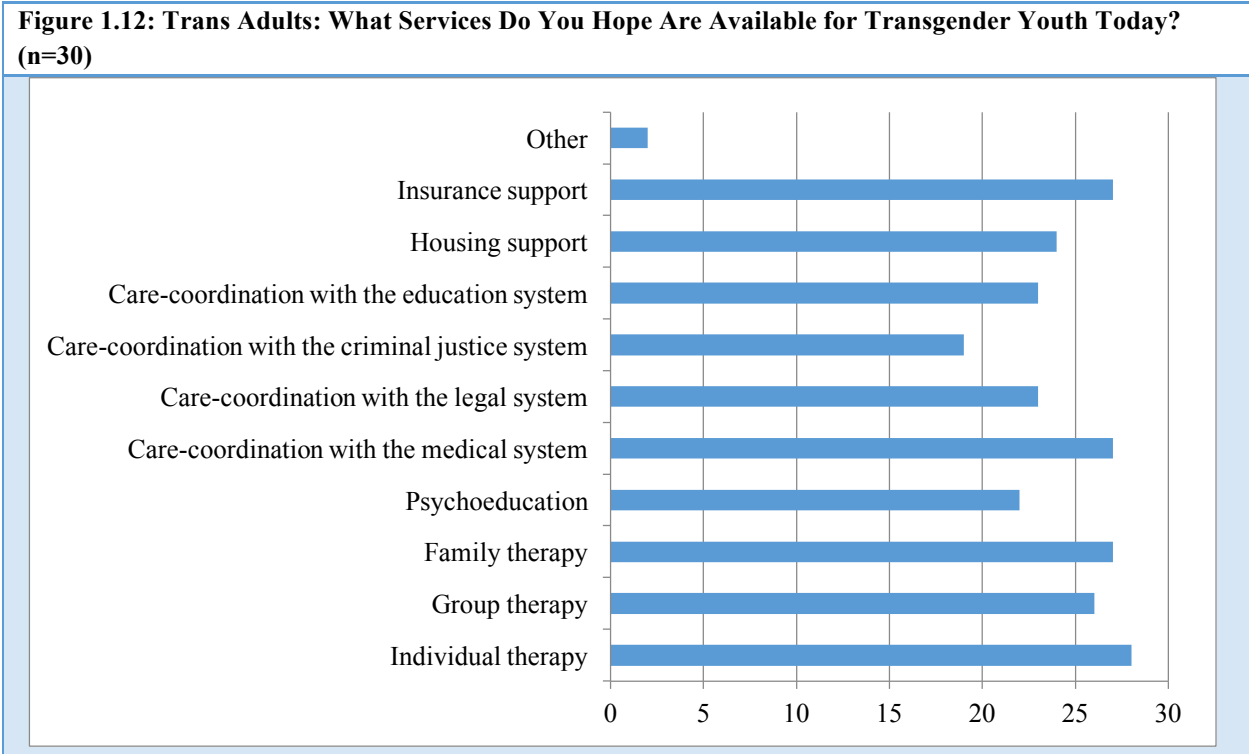
TRANSFIGURED TREATMENT

**Figure 1.11: Providers: How Needed Are the Following Clinical Services for Transgender Youth in the Bay Area? (1 is not needed; 5 is most needed) (n=20)**



Transgender adults also identified the services they hope are available for transgender youth today, presented in Figure 1.11. Transgender adults identified the following clinical services as needed among transgender youth today, in order from most to least needed: individual therapy; family therapy; care-coordination with the medical system; insurance support; group therapy; housing support; care-coordination with the legal system; care-coordination with the education system; psychoeducation; and care-coordination with the criminal justice system.

TRANSFIGURED TREATMENT



Both providers and trans adults identified and ranked numerous clinical services needed by transgender youth in the Bay Area today. Table 2.8 identifies the differences in rankings between the two study groups’ reports. Clinical providers and transgender adults were only aligned in their needs identification for housing support (7<sup>th</sup> most needed) and care-coordination with the criminal justice system (10<sup>th</sup> most needed). The two groups appeared to rank individual therapy, family therapy, care-coordination with the medical system, and care-coordination with the legal system similarly, with only differences of 1 or 2 between their rankings. However, trans adults ranked group therapy as much more needed than did clinical providers, with a difference of 4; and clinical providers ranked care-coordination with the education system as much more needed than did trans adults, with a difference of 6. Implications of these findings to clinical care and further research will be discussed in the following chapter.

## TRANSFIGURED TREATMENT

<b>Table 2.8: Identified Clinical Needs, Ranked</b>			
	<i>Trans Adult (n=30)</i>	<i>Provider (n=20)</i>	<i>Difference in Ranking</i>
Individual therapy	1	3	2
Family therapy	2	4	2
Care-coordination with the medical system	3	1	2
Insurance support	4	7	3
Group therapy	5	9	4
Housing support	6	6	0
Care-coordination with the legal system	7	8	1
Care-coordination with the education system	8	2	6
Psychoeducation	9	5	4
Care-coordination with the criminal justice system	10	10	0

## CHAPTER 5

### Discussion

This study aimed to assess the current landscape of multidisciplinary gender-specific clinical care in the Bay Area for transgender youth ages 12 through 24. In order to study such a clinical climate, a local joint needs and services assessment was conducted. The original online survey instrument collected data from two study groups: adults 18 years of age or older who self-reported living in the Bay Area and having a transgender or gender expansive identity between the ages of 12 and 24; and local multidisciplinary clinical providers, also 18 years of age or older, who offer at least one gender-specific service to transgender or gender expansive youth ages 12 to 24. *Transfigured Treatment* sought to assess population-specific clinical needs, clinical services, and barriers to accessing care. This study also aimed to assess the role of gender specialists in the local clinical climate. This chapter will discuss the findings presented in the previous chapter, as well as present this study's limitations, suggestions for further research, and implications for both theory development and clinical practice.

#### I. Study Sample

As noted above, this study included data from two sets of individuals. In addition to significant differences between the two study groups, such as the frequency of participants living below the federal poverty line, there is a critical aspect of the study sample overall to consider: that this study sample was predominantly white (74%). This variable may have been racially skewed due to the fact that the data were collected via convenience “snowball” sampling techniques, rather than a randomized sampling method that would ensure a representative



## TRANSFIGURED TREATMENT

sample. As regards each study group, 95% of the clinical providers were white. Although the providers in this study were multidisciplinary, including medical doctors, psychologists, and clinical social workers, this figure does correspond with that cited by the American Psychological Association, such that “a large majority (approximately 90%) of mental/behavioral health professionals are non-Hispanic White” (1). However, 90% of the transgender adult study sample were also white, a figure most likely disproportionate to the overall transgender population in the Bay Area. Although exact data on the racial makeup of transgender people is not recorded by the United States Census Bureau, no known report projects the U.S. nor California transgender population to be 90% white, and in fact the NTDS reported a sample of only 76% white participants. This study then follows a harmful pattern of empirical research, such that it leaves out the significant voices of racial minorities—projected to make up the majority of U.S. youth, rather than the current majority white population, by 2020 (NPR).

It is also critical to discuss the economic disparities present in the data: 23% of transgender adults surveyed and 5% of clinical providers live below the federal poverty line. There was a significant difference in the age of the two study groups (trans adults mean age: 26.5 years; provider mean age: 44.4 years), and perhaps the confounding social, political, and familial factors that influence differences between age categories were in effect, such as educational opportunities, legal marriage status, and familial inheritance.

Each of those confounding factors associated with age also specifically marginalize and suppress economic development among transgender youth and adults. For example, many trans people do not experience the same access to educational opportunities as their cisgender peers. In fact, the NTDS (2011) found that 11% of college students were denied financial aid or scholarships due to their gender, and 35% of transgender college students reported physical,

## TRANSFIGURED TREATMENT

sexual, and/or verbal abuse by students, professors, and/or school staff. Additionally, the NTDS reported 57% of their participants experienced family rejection. Perhaps trans youth who have been rejected by their families are less likely than cisgender adults to receive familial financial assistance or inheritance as aide to economic stability. In California, 14% of adults of all genders between the ages of 19 and 64 live below the poverty line (Kaiser). Given the relevant literature presented in Chapter 2, it is not difficult to imagine the discriminatory factors, such as lack of educational opportunity, family rejection, systemic racism, systemic transphobia and (trans)misogyny, and discriminatory workplace practices, that may contribute to a 9% difference between the frequency of this study's transgender study sample and the frequency of same-aged all-gender Californians living beneath the federal poverty line.

## II. Clinical Needs

This study assessed clinical needs for trans adults who accessed services as youth, as well as needs among those who desired but did not obtain services. Among both groups, the most frequently-cited clinical needs were consistent: individual therapy, care-coordination with the medical system, and group therapy. It is important to note that individuals who embody “gender variance,” or genders that are unintelligible to a gaze rooted in a binary, historically situated, sociopolitical status quo, have been historically categorized, diagnosed, medicalized, and stigmatized. The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV-TR (American Psychiatric Association, 2000) included among its diagnoses “gender identity disorder.” Additionally, certain experiences of gender are *still* categorized, diagnosed, medicalized, and stigmatized, such as in the current DSM V (American Psychiatric Association, 2013), which includes “gender dysphoria” and “transvestic fetishism,” a diagnosis particularly

## TRANSFIGURED TREATMENT

harmful to systemically-marginalized trans feminine folks. That trans youth desire care-coordination with the medical system, individual therapy, and group therapy, is not at all surprising if one considers that clinical dysphoria is rooted not in the individual, but rather in the structural medicalization and stigmatization of gender. Identifying these frequently-reported needs and considering them in a historical and marginalized context is critical to designing and implementing supportive, effective clinical care for this population.

This study also identified important trends in service acquisition, such that not a single Black or African American, nor American Indian or Native American, participant reported accessing services as trans youth, despite Black or African American respondents desiring care-coordination with the medical system and housing support. Additionally, Asian respondents reported accessing the widest variety of services, reportedly obtaining 7 of the 10 identified services; and mixed race participants reported obtaining 5 of the 10 services. For those who desired but did not obtain services, white respondents identified desiring the widest variety of clinical supports, or 9 of the 10 identified services, followed by mixed race participants who identified desiring 4 of the 10 services. Perhaps local service education and outreach is more effective and/or funded for certain communities, or perhaps certain communities are more likely to seek support outside of the home in outpatient and/or community settings.

The clinical services acquired and desired by race in this study both align with and diverge from trends identified in a 2015 report by the Substance Abuse and Mental Health Services Administration (SAMHSA), which report that clinical service acquisition rates are highest for mixed race and white clients, and lowest for Asian clients. Direct comparison may not be drawn between SAMHSA's report and this study though. SAMHSA surveyed adults about their clinical needs only after age 18, whereas this survey asks adults to report their needs

## TRANSFIGURED TREATMENT

experienced between the ages 12 and 24. Even so, productive analysis may still be made between trends that emerged in the two reports.

Indeed, this study found that mixed race participants reported acquiring and desiring a wide variety of services, and white respondents did report desiring, although not acquiring, the widest service variety overall. However, this study's results are not consistent with SAMHSA as regards its Asian participants, such that Asian respondents reported the largest variety of service acquisition among all race categories.

Further research devoted to comprehensively understanding race-related clinical needs, access issues, and acquisition patterns is required in order to provide affirming services for *all* transgender youth. This study notes that it appears particularly important to remedy the absence of Black or African American and American Indian or Native American youth in the clinical paradigm.

### **III. Clinical Services**

Clinicians most-frequently reported providing individual therapy, family therapy, psychoeducation, and care-coordination with the medical system. Two of the three most-frequently identified clinical needs from the previous section are represented in the services offered. However, group therapy is absent. As reported in the previous chapter, three clinicians recommended peer support groups for patients, and another provider identified the supportive potential of a mentoring relationship between trans adults and trans youth, or individuals at different stages of gender experience regardless of age. So, why are such services not being offered?

## TRANSFIGURED TREATMENT

Providers identified the most influential factors when deciding which services to provide: client demand, client request, and licensed scope of practice. It was an oversight in this study to include both client demand *and* client request in the survey, however it is important to note that they received different frequency reports (demand: 14; request: 13). Regardless of request versus demand, it appears licensed scope of practice and client opinion are of utmost importance when structuring services. Perhaps, then, providers' particular clients have not requested/demanded group therapy. Additionally, in this survey, most trans respondents reported *retrospective* needs, so maybe group therapy is no longer a critical *contemporary* request. Yet four clinicians identified group support in some form as both lacking and recommended. Perhaps clinicians are indeed hearing a clinical need from their clients, but there might not be functional transmission from need to service; such a communication and clinical application route warrants additional research and perhaps modification.

The clinical care desired by transgender youth varies across licensed scopes of practice, such that housing support, individual therapy, and care-coordination with the education system are all desired services. It is important to explore the treatment potential of multidisciplinary centers, such as UCSF's Child and Adolescent Gender Center. Such clinical spaces could support the variety of clinical needs experienced by local trans youth, as well as diminish many of the barriers to care reported by the trans adults, such as: lack of knowledge about services on provider's behalf, since the youth would be treated by a multidisciplinary team rather than a singularly-licensed provider; location of services, as many services would be offered in the same setting, or could be triaged to nearby sites with the team's expanded network of peer providers; and service cost and insurance coverage conflicts, which might also be remedied in a hospital setting or in an otherwise highly networked community-based setting.

### IV. Stigma

*Stigma* is an enormous concept, with multidisciplinary theoretical roots and endless branches of contemporary lived experience. Stigma appeared in the relevant literature presented in Chapter 2 in myriad forms, such as familial rejection, HIV status and treatment, and one's experience of "coming out" as transgender. In this study, stigma featured prominently, as both transgender youth who did and did not access clinical care identified "stigma from family" as a barrier to receiving the care they desired. Interestingly, "parent request" was the fourth-frequently cited factor by providers when determining which services to offer, following only client request/demand and licensed scope of practice. Considering that the NTDS reported the majority (57%) of transgender youth experience rejection from their families, it is critical to acknowledge that family involvement in the therapeutic process is not necessarily beneficial to the clinical care of youth. Perhaps the providers surveyed in this study encounter affirming, supportive parent(s)—but how do they know if this is the case or not? The stakes of parental and familial support for transgender youth are high; family acceptance is a protective factor for trans youth against HIV infection, suicide, homelessness, and incarceration (Grant et al., 2011).

Most supports delivered through medical, educational, or legal settings require the client to provide authorization from a parent or be the age of majority in order to provide informed consent for treatment (WPATH, 2012). In the U.S., the age of majority for most relevant interventions is 18, although some clinics and some interventions allow for client consent at earlier ages or separate from parents altogether. Due to multidisciplinary standards of care recommending informed consent procedures, clinicians working with trans youth will likely work with parent(s) in some capacity. Unsupportive, rejecting, and/or abusive family members

## TRANSFIGURED TREATMENT

can prevent or harmfully direct life-changing and life-saving treatment for trans youth; they could also seek, finance, and/or fully embrace affirming care. Thus given the hugely variant impact parent(s) on their transgender children, and with the report that clinicians privilege parental request so strongly when making clinical decisions, further research is needed in order to establish clear clinical guidelines for interfacing with parent(s) in the treatment paradigm. Additionally, further research is needed to identify and explore what exactly is meant by *stigma*, and by whom, in the many institutional and personal reports in which the term is cited.

### **V. Gender Specialists**

Among clinicians surveyed, 65% considered themselves gender specialists, while 35% did not. From the participants' additional comments, it appears the term "gender specialist" may not correlate with clinical needs nor licensure specialization, but rather it is an unregulated professional designation that may be adopted without oversight. Such a designation has the potential to highlight the reality and relevance of clinical care provided to transgender youth, as well as the professional energy behind local multidisciplinary specialization. However, it also carries with it the common risks of unregulated professional titles, such that client care is inconsistent and at-risk of widespread discrimination from providers, clinics, and institutions. However, the notion of specializing in gender in a manner that could be regulated and consistent across patient paradigms might be equally dangerous to transgender youth, such that it posits *gender* as something to be clinically mastered and clinically regulated. Such regulation may itself be the antithesis to the gender expansiveness that gender specialists support.

### VI. Limitations of Study Design

This study included significant limitations. Perhaps the limitation with the most profound effect on both participant experience and data collection was that the survey instrument sent participants down one of two tracks: trans adults who had a transgender identity between the ages of 12 and 24; or clinical providers who offered at least one gender-specific service. There were numerous participants who would fit in both survey tracks, but were asked to choose only one clinical perspective to share with the study. If modified and repeated, this survey instrument would incorporate a method with which to collect data from both/all clinical experiences of participants.

Additionally, this research design included data from trans adults who primarily reported *retrospective* experiences and data from clinicians who reported *current* experiences. Certainly these two data sets could not be directly compared as if speaking of the same clinical moment. It is recommended that any future needs assessment take into account the data from trans youth *today* so that their clinical experiences may be more directly compared to the clinical services offered to the same trans cohort.

Finally, there is the issue of quantitative statistics being utilized to code and measure queer lives and experiences. Ian Hacking (1990, 2013) offers useful insight into the complexities inherent in such research methodologies. In his work reviewing the DSM-V, Hacking (2013) looks at quantitative measures of mental health, and claims, “the *DSM* is not a representation of the nature or reality of the varieties of mental illness,” and in fact it “perpetuates the long-standing idea that, in our present state of knowledge, the recognised varieties of mental illness should neatly sort themselves into tidy blocks, in the way that plants and animals do” (p.8). Hacking offers a critique of the quantitative borders that are uncritically used to statistically and



## TRANSFIGURED TREATMENT

clinically demarcate experiences of mental health and illness. Clinical social work, psychiatry, psychology, and other fields continue to measure “illness,” such as gender dysphoria or transvestic fetishism, categorically and quantitatively, which leads to possibly problematic, if not inaccurate, methodologies that confine life experiences to discrete “blocks” and diagnostic check-lists.

Hacking critiques the long-standing modern Western mental health system that measures mental experience, which includes both *illness* and *identity*. The field of modern statistics arose from and alongside this system of measurement based on natural selection and evolutionary inheritance. Hacking describes how the field of modern statistics is inextricably connected to historical ideals of the eugenics movement and, through this foundation of racialized science and quantifiable bodies, our contemporary sociopolitical ideas of normalcy and pathology have grown. Statistical tests are foundationally methods with which entities, such as queer bodies or trans experiences, become measurable and quantifiable. What are the sociopolitical implications of normalcy and pathology if a subject falls outside of the given quantitative categories and therefore cannot even be measured?

This type of situation arose in this study. *Transfigured Treatment* utilized statistics in order to measure diverse and self-described experiences and identities. The survey instrument was designed with mostly “select all” options and/or additional write-in spaces so that respondents could fully articulate their experience of gender, race, stigma, etc. However, without a much larger sample size or randomization, most sophisticated statistical tests were not equipped to measure the data collected through this study. In order to satisfy the requirements of certain analyses, much of the data collected in this survey were recoded by this researcher, whose own sociopolitical position undoubtedly influenced choices made during categorization.

## TRANSFIGURED TREATMENT

Responses were re-coded in order to be more effectively statistically analyzed and in this way the data became influenced by researcher intervention and assumptions.

The significant limitation here is twofold. This study's methodology did not include randomized sampling, nor did it produce a study sample large enough for many statistical analyses. Had it included these methodological advantages, perhaps data would have required less re-coding and been available for more critical analyses, thus more accurately reflecting the lived reality of participants. However, it would not have remedied the other critical issue regarding quantitative statistics in this research. This study foundationally operated upon the assumption that bodies and experiences can be measured, a *quantification* that conceptually challenges *queerness*, an identity that is often understood, experienced, and embodied as including a spectrum of, or being altogether separate from, bounded categories.

### **VII. Implications for Practice**

Perhaps this study's most useful collection of data for improved clinical practice comes in the comparison of ranked contemporary clinical needs identified by transgender adults and ranked contemporary clinical needs by clinicians who provide gender-specific care. For the most part, these two study groups identified similar needs. As presented in the previous chapter, trans adults and providers ranked most services similarly, which may indicate congruency between community and clinic in the Bay Area.

However, there were a few significant discrepancies. One was the ranking of group therapy, which trans adults ranked 5<sup>th</sup> and providers ranked 9<sup>th</sup> out of 10 identified services. As discussed above, the desire for group therapy, or social affirmation, peer connection, potential chosen family, and a remedy for isolation, is not a surprising clinical desire for trans youth to

## TRANSFIGURED TREATMENT

report. Likewise, perhaps clinical providers, as part of an extensive history of pathologization, underestimate the clinical need for and healing potential of social connection inherent in group therapy. Additionally, trans adults ranked care-coordination with the education system 8<sup>th</sup> and providers ranked it 2<sup>nd</sup>. Perhaps this discrepancy connects to provider's report of strongly considering parent request in their clinical decisions. Parents might first learn of social, psychological, or medical concerns not from their teenager, but from their teenager's school, which we know from the NTDS is likely to employ discriminatory practices against trans students (Grant et al., 2011). Perhaps they bring those concerns to the clinician, and report after report after report begins to skew the provider's perspective of clinical need. Or perhaps they have been influenced by the U.S. Federal response to North Carolina's recent House Bill 2, a bill which bans transgender people from using bathrooms that correspond with their gender identity if that differs from the sex assignment on their birth certificate, and which also bans the passing of certain anti-discrimination policies that protect sexual and gender minority folks. However, the Obama administration, through a letter from the Departments of Education and Justice, issued a guidance that all public schools must allow students to use the bathroom that matches their gender identity (CNN, 2016). Thus perhaps clinical providers have located schools as the site of national transgender youth discrimination. It appears principally important that transgender youth and adults and clinical providers understand the reasons behind their respective rankings, and construct a community dialogue in order to create cohesive clinical change.

### **VIII. Structural Competency**

Coined by Helena Hansen, Psychiatrist and Medical Anthropologist, and Jonathan Metzl, Psychiatrist and American Culture Scholar, *structural competency* “calls for a new approach to the relationships among race, class, and symptom expression” (Structural Competency). The Critical Social Medicine Working Group at University of California, Berkeley, adds that structural competency “represents a novel pedagogical strategy for eliciting and developing consciousness of illness and health as the downstream effects of broad social, political, and economic structures” (Structural Competence). This clinical framework was presented by Metzl in his book *The Protest Psychosis*. In this book, Metzl describes a historical shift in diagnostic categorization of schizophrenia that led to the disproportionate diagnosis of African-American men. Metzl connects this shift to larger structural societal forces, including the backlash against the civil rights movement and a pathologization of Black anger and resistance.

Structural competency adds an indispensable pedagogical tool—a structural lens—to the Minority Stress Model, such that individual stress, even stigma, is rooted in structural forces, such as the naturalization of inequality and systemic racism. Within this framework, symptoms are not only individual markers of stress, even if socio-politically rooted, but rather markers of a “sick society” in which the individual lives. This framework, and the clinical possibilities inherent within it, are critical to consider when studying trans youth’s clinical needs and developing clinical guidelines. Integrating a structurally aware lens into such research would lead to recommendations and practices that no longer focus solely on pathologization and treatment of the individual, but rather turns the focus of intervention onto the stratified society, that which causes such stark inequalities in quality of life, symptom expression, and treatment options.

### **IX. Further Research**

As situated above, additional research is recommended in order to assess, modify, and/or create clinical services accessible and effective for transgender youth of any racial identity. Further research is also needed in order to comprehensively understand the influence of trans youth's parents on the clinical encounter, as well as to create clear clinical guidelines for interfacing with parents in the service setting. Additionally, further research is recommended on the complexities of stigma in trans youth's lives, specifically as relates to their interest in and/or access of clinical services. Finally, a more in-depth analysis is recommended of gender specialists, their clinical practices, and their effect on local multidisciplinary gender-related care.

### **X. Conclusion**

This study encompasses a joint needs and services assessment of gender-specific clinical care for transgender and gender expansive youth in the Bay Area. Findings suggest that multidisciplinary services are both provided for and accessed by trans youth, yet there remain discrepancies between trans adults and clinical providers about which clinical needs were identified for trans youth growing up today. As regards individual therapy and care-coordination with the medical system, clinicians frequently reported providing these services, trans adults frequently reported accessing them as youth, and both groups frequently reported identifying them as current clinical needs for trans youth. However, there appears the need for enhanced communication and cohesion between the communities of trans youth and clinical providers as regards care-coordination with the education system, group therapy, and family involvement in treatment.

## TRANSFIGURED TREATMENT

This study recognizes systemic transphobia, structural violence, and stigma as foundational factors influencing the critical need for accessible, safe, and affirming clinical care for transgender youth in the Bay Area today. Further research on the implications and impact of gender specialist clinical providers is recommended, as is incorporating structural competency into any study that includes transgender and gender expansive youth.

## TRANSFIGURED TREATMENT

### References

- American Progress. (2010, June). Gay and Transgender Youth Homelessness by the Numbers. Retrieved from <https://www.americanprogress.org/issues/lgbt/news/2010/06/21/7980/gay-and-transgender-youth-homelessness-by-the-numbers/>
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Arlington, VA: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*. Washington, D.C.: American Psychiatric Association.
- American Psychological Association. (n.d.). Health Disparities & Mental/Behavioral Health Workforce. Retrieved June 5, 2016, from <http://www.apa.org/about/gr/issues/workforce/disparity.aspx>
- American Psychological Association. (2015). Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression\_APA. Retrieved November 17, 2015, from <http://www.apa.org/topics/lgbt/transgender.aspx>
- Birkett, M., Newcomb, M. E., & Mustanski, B. (2015). Does It Get Better? A Longitudinal Analysis of Psychological Distress and Victimization in Lesbian, Gay, Bisexual, Transgender, and Questioning Youth. *Journal of Adolescent Health, 56*(3), 280–285. <http://doi.org/10.1016/j.jadohealth.2014.10.275>
- Bith-Melander, P., Sheoran, B., Sheth, L., Bermudez, C., Drone, J., Wood, W., & Schroeder, K. (2010). Understanding Sociocultural and Psychological Factors Affecting Transgender People of Color in San Francisco. *Journal of the Association of Nurses in AIDS Care, 21*(3), 207–220. <http://doi.org/10.1016/j.jana.2010.01.008>

## TRANSFIGURED TREATMENT

- Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211–224. <http://doi.org/10.1016/j.sexol.2008.08.001>
- Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient Satisfaction with Transgender Health Services. *Journal of Sex & Marital Therapy, 30*(4), 277–294. <http://doi.org/10.1080/00926230490422467>
- Butler, J. (2014). *Bodies That Matter: On the Discursive Limits of “Sex.”* Routledge.
- Centers for Disease Control and Prevention, M. and M. W. R. (2014). Youth Risk Behavior Surveillance — United States, 2013. *Surveillance Summaries, 63*(4). Retrieved from <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>
- CNN, E. G. (n.d.). W.H. issues guidance on transgender bathrooms. Retrieved June 5, 2016, from <http://www.cnn.com/2016/05/12/politics/transgender-bathrooms-obama-administration/index.html>
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Geldman, J., & Zucker, K. (2012). *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*. World Professional Association for Transgender Health. Retrieved from [http://www.wpath.org/uploaded\\_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf](http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf)
- Collins, P. H. (2000). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. Psychology Press.
- Craig, S. L. (2011). Precarious Partnerships: Designing a Community Needs Assessment to Develop a System of Care for Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) Youths. *Journal of Community Practice, 19*(3), 274–291. <http://doi.org/10.1080/10705422.2011.595301>



## TRANSFIGURED TREATMENT

- Cross, C. (2014). Toronto clinic addresses unique needs of transgender youth. *Canadian Medical Association Journal*, 186(1), 21–21. <http://doi.org/10.1503/cmaj.109-4659>
- Davis, T. S., Saltzburg, S., & Locke, C. R. (2009). Supporting the emotional and psychological well being of sexual minority youth: Youth ideas for action. *Children and Youth Services Review*, 31(9), 1030–1041. <http://doi.org/10.1016/j.chilyouth.2009.05.003>
- Durso, L. E., & Gates, G. J. (2012). *Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless*. Los Angeles: The Williams Institute with True Colors Fund and The Palette Fund.
- Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*. Vintage Books.
- Gamarel, K. E., Walker, J. J., Rivera, L., & Golub, S. A. (2014). Identity Safety and Relational Health in Youth Spaces: A Needs Assessment with LGBTQ Youth of Color. *Journal of LGBT Youth*, 11(3), 289–315. <http://doi.org/10.1080/19361653.2013.879464>
- Gay, Lesbian, and Straight Education Network (GLSEN). (2013). 2013 National School Climate Survey. Retrieved November 22, 2015, from <http://www.glsen.org/article/2013-national-school-climate-survey>
- Gender Equity Resource Center. (2013, July). Definition of Terms. Retrieved from [http://geneq.berkeley.edu/lgbt\\_resources\\_definiton\\_of\\_terms#srs](http://geneq.berkeley.edu/lgbt_resources_definiton_of_terms#srs)
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Simon and Schuster.
- Grant, J. M., Mottet, L. A., & Tanis, J. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey - Executive Summary. Retrieved November 17, 2015, from [http://endtransdiscrimination.org/PDFs/NTDS\\_Exec\\_Summary.pdf](http://endtransdiscrimination.org/PDFs/NTDS_Exec_Summary.pdf)

## TRANSFIGURED TREATMENT

- Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., ... Clayton, P. J. (2011). Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. *Journal of Homosexuality*, 58(1), 10–51.  
<http://doi.org/10.1080/00918369.2011.534038>
- Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014). *Suicide Attempts among Transgender and Gender Non-Conforming Adults - FINDINGS OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY*. Williams Institute, University of California, Los Angeles.  
Retrieved from <http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf>
- Hacking, I. (2013, August 8). Lost in the Forest. *London Review of Books*, pp. 7–8.
- Hacking, I. (1990). *The taming of chance*. Cambridge [England] ; New York: Cambridge University Press.
- Hoffman, N. D., Freeman, K., & Swann, S. (2009). Healthcare Preferences of Lesbian, Gay, Bisexual, Transgender and Questioning Youth. *Journal of Adolescent Health*, 45(3), 222–229.  
<http://doi.org/10.1016/j.jadohealth.2009.01.009>
- HRC. (2015). Growing Up LGBT in America: View Statistics. Retrieved November 18, 2015, from <http://www.hrc.org/youth/view-statistics/#.Vkvq0rRE958>
- Hussey, H. (2015, February). Beyond 4 Walls and a Roof. Retrieved from <https://www.americanprogress.org/issues/lgbt/report/2015/02/02/105754/beyond-4-walls-and-a-roof/>
- Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, D.C.: National Academies Press.  
Retrieved from <http://www.nap.edu/catalog/13128>

## TRANSFIGURED TREATMENT

- Lorde, A. (1982). *Zami, a New Spelling of My Name*. Crossing Press.
- Meyer, I. H. (2003a). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93*(2), 262–265.
- Meyer, I. H. (2003b). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin, 129*(5), 674–697. <http://doi.org/10.1037/0033-2909.129.5.674>
- Miller, L. R., & Grollman, E. A. (2015). The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health. *Sociological Forum, 30*(3), 809–831. <http://doi.org/10.1111/socf.12193>
- Moe, J. L., Perera-Diltz, D., Sepulveda, V., & Finnerty, P. (2014). Salience, Valence, Context, and Integration: Conceptualizing the Needs of Sexually and Gender Diverse Youth in P–12 Schools. *Journal of Homosexuality, 61*(3), 435–451. <http://doi.org/10.1080/00918369.2013.842437>
- Movement Advancement Project. (2015a). Movement Advancement Project | Paying an Unfair Price: The Financial Penalty for Being Transgender in America. Retrieved November 18, 2015, from <http://www.lgbtmap.org/policy-and-issue-analysis/unfair-price-transgender>
- Movement Advancement Project. (2015b). Movement Advancement Project | Understanding Issues Facing Transgender Americans. Retrieved November 18, 2015, from <http://www.lgbtmap.org/lgbt-movement-overviews/understanding-issues-facing-transgender-americans>
- NAACP. (2015). Criminal Justice Fact Sheet. Retrieved November 22, 2015, from <http://www.naacp.org/pages/criminal-justice-fact-sheet>
- National Center for Transgender Equality. (2011). Peer Violence and Bullying Against Transgender and Gender Nonconforming Youth: Submission to the United States Commission on Civil

## TRANSFIGURED TREATMENT

Rights. Retrieved November 17, 2015, from

<http://www.eusccr.com/10.%20national%20center%20for%20transgender%20equality.pdf>

National Center for Transgender Equality. (n.d.). Youth & Students. Retrieved November 18, 2015,

from <http://www.transequality.org/issues/youth-students>

National Health Care for the Homeless Council. (2014). Gender Minority & Homelessness:

Transgender Population. *A Quarterly Research Review of the National HCH Council*, 3(1).

Retrieved from [http://www.nhchc.org/wp-content/uploads/2014/10/in-](http://www.nhchc.org/wp-content/uploads/2014/10/in-focus_transgender_sep2014_final.pdf)

[focus\\_transgender\\_sep2014\\_final.pdf](http://www.nhchc.org/wp-content/uploads/2014/10/in-focus_transgender_sep2014_final.pdf)

Olson-Kennedy, J. (2016). Mental Health Disparities Among Transgender Youth: Rethinking the

Role of Professionals. *JAMA Pediatrics*, 170(5), 423.

<http://doi.org/10.1001/jamapediatrics.2016.0155>

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental Health of

Transgender Children Who Are Supported in Their Identities. *PEDIATRICS*, 137(3), 1–8.

<http://doi.org/10.1542/peds.2015-3223>

Poverty Rate by Age. (n.d.). Retrieved from <http://kff.org/other/state-indicator/poverty-rate-by-age/>

Rachlin, K. (2002). Transgender Individuals' Experiences of Psychotherapy. *The International*

*Journal of Transgenderism*, 6(1).

Stieglitz, K. A. (2010). Development, Risk, and Resilience of Transgender Youth. *Journal of the*

*Association of Nurses in AIDS Care*, 21(3), 192–206. <http://doi.org/10.1016/j.jana.2009.08.004>

Structural Competence. (n.d.). Retrieved June 5, 2016, from [http://www.rad-](http://www.rad-med.com/structuralcompetence/)

[med.com/structuralcompetence/](http://www.rad-med.com/structuralcompetence/)

Structural Competency. (n.d.). Retrieved June 5, 2016, from <https://structuralcompetency.org/>

## TRANSFIGURED TREATMENT

- Substance Abuse and Mental Health Services Administration. (2015). *Racial/Ethnic Differences in Mental Health Service Use among Adults*. Retrieved from <http://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf>
- The Trevor Project. (2015). Facts About Suicide. Retrieved November 18, 2015, from <http://www.thetrevorproject.org/pages/facts-about-suicide>
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 46*(6), 1580–1589. <http://doi.org/10.1037/a0020705>
- Travers, R., Guta, A., Flicker, S., Larkin, J., McCardell, S., & van der Meul. (2010). Service provider views on issues and needs for lesbian, gay, bisexual, and transgender youth. *The Canadian Journal of Human Sexuality, 19*(4).
- UCSF Center of Excellence for Transgender Health. (n.d.). Youth: Special Considerations. University of California, San Francisco. Retrieved from <http://transhealth.ucsf.edu/trans?page=protocol-youth>
- Valentine, D. (2007). *Imagining Transgender: An Ethnography of a Category*. Duke University Press.
- Wells, E. A., Asakura, K., Hoppe, M. J., Balsam, K. F., Morrison, D. M., & Beadnell, B. (2013). Social services for sexual minority youth: Preferences for what, where, and how services are delivered. *Children and Youth Services Review, 35*(2), 312–320. <http://doi.org/10.1016/j.childyouth.2012.11.011>

TRANSFIGURED TREATMENT

Appendix A

2015-2016

Smith College School for Social Work

Human Subjects Review Application

Project title: Transfigured Treatment: A Comparative Social Work Needs and Specialized Services  
Assessment of Transgender Youth and Gender-Specialist

Providers in the Bay Area

Name of researcher: Lark Endean Nierenberg

Check one:  MSW  PhD

Home phone: (xxx) xxx-xxxx

\_\_\_\_\_  
Email: lnierenberg@smith.edu

Research advisor: Dr. Diana Fuery

The signature below testifies that I, as the researcher, pledge to conform to the following: As one engaged in research utilizing human subjects, I acknowledge the rights and welfare of the participants involved. I acknowledge my responsibility as a researcher to secure the informed consent of the participants by explaining the procedures and by describing the risks and benefits of the study. I assure the Committee that all procedures performed under the study will be conducted in accordance with those federal regulations and Smith School for Social Work policies that govern research involving human subjects.

**Any deviation from the study (e.g.: change in researcher, research methodology, participant recruitment procedures, data collection procedures, etc.) will be submitted to the Committee by submitting a Protocol Change Form for which you MUST receive approval *prior* to implementation. I agree to report all deviations to the study protocol or adverse events IMMEDIATELY to the Committee.**

Researcher: Lark Endean Nierenberg

1/9/2016



\_\_\_\_\_  
(Typed name)

\_\_\_\_\_  
(Signature)

(Date)

Research Advisor/Committee Chair: \_\_\_\_\_

\_\_\_\_\_  
(Typed name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

(For Committee Use)

REVIEW STATUS:  Exempt  Expedited  Full  Not Approved

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

\_\_\_\_\_  
Chair, Smith College SSW HSRC

\_\_\_\_\_  
Date

**IN THE SECTIONS BELOW WHERE DESCRIPTIONS ARE REQUESTED, BE SURE TO PROVIDE SUFFICIENT DETAIL TO ENABLE THE COMMITTEE TO EVALUATE YOUR PROCEDURES AND RESPONSES.**

**1. DESCRIPTION OF RESEARCH PROJECT INVOLVING HUMAN PARTICIPANTS**

This community needs and services assessment will utilize mixed-methods data collection via an original survey in order to assess the local, current, and specific clinical social work-related needs of Bay Area transgender youth, and to further compare such needs to the services provided by local social work clinicians who consider themselves “gender specialists.” The following paragraphs provide a synopsis of the relevant literature pointing to the need for this local, multifaceted study. Also included below is a summary of the proposed research design and involvement of human participants.

In 2011, The National Gay and Lesbian Task Force and the National Center for Transgender Equality released the findings from the National Transgender Discrimination Survey (NTDS), a study including almost 6,450 transgender and gender-variant people across the U.S. (Grant et al.). The NTDS revealed that “it is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the workplace and health care settings, every day (Grant et al., 2011, p.7).” The NTDS claims that the structures and institutions commonly thought of as providing and ensuring safety, such as health systems, schools, families, and police departments, as are actually “failing daily in [their] obligation to serve transgender and gender non-conforming people” (Grant et al., 2011, p.7). According to the Institute of Medicine (2011), “LGBT youth report experiencing elevated levels of violence, victimization, and harassment compared with heterosexual and non-gender-variant youth (p.4). To that end, the Institute of Medicine (2011) has designated transgender-specific health needs a “priority research area” (p.6). Much of the extant research on transgender-specific health needs has reflected the violence, discrimination, and structural oppression experienced throughout this population in varied settings and institutions.

In addition to highlighting chronic marginalization, extant research has begun to illustrate the varied clinical needs and preferences within trans youth populations. For example, an Internet-based survey conducted by Wells et al. (2013) surveyed 544 domestic sexual minority youth, ages 14-19, about their clinical needs and clinical preferences. Responses varied depending on youths’ racial identity and how certain youth were of their gender identity. For instance, “African American youth were more likely than others to prefer services offered in a place of worship,” despite the finding that “the majority preferred to receive services at an agency specifically designated for LGBTQ youth” (Wells et al., 2013, p.312-318). Additionally, those who were questioning their gender identity “expressed stronger interest than others in services to address stress, family issues, and self-defense, and in receiving support and guidance from LGBTQ adults” (Wells et al., 2013, p.312). Thus despite Hoffman, Freeman, and Swann’s (2009) findings that providers need not be transgender to provide satisfactory care, perhaps for those questioning their identity, receiving care from an LGBTQ provider would actually act as a protective factor. This discrepancy in clinical need and provision is ripe for further study.

Although the Institute of Medicine (2011) has identified transgender-specific health as a “priority research area” (p.6), most research to date has focused on need and risk within the population, rather than service delivery and satisfaction ratings within the population. A community needs assessment, such as the one utilized in this research, is one method through

## TRANSFIGURED TREATMENT

which to examine needs, existing delivery systems, and service preferences simultaneously (Craig, 2011). Following are summaries of two studies, one reporting risk, the other reporting needs, specifically of trans youth in the Bay Area. However, neither addresses existing delivery systems or the satisfaction ratings of those delivery systems.

Toomey et al. (2010) examined school victimization and its subsequent mental health presentation among 245 gender nonconforming (GNC) students in the Bay Area. The authors found that the presentation of depression in GNC students could be fully accounted for by levels of identity-based victimization, experienced as “distal stigma,” at school (Toomey et al., 2010, p.2). Toomey et al. (2010) also identify an association between identity-based school victimization and young adult presentation of depression, anxiety, and lower life satisfaction among other adjustment problems. These results suggest early intervention in identity-based victimization could radically decrease later adjustment difficulty.

Another Bay Area, ethnographic study assessed the needs of 43 trans youth and adults of color in San Francisco (Bith-Melander, 2010). Participants identified a number of barriers encountered due to their gender identity. Their responses, localized to San Francisco, reflect the national trends detailed above. Barriers to care included a lack of health insurance, fear of not accessing a competent provider, lack of knowledge about available or free services, and lack of transportation to reach services. Additionally, youth reported “they struggled with being accepted by their families and lacked direction or resources to pursue their interests” (Bith-Melander, 2010, p.217). Finally, youth stated main areas of concern are employment opportunities and stable housing (Bith-Melander, 2010). Altogether, the needs reflected in this small, ethnographic Bay Area study reflect the national trends of numerous, varied, and far-reaching opportunities to support transgender youth.

The proposed survey instrument, attached to this proposal as Attachment D, will collect both quantitative and qualitative data. Quantitative responses will be coded and analyzed using the support of my research advisor, Dr. Diana Fuery, and Marjorie Postal, of Smith SSW. Additionally, given that the experiences of trans folks and clinicians are so varied and expansive, many survey questions are accompanied by an additional write-in space for respondents to clarify, expand upon, or challenge the given question. Data collected in these write-in spaces will be qualitatively analyzed using matrix coding and analysis organized by theme.

A survey was selected as the most comprehensive and efficient way to collect data from the two chosen data sets (i.e., Bay Area transgender adults and gender specialist providers). This survey, hosted on Qualtrics, will be accessible to anyone with Internet access. Furthermore, its link will be easily shared among social media contacts, through professional listservs, and via email requests to local clinics, organizations, and institutions. The survey’s estimated N is 50, with 30 respondents expected from the transgender adult data set and 20 from the provider data set. Recruitment measures will be subsequently discussed in this application, but all participants will be recruited by convenience and snowball sampling techniques, and via a digital posting rather than an in-person appeal. Following, all consent agreements will be transacted digitally via the survey host.

This research will attempt to capture transgender youth’s perspective through a retrospective needs assessment and service satisfaction survey of trans adults. Youth’s voices are too oft left out of empirical efforts, and unfortunately this report will also lack their direct insight. However, most trans adults were trans youth at one point, and this survey offers an opportunity to tend to younger generations and contribute truth and power to the trans population as a whole. Furthermore, this research will integrate client *and* clinician responses. It will assess



## TRANSFIGURED TREATMENT

the present needs of the community, and it will also assess the present services delivered by providers committed to competent trans care. No other report has yet compared the two data sets in order to assess for gaps, recommendations, or models.

In addition to the aforementioned contributions to the extant literature, this research also retains two significant limitations. The survey for trans adults will be retrospective, while the survey for clinicians will be current. Thus, the two data sets may not be analyzed as if they represent the same clinical and community environment. The data sets will be compared and analyzed against each other, but with the caveat that they are not representative of the same point in time. Additionally, the survey will not be a representative sample of Bay Area transgender youth. Data will be collected via convenience and snowball sampling, and thus the data will not be a stringently representative sample of the population it aims to measure. Despite these limitations, the study will contribute new knowledge to the field and may serve as a reference for service modification, recommendation, and creation.

### References

- Bith-Melander, P., Sheoran, B., Sheth, L., Bermudez, C., Drone, J., Wood, W., & Schroeder, K. (2010). Understanding Sociocultural and Psychological Factors Affecting Transgender People of Color in San Francisco. *Journal of the Association of Nurses in AIDS Care, 21*(3), 207–220. <http://doi.org/10.1016/j.jana.2010.01.008>
- Craig, S. L. (2011). Precarious Partnerships: Designing a Community Needs Assessment to Develop a System of Care for Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) Youths. *Journal of Community Practice, 19*(3), 274–291. <http://doi.org/10.1080/10705422.2011.595301>
- Grant, J. M., Mottet, L. A., & Tanis, J. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey - Executive Summary. Retrieved November 17, 2015, from [http://endtransdiscrimination.org/PDFs/NTDS\\_Exec\\_Summary.pdf](http://endtransdiscrimination.org/PDFs/NTDS_Exec_Summary.pdf)
- Hoffman, N. D., Freeman, K., & Swann, S. (2009). Healthcare Preferences of Lesbian, Gay, Bisexual, Transgender and Questioning Youth. *Journal of Adolescent Health, 45*(3), 222–229. <http://doi.org/10.1016/j.jadohealth.2009.01.009>
- Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, D.C.: National Academies Press. Retrieved from <http://www.nap.edu/catalog/13128>
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 46*(6), 1580–1589. <http://doi.org/10.1037/a0020705>
- Wells, E. A., Asakura, K., Hoppe, M. J., Balsam, K. F., Morrison, D. M., & Beadnell, B. (2013). Social services for sexual minority youth: Preferences for what, where, and how services are delivered. *Children and Youth Services Review, 35*(2), 312–320. <http://doi.org/10.1016/j.childyouth.2012.11.011>

**2. PARTICIPANTS:** if you are only observing public behavior, skip to question d in this section.

a). How many participants will be involved in the study?

     12-15        X    $\geq 50$            Other (how many do you anticipate)

b). List specific eligibility requirements for participants (or describe screening procedures), including exclusionary and inclusionary criteria. For example, if including only male

## TRANSFIGURED TREATMENT

participants, say so, and *explain why*. If using data from a secondary de-identified source, skip to question e in this section.

Participants will be members of 1 of 2 groups.

Group 1 will consist of residents of the Bay Area, delineated by nine California Counties: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma. Participants will be  $\geq 18$  years old, and will be able to consent to participation independently. Participants must have/had a gender-expansive identity (e.g., transgender, genderqueer, aggressive/AG) when they were 12-24 years old.

Group 2 will consist of mental health, medical, and social service providers (e.g. MSWs, LCSWs, MFTs, MDs, PhDs, etc.) who practice in the Bay Area. Participants will be over age 18, and will be able to consent to participation independently. Participants must identify one or more of their services as specialized to the needs of gender-expansive youth.

c). Describe how participants will be recruited. ***Be specific: give step-by-step description.*** (Attach all flyers, letters, announcement, email messages etc. that will be used to recruit. ***Include the following statement on any/all recruitment materials/emails/postings, ect:*** This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).)

1. The participant recruitment message, attached here as Attachment A, will be distributed on Facebook, via: my personal profile; Smith College School for Social Work Class of 2016's Group Page; Smith Social Workers Speakeasy Group Page; and Smithies in the Bay Group Page. It will also be distributed on Reddit.com in the sub-reddits: r/socialwork, r/transgender, r/asktransgender, r/trans, r/queer, r/lgbt, r/radicalqueers, r/genderqueer, r/bayarea, r/research, and r/socialscience.
2. I will contact via email the following list of local clinics, organizations, and institutions providing care to transgender youth. The email body will include the participant recruitment message attached as Attachment B. Local organizations include:
3. All social media posts and email outreach (Attachments A and B) will be accompanied by two flyers, attached here as Attachment C. The flyers will be added as image attachments in both social media posts and email messages. (Please note: the email address listed on the flyers will be updated to reflect the actual survey link once finalized.)
4. Hard-copy flyers (Attachment C) will be delivered by the researcher to the organizations below in **bold**, 10 of each style flyer per organization, in addition to the email recruitment noted in #2 above.

**Mind the Gap; University of California, Berkeley, Queer Alliance Resource Center;** University of California, San Francisco, Child and Adolescent Gender Center Clinic; 3<sup>rd</sup> Street Youth Center & Clinic; AQU25A; Bayview Hunters Point Foundation Youth Services; Asian Youth Prevention Services; Bay Area Young Positives; Berkeley Youth Alternatives; Boys & Girls Club San Francisco; CHALK; Billy DeFrank LGBT Center; DreamCatcher Emergency Youth Shelter & Support Center; East Oakland Youth Development Center; Eureka Valley Recreational Center; Girls 2000; Girls Inc. of Alameda County; Futures Without Violence; GLBT Studies Department/Queer Resource Center at City College of San Francisco; Glide Health Services at Glide Memorial United Methodist Church; Horizons, Inc.; Lambda Youth Project; LIFT Bay Area; Lighthouse Community Center; **LYRIC**; Magnet Health Clinic; Native American Health Center/Circle of Healing; Our Family Coalition- East Bay and San Francisco;

## TRANSFIGURED TREATMENT

OutLoud Radio; **Pacific Center for Human Growth**; Potrero Hill Neighborhood House; Project Outlet; SAGE; **The San Francisco LGBT Community Center**; SHANTI/The Lift Program; Sexual Minority Alliance of Alameda County; Spectrum LGBT Center of The North Bay; TRANS:THRIVE; Westside Crisis Clinic Teen Core; Youth Speaks; Youth Uprising; A Safe Place; Bay Area Local Legal Aid; Allen Temple Health and Social Services Ministries; Berkeley High School Health Center; Cole Street Youth Clinic; CUAV; Instituto Familiar De La Raza; La Casa De Las Madres; The Lighthouse Community Center; Redwood City Domestic Violence Clinic; SFWAR; Youth Alive!; AGUILAS; **AIDS Project East Bay**; AIDS Medicine & Miracles; Ally Action; And Castro for All; Asian and Pacific Islander Wellness Center; Asian Health Services- Youth Program; At the Crossroads; Balboa Teen Health Center; **Berkeley Free Clinic**; Beyond Emancipation Teen Health Center; San Francisco Aids Foundation; Black Coalition on AIDS; Castro-Mission Health Center; Center for Young Women’s Development; Court Appointed Special Advocates; Daly City Youth Health Center; **Dimensions Clinic at Castro-Mission health Center**; Face to Face Sonoma AIDS County Network; Haight Ashbury Free Clinics, Inc.; Huckleberry Youth Programs; La Clinica De La Raza; **Larkin Street Youth Clinic**; Marin AIDS Project; Clinica Esperanza; Native American AIDS Project; Planned Parenthood Golden Gate; **St. James Infirmary**; San Francisco Independent Living Skills Program; The Stonewall Project; Kaiser’s Teen Clinic; Transgender Law Center; Valencia Health Services; Youth TIES; ACLU LGBT Project- Northern California Chapter; AIDS Legal Referral Panel- SF; MISSEY; West Coast; Out and Equal Workplace Advocates; Tenderloin Health; **Tom Waddell Transgender Clinic**; Transgender, Gender Variant, Intersex Justice Project; Walden House, Inc.; Eviction Defense; Collaboration; Downtown Youth Clinic; Hip Hop to Health Clinic; **Lyon Martin Health Services**; San Francisco City Clinic; Alcoholics Anonymous; Al-Anon & Al-Teen Information; Castro Country Club; The Iris Center; Saint Anthony’s Free Clinic; Sequoia Teen Wellness Center; Thunder Road Adolescent Treatment Centers, Inc.; Teen Clinic at Children’s Hospital Oakland; Teen Clinic at Family Health Center; Teen Clinic at UCSF Children’s Hospital; Tri-City Health Center; AMASSI, Inc.; Youth in Focus; Youth Together.

d). Is there any relationship between you as the researcher and the participants (e.g. teacher/student, superintendent/principal/teacher; supervisor/clinician; clinician/client, etc.) that might lead to the appearance of coercion? If so, what steps will you take to avoid this situation. For example: “I will not interview individuals who have been direct clients.”

I have attended one Mind the Gap meeting, and I have professionally shadowed the clinical social worker and have interacted in a professional capacity with the staff of the Child and Adolescent Gender Center Clinic at UCSF. These social service providers will be among those asked to complete my survey, but they will be assured—as will all participants—that their responses are anonymous.

e). Are the study *target subjects* members of any of the following federally defined vulnerable populations? (ONLY check if the study focus area is SPECIFICALLY based on any of the listed groups. For instance, if your study is about how persons who are economically disadvantaged access services, you DO check ‘Economically disadvantaged’ category below. DO NOT CHECK IF SOME OF THESE FOLKS MAY BY CHANCE BE IN A MIXED SAMPLE – EXCEPT IF THERE ARE CHILDREN/UNDER 18 YEAR OLDS. Thus: if you are asking about how individuals who live in inner city locations get to services, you DO NOT check any of the categories below, because there is a range of types of people who live in these environments who may wish to participate, and you do not define the population as ‘economically disadvantaged’).

## TRANSFIGURED TREATMENT

Be aware that checking ‘yes’ ***automatically requires the HSR Full Review.***

Yes  No

If ‘Yes’, check the group(s) all that apply in your study:

minors (under 18 years of age) Please indicate the approximate age range of minors to be involved. Participants under age 18 require participant assent AND written consent from the parent/legal guardian. Please use related forms.

prisoners

pregnant women

persons with physical disabilities

persons with diagnosed mental disabilities

economically disadvantaged

educationally disadvantaged

### **3. RESEARCH METHODS:**

(Check which applies)

Interview, focus group, non-anonymous questionnaire

Anonymous questionnaire/survey

Observation of public behavior

Analysis of de-identified data collected elsewhere (‘secondary data’)

() Where did these data come from originally?

---

---

---

Did this original research get IRB approval?  Yes  No

(Skip to BENEFITS section)

Other (describe)

---

Describe the nature of the interaction between you and the participants. Additionally, if applicable, include a description of the ways in which different subjects or groups of participants will receive different treatment (e.g., control group vs comparison group, etc.).

For most participants, I will not directly interact with them. They will find the survey link elsewhere, complete it online anonymously, and we will never cross paths during the course of the research. For some participants, I may interact with them digitally or in-person if they learn of the survey directly from me (via email, Facebook, etc.), and if they respond directly to me with inquiry. Otherwise, participation and data remain anonymous.

a). Please describe, with sufficient detail, the procedure/plan/research methodology to be followed in your research (e.g. this is a quantitative, survey based study; tell us what participants will do; etc).

This is a survey-based study hosted online via Qualtrics. Participants will learn of the survey via a social media post, email, professional listerv, or word of mouth, and will access the survey online, independent of interaction with the researcher. Respondents will consent to participation digitally via the survey. They will then complete the survey, a time requirement of approximately 5-15 minutes. After the survey, they will be shown a list of three local medical and mental health clinics available should they have experienced distress linked to the survey;

## TRANSFIGURED TREATMENT

this same list will have been included in the initial consent to participation form. Participation ceases once the survey is completed.

b). How many times will you meet/interact with participants? (*If you are only observing public behavior, SKIP to question d in this section.*)

I will never knowingly meet participants. They will be recruited by emails or social media posts, as noted above, and will complete an online survey. I will interact in a digital capacity, such that I will send initial digital recruitment messages, and will be available by email and phone should participants have any questions or concerns.

c). How much total time will be required of each participant?

The survey questions branch depending on the answers respondents provide. At its shortest manifestation, they survey should take approximately 5 minutes to complete. At its longest, it may take approximately 15 minutes to complete. Completing the survey is the only time requirement of each participant.

d). Where will the data collection occur (please provide sufficient detail)?

Data will be collected via Qualtrics (the survey's host), and will be shared with my Research Advisor, Dr. Diana Fuery, and Marjorie Postal at Smith SSW for analysis support. I will use my personal computer when accessing data, which is both password-protected and encrypted.

e). If you are conducting surveys, attach a copy of the survey instrument to this application. If you are conducting individual interviews or focus groups, including ethnographies or oral histories, attach a list of the interview questions as an "Attachment". Label attachments alphabetically, with descriptive titles (e.g.: *Attachment A: Interview Questions*).

Survey instrument is attached to this application as Attachment D.

### **4. INFORMED CONSENT:** (*If you are only observing public behavior, SKIP to next section*)

a). What categories of consent documentation will you be obtaining from your participants?

(Check all that apply)

- written participant consent
- written parent/guardian consent
- Child assent 14-17
- Child assent, assent 6-13
- Adult with guardian consent

b). Attach original consent documents. \*note: be advised that, electronic signatures and faxed, signed consents ARE allowed. Please describe how you will gain consent.

Consent will be obtained via an electronic signature on the digital Consent Form, which will appear as the initial page of the electronic survey. Consent form attached as Attachment C.

### **5. COLLECTION /RETENTION OF INFORMATION:**

a). With sufficient detail, describe the method(s) of recording participant responses (e.g., audiotape, videotape, written notes, surveys, etc.)

Participant responses will be recorded via electronic survey, hosted on Qualtrics.

b). Include the following statement to describe where and for how long will these materials will be stored and the precautions being taken to ensure the security and safety of the materials,.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer

## TRANSFIGURED TREATMENT

needed, and then destroyed. All electronically stored data will be password protected during the storage period.

c). Will the recordings of participant responses be coded for subsequent analysis? ***If you are only observing public behavior, SKIP to next section.***

Yes  
 No

### **6. CONFIDENTIALITY:**

a). What assurances about maintaining privacy will be given to participants about the information collected?

1. Anonymity is assured (data cannot be linked to participant identities)  
 2. Confidentiality is assured (names and identifying information are protected, i.e., stored separately from data).  
 3. Neither anonymity nor confidentiality is assured

b). If you checked (2) above, describe methods to protect confidentiality with sufficient detail. Describe how you will maintain privacy of the participant as well as the data

N/A

c). If you checked (3) above, explain, with sufficient detail, why confidentiality is not assured.

N/A

d). If you checked (3) above, provide sufficient detail that describes measures you will take to assure participants understand how their information will be used. Describe and attach any permissions/releases that will be requested from participants.

N/A

### **7. RISKS:**

a). Could participation in this study cause participants to feel uncomfortable or distressed?

Yes  
 No

If yes, provide a detailed description of *what steps* you will take to protect them.

In the consent form, which each participant must click through before beginning the survey, and again at the final page of the survey, there will be a list of three local and one national resources, including contact information, for participants to access if they are triggered, distressed, or otherwise shaken by this survey and research. Organizations include: Berkeley Free Clinic (a community staple and worker collective providing no-cost, limited medical and mental healthcare), St. James Infirmary (medical and mental healthcare by-and-for people with experiences in the sex trades), Tom Waddell Transgender Clinic (San Francisco Department of Public Health multi-disciplinary mental and medical healthcare provided to anyone who identifies as transgender), and Trans Lifeline (a hotline staffed by-and-for transgender people to respond to our community's needs).

b). Are there any other risks associated with participation (e.g. financial, social, legal, etc.)?

Yes  
 No

If yes, provide a detailed description of the measures you will take to mitigate these additional risks.

## TRANSFIGURED TREATMENT

### **8. COMPENSATION: (If you are only observing public behavior, SKIP to the next section)**

Describe any cash or ‘gifts’ (e.g.: coffee shop gift card) that participants will receive for participating in this research (see guidance about payment/gift compensation in the Smith School for Social Work Human Subjects Review Guideline, at the HSR site in the SSW website).

NONE.

### **9. BENEFITS:**

a). Describe the potential benefits for you, the researcher, in conducting this study.

This research is near and dear to my heart and psyche. I am a trans adult living in the Bay Area, and I wish to pay academic homage to my past as a trans youth; to the many trans youth growing up today, for all of whom I so deeply wish health and safety; and to the *helpers*, who continue to provide trust, guidance, and care. I am honored and thrilled to engage in this type of research, and I can think of no greater benefit than to give back to and further support this local, chronically marginalized, and incredibly powerful clinical community.

b). Describe the potential benefits for individuals who participate as subjects, EXCLUDING payment/gift compensations.

I hope that participants, regardless of gender identity, feel heard through this research. I hope they see their participation as a marker of change and as a tool with which to transform the clinical picture of gender-specific support in the Bay. I hope the participants of this research feel empowered.

c). Describe the potential benefits to the field of clinical social work from this research?

Conducting a needs assessment and comparing it directly to a service assessment will produce invaluable insight into the alignment of a population (trans youth) and a profession (clinical social work). Understanding the clinical climate in the Bay in this way has the potential to illustrate a sore gap in clinical care, or to highlight a successful model of care. Either result—or likely somewhere in between—will help distill and create systems of clinical services that most successfully benefit the target populations, while simultaneously supplying providers with clarity and direction in their work.

### **10. FINAL APPLICATION ELEMENTS:**

a. Include the following statement to describe the intended uses of the data:

The data collected from this study will be used to complete *my Master’s in Social Work (MSW) Thesis*. The results of the study may also be used in publications and presentations.

b. If there are Co- Researchers, cooperating departments, and/or cooperating institutions, follow the following instructions:

N/A

c. TRAINING: Include the following statement to describe training:

I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.

## TRANSFIGURED TREATMENT

### Attachment A: Recruitment Letter #1

Hello Bay Area Friends and Colleagues:

I invite you to participate in *a comparative community needs and specialized services assessment of transgender youth and gender-specialist providers in the Bay Area*. The anonymous data you provide will help this research reflect an accurate clinical picture of the Bay today. This mixed-methods study will also help me complete my Master of Social Work Thesis at Smith College School for Social Work, and it may be used in future publications and presentations.

This study consists of an online survey for two groups of Bay Area adults:

1. *If you have/had a gender-expansive identity (e.g., transgender, aggressive/AG, genderqueer) between the ages of 12 and 24, please consider participating in this research.* The survey, found at the link below, will take approximately 10-15 minutes to complete, and will ask you about your experiences, or lack thereof, as a youth with a broad range of clinical social work services.
2. *If you are a gender-specialist provider (MSW, LCSW, MFT, PhD, MD, etc.) working with youth, please consider participating in this research.* The survey, found at the link below, will take approximately 10-15 minutes to complete, and will ask you about the clinical services you do and do not provide for gender-expansive youth.

If both of these groups apply to you, please select which perspective you would most like to share with this research and complete the survey only once. Your contributions to this research will help inform the retrospective and current understanding of gender-expansive needs and services in the Bay—and they will help develop the clinical landscape of tomorrow.

I am hoping to include as many experiences and participants as possible, so I invite you to share this study with your Bay Area friends and colleagues who may be interested in participating. If you have questions or concerns about this research, I welcome your communication at: [lnierenberg@smith.edu](mailto:lnierenberg@smith.edu) or (xxx) xxx-xxxx.

*[Insert Survey Link Once Created]*

Thank you,  
Lark Endean Nierenberg  
MSW Candidate, 2016  
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).



## TRANSFIGURED TREATMENT

Attachment B: Recruitment Letter #2

Hello Bay Area Friends and Colleagues:

My name is Lark Endean Nierenberg, and I invite you to participate in original research being conducted to assess and improve multidisciplinary clinical care of transgender youth in the Bay Area. You and/or your organization have been identified as a resource benefitting the health and wellbeing of local gender-expansive youth, and I hope you will consider participating.

This mixed-methods study is *a comparative community needs and specialized services assessment of transgender youth and gender-specialist providers in the Bay Area*. The anonymous data you provide will help this research reflect an accurate clinical picture of the Bay today. This research will also help me complete my Master of Social Work Thesis at Smith College School for Social Work, and it may be used in future publications and presentations.

This study consists of an online survey for two groups of Bay Area adults:

1. *If you had/have a gender-expansive identity (e.g., transgender, aggressive/AG, genderqueer) between the ages of 12 and 24, please consider participating in this research.* The survey, found at the link below, will take approximately 10-15 minutes to complete, and will ask you about your experiences, or lack thereof, as a youth with a broad range of clinical social work services.
2. *If you are a gender-specialist provider (MSW, LCSW, MFT, PhD, MD, etc.) working with youth, please consider participating in this research.* The survey, found at the link below, will take approximately 10-15 minutes to complete, and will ask you about the clinical services you do and do not provide for gender-expansive youth.

If both of these groups apply to you, please select which perspective you would most like to share with this research and complete the survey only once. Your contributions to this research will help inform the retrospective and current understanding of gender-expansive needs and services in the Bay—and they will help develop the clinical landscape of tomorrow.

I am hoping to include as many experiences and participants as possible, so I invite you to share this study with your Bay Area friends and colleagues who may be interested in participating, and to distribute it throughout your organization if able. If you have questions or concerns about this research, I welcome your communication at: [lnierenberg@smith.edu](mailto:lnierenberg@smith.edu) or (xxx) xxx-xxxx.

*[Insert Survey Link Once Created]*

Thank you,  
Lark Endean Nierenberg  
MSW Candidate, 2016  
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).



# **CALLING ALL PARTICIPANTS!**

## Bay Area Trans\* Adults

==== HELP IMPROVE ====

# CLINICAL SOCIAL SERVICES



Are you a trans\* adult 18+ years old living in the Bay Area? Would you like to add your voice to new research that assesses the needs of trans\* youth, including mental health support, access to medical care and housing assistance?

This trans-led study compares community needs with local services. Your information can help improve care for trans\* youth today!

====  
IMPROVE  
CARE  
FOR  
**TRANS\***  
**YOUTH**  
====

=====  
**GO TO [WWW.XYZ.COM](http://WWW.XYZ.COM) TO COMPLETE A  
5-15 MINUTE ANONYMOUS ONLINE SURVEY**

Contact Lark Endean Nierenberg at (██████████) or  
lnierenberg@smith.edu with questions

This study protocol has been reviewed and approved by the Smith College  
School for Social Work Human Subjects Review Committee (HSRC)

## TRANSFIGURED TREATMENT

### Attachment D: Screening Page

Welcome to the anonymous online survey of *Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area*.

**Before proceeding with the survey, please read through the following statements and select the subsequent response that best applies to you.**

**Please select only ONE group of criteria and only ONE response.** For example, select only ONE response from the trans\* adult criteria, OR select only ONE response from the gender specialist provider criteria. If both sets of criteria apply to you, select only ONE for the purposes of this study.

Thank you!  
Lark Endean Nierenberg  
Smith College School for Social Work  
MSW Candidate, 2016

#### Trans\* Adult Criteria:

- I am currently 18+ years old.
- I have/had a gender-expansive identity (e.g., transgender, aggressive/AG, genderqueer) between the ages of 12 and 24.
- I lived in the Bay Area at some point between the ages of 12 and 24.

\*\* I agree that I meet ALL of these criteria.

\*\*\* I agree that I meet some or none of these criteria.

PLEASE SELECT *ONLY ONE RESPONSE*- EITHER FROM THE CRITERIA ABOVE OR FROM THE CRITERIA BELOW.

#### Gender Specialist Provider Criteria:

- I am currently 18+ years old.
- I am a mental health, medical, and/or social service provider (e.g. MSWs, LCSWs, MFTs, MDs, PhDs, etc.) practicing in the Bay Area with youth.
- I provide at least one gender-specific service.

\*\* I agree that I meet ALL of these criteria.

\*\*\* I agree that I meet some or none of these criteria.

## TRANSFIGURED TREATMENT

### Attachment E: Consolation Page

Thank you for your interest in *Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area*.

**Due to your response on the previous page, it appears this study is not suited to address your specific experiences.**

Thank you, again, for your interest and time.

Sincerely,

Lark Endean Nierenberg  
Smith College School for Social Work  
MSW Candidate, 2016



SMITH COLLEGE

2015-2016

Consent to Participate in a Research Study  
Smith College School for Social Work • Northampton, MA

.....

**Title of Study:**

Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area

**Investigator(s):**

Lark Endean Nierenberg  
lnierenberg@smith.edu  
(xxx) xxx-xxxx  
MSW Candidate, 2016  
Smith College School for Social Work

.....

**Introduction**

You are being asked to participate in a research study that will compare the clinical social work needs of transgender youth to the specialized services provided by gender-specialists in the Bay Area. This research will ask adults who had/have a gender-expansive identity (e.g., transgender, aggressive/AG, genderqueer) between the ages of 12 and 24 to recall and share their experiences, or lack thereof, with a broad range of clinical social work services. It will also ask adult gender-specialist providers (MSW, LCSW, MFT, PhD, MD, etc.) working with youth today about which services they do and do not provide.

You were selected as a possible participant because you align with one of the two research groups noted above (i.e., gender-expansive youth identity or gender-specialist provider). Additionally, if you had/have a gender-expansive identity as a youth, it is a participation requirement that you lived in the Bay Area at some point between the ages of 12-24. If you are a gender-specialist provider, it is a participation requirement that you currently practice in the Bay Area. Regardless of research group, it is a participation requirement that you are 18+ years old.

We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

## TRANSFIGURED TREATMENT

### **Purpose of Study**

The purpose of the study is to assess the clinical social work needs of Bay Area transgender and gender-expansive youth, and to compare those needs with the services offered by gender-specialist providers (MSWs, LCSWs, MFTs, PhDs, MDs, etc.). This study is being conducted as a research requirement for my Master's in Social Work degree. Ultimately, this research may be published or presented at professional conferences.

### **Description of the Study Procedures**

If you agree to be in this study, you will be asked to do the following things:

- Sign this Consent Form, and understand that you have the right to end your participation at any time throughout the study.
- Complete an online survey, found here: [*Will Insert Survey Link Once Available*]. This survey will take approximately 5-15 minutes to complete. All information provided will remain anonymous throughout the collection, analysis, and presentation of data.
- Communicate with the researcher any questions or concerns you may have before, during, or after research participation.

### **Risks/Discomforts of Being in this Study**

There may be a small possibility you might feel uncomfortable due to the nature of this study and the content of its survey. If any of the material upsets you, please contact any of the following local agencies for further support:

- Berkeley Free Clinic: worker collective providing no-cost, limited medical and mental healthcare  
2339 Durant Avenue, Berkeley, CA 94704  
(510) 548-2570 or (800) 6-CLINIC  
Berkeleyfreeclinic.org
- St. James Infirmary: medical and mental healthcare by-and-for people with experiences in the sex trades  
1372 Mission St, San Francisco, CA 94103  
(415) 554-8494  
Stjamesinfirmary.org
- Tom Waddell Transgender Clinic: San Francisco Department of Public Health multi-disciplinary mental and medical healthcare provided to anyone who identifies as transgender  
230 Golden Gate Avenue  
(415) 355-7400  
<https://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransgenderHlthCtr.asp>
- Trans Lifeline: national hotline by-and-for transgender people to respond to the needs of our community  
(877) 565-8860

Translifeline.org

## **Benefits of Being in the Study**

The main benefit of participation in this research, regardless of your gender identity, is feeling empowered and feeling that your voice is central in empirical efforts to evolve clinical care. Participation offers the opportunity to inform the retrospective and current understanding of gender-expansive needs and services in the Bay Area, and to be an integral part of the development of the ever-evolving clinical landscape of gender-related care. This research is a tool with which to share histories of need and transform them into legacies of care.

Additionally, your participation would lead to benefits within the profession of clinical social work. Conducting a needs assessment and comparing it directly to a service assessment will produce invaluable insight into the alignment of a population (trans youth) and a profession (clinical social work). Understanding the clinical climate in the Bay in this way has the potential to illustrate a sore gap in clinical care, or to highlight a successful model of care. Either result—or likely somewhere in between—will help distill and create systems of clinical services that most successfully benefit the target populations, while simultaneously supplying providers with clarity and direction in their work.

## **Confidentiality**

This study is anonymous. We will not be collecting or retaining any information about your identity.

## **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. You may refuse or withdraw without affecting your relationship with the researchers 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 by leaving the survey uncompleted. If you choose to withdraw, I will not use any of your information collected for this study. If you choose to withdraw before completing the survey, your incomplete survey will be discarded. Please note: it will be impossible to withdraw once you have completed the survey, as your answers will be anonymous and thus I will not be able to identify and remove your answers.

## **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, Lark Endean Nierenberg at [lnierenberg@smith.edu](mailto:lnierenberg@smith.edu) or by telephone at (xxx) xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. 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.



## TRANSFIGURED TREATMENT

### Consent

By clicking on the “I Consent to Participate” button below, you indicate that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

**Please print or save a copy of this consent form.** A copy of this anonymous digital signing will also be retained with your survey responses.

.....

*[Survey will have an “I Consent to Participate” button that must be clicked in order to continue to the survey. The consent will not require participant’s name, so as to keep the data anonymous. Each completed survey will include the initial consent form/screen, so as to ensure each participant clicked through the form and willfully completed the survey.]*

## TRANSFIGURED TREATMENT

### Attachment F: Survey Instrument

#### Demographics

1. How old are you? (drop-down menu: 18, 19, ...)
2. Do you live in the Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and/or Sonoma County) now? (Y/N)
3. Did you live in the Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and/or Sonoma County) at some point between the ages of 12 and 24? (Y/N)
4. Please select your race and/or ethnicity from the following list and/or complete the write-in option; select all that apply:
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Hispanic or Latin@
  - Native Hawaiian or Other Pacific Islander
  - White
  - Don't Know
  - [Write-In]
5. Please select your gender identity from the following list and/or complete the write-in option; select all that apply:
  - Aggressive/AG
  - Agender
  - Butch
  - Cisgender
  - Cisman
  - Ciswoman
  - Femme
  - FTM/F2M
  - Gender Diverse
  - Gender Fluid
  - Gender Non-Conforming

## TRANSFIGURED TREATMENT

- Genderqueer
  - Intergender
  - Man
  - MTF/M2F
  - Pangender
  - Queer
  - Transgender
  - Transman
  - Transwoman
  - Transsexual
  - Two-Spirit
  - Woman
  - [Write-In]
6. This survey uses the National Center for Transgender Equality’s definition of transgender: “A term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth.” Do you identify as transgender today? (Y/N)
7. Did you identify as transgender at some point between the ages of 12 and 24? (Y/N)
8. Are you employed? (Y/N)
9. Annual household income; select one:
- ≤ \$11,770
  - \$11,770 - \$15,930
  - \$15,930 – \$20,090
  - \$20,090 - \$24,250
  - \$24,250 - \$28,410
  - \$28,410 - \$32,570
  - \$32,570 - \$36,730
  - \$36-730 - \$40,890
  - \$40,890 - \$75,000
  - \$75,000 - \$100,000
  - \$100,000 - \$150,000

## TRANSFIGURED TREATMENT

- \$150,000 - \$200,000
  - ≥ \$200,000
10. How many people live in your household? (1, 2, ...)
  11. What kind of home do you live in? (House, condo, apartment, hotel, shelter, car, [write-in])
  12. Do you rent your home? (Y/N)
  13. Do you own your home? (Y/N)
  14. Do you have health insurance? Select all that apply:
    - Public Health Insurance
    - Private Health Insurance
  15. Do you have dental insurance? Select all that apply:
    - Public Health Insurance
    - Private Health Insurance
  16. Are you religiously or spiritually affiliated? (Y/N)
    - If yes, with which denomination? [Write-In]

### Survey Fork:

*Please select one:*

- I have/had a transgender identity between the ages of 12 and 24 (*will send respondents down one track of the survey*)

*or*

- I am a provider offering transgender-specific services (*will send respondents down a different track of the survey*)

### Trans Participants:

1. Have you ever received clinical social work services? (Y/N)
  - If Yes, select all that apply:
    - Individual therapy
    - Group therapy
    - Family therapy
    - Psycho-Education

## TRANSFIGURED TREATMENT

- Care-coordination with the medical system
- Care-coordination with the legal system
- Care-coordination with the criminal justice system
- Care-coordination with the education system
- Housing support
- Insurance support
- [Write-In]

2. *For each type of service selected above, following survey pages will ask:*

- When were the services obtained? (two year options to create a range – e.g., 2005-2008)
- How frequent were the services? (1x, bi weekly, weekly, monthly, annually, [write-in])
- Where were the services provided? (SF, East Bay, Marin, South Bay, [write-in])
- Why were services sought? (crisis, diagnosis, long-term support, court-mandated, [write-in]); write-in additional comments.
- Who referred you? (Parent, self, doctor, court, mentor, teacher, sibling, friend, [write-in])
- While you received this service:
  - Did you feel safe with your provider? (Y/N; [write-in])
  - Did you feel your provider was trustworthy? (Y/N; [write-in])
  - Did your provider connect you with other for peer support? (Y/N; [write-in])
  - Did you feel a sense of collaboration with your provider in determining the goals of care? (Y/N; [write-in])
  - Did you feel empowered to express your own opinions and choices? (Y/N; [write-in])
  - Did your provider respect your gender? (Y/N; [write-in])
  - Did you believe your provider had a useful working knowledge of the way your gender(s) interacts with your other identities and experiences? (Y/N; [write-in])

## TRANSFIGURED TREATMENT

- Did you believe your provider had a useful working knowledge of the way stigma, discrimination, and violence affect your overall health? (Y/N; [write-in])
- Did your provider interact with your family (of origin or chosen)? (Y/N; [write-in])
- Did your provider use language that was both affirming and clinically-informed? (Y/N; [write-in])
- Do you believe this service was transgender-affirming? (Y/N; [write-in])
- Did you experience any of the following hurdles to accessing the care desired?  
Select all that apply:
  - Cost of services
  - Insurance coverage conflicts
  - Location of services
  - Lack of knowledge about services on your behalf
  - Lack of knowledge about needs on provider's behalf
  - Structural barriers such as racism, transphobia, sexism, classism, ableism
  - Stigma from family
  - Stigma from teachers
  - Stigma from other type of provider
  - Stigma from friends
  - Stigma from self
  - [write-in]
- What was your overall satisfaction with the service while you were receiving it? 1 is not all satisfied; 5 is extremely satisfied. (Likert, 1-5)
- What is your overall satisfaction with the service now, in retrospect? 1 is not all satisfied; 5 is extremely satisfied. (Likert, 1-5)
- Is there anything else you would like to share about accessing and/or receiving this service? [write-in]

*After all service-specific questions and pages have been completed, the following question will appear*

## TRANSFIGURED TREATMENT

- What services do you hope are available for transgender youth growing up today?

Check all that apply:

- Individual therapy
- Group therapy
- Family therapy
- Psycho-Education
- Care-coordination with the medical system
- Care-coordination with the legal system
- Care-coordination with the criminal justice system
- Care-coordination with the education system
- Housing support
- Insurance support
- [Write-In]

*On a final page after this groups' survey questions:*

Thank you for completing the survey component of “Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area.”

Your responses are much appreciated and thoroughly valued!

If you have become triggered or upset due the research material just encountered, please contact any of the following local agencies for further support:

- Berkeley Free Clinic: worker collective providing no-cost, limited medical and mental healthcare  
2339 Durant Avenue, Berkeley, CA 94704  
(510) 548-2570 or (800) 6-CLINIC  
Berkeleyfreeclinic.org
- St. James Infirmary: medical and mental healthcare by-and-for people with experiences in the sex trades  
1372 Mission St, San Francisco, CA 94103  
(415) 554-8494  
Stjamesinfirmary.org
- Tom Waddell Transgender Clinic: San Francisco Department of Public Health multi-disciplinary mental and medical healthcare provided to anyone who identifies as transgender  
230 Golden Gate Avenue

## TRANSFIGURED TREATMENT

(415) 355-7400

<https://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransgenderHlthCtr.asp>

- Trans Lifeline: national hotline by-and-for transgender people to respond to the needs of our community  
(877) 565-8860  
Translifeline.org

Thank you again for your participation!

*If the participant has not received any clinical social work services, the following questions will appear:*

- Between the ages of 12-24, were you interested in obtaining services, but did not receive them? (Y/N)
  - If Yes, which services were you interested in obtaining? Check all that apply.
    - Individual therapy
    - Group therapy
    - Family therapy
    - Psycho-Education
    - Care-coordination with the medical system
    - Care-coordination with the legal system
    - Care-coordination with the criminal justice system
    - Care-coordination with the education system
    - Housing support
    - Insurance support
    - [Write-In]
  - If Yes, why were the services not obtained? Check all that apply:
    - The services I desired were not actually offered
    - I didn't know how to find the service
    - Cost
    - Insurance coverage conflict



## TRANSFIGURED TREATMENT

- Location of service
  - Structural barriers such as racism, transphobia, sexism, classism, ableism
  - Stigma from family
  - Stigma from teachers
  - Stigma from other type of provider
  - Stigma from friends
  - Stigma from self
  - [Write-In]
- What services do you hope are available for transgender youth growing up today? Check all that apply:
    - Individual therapy
    - Group therapy
    - Family therapy
    - Psycho-Education
    - Care-coordination with the medical system
    - Care-coordination with the legal system
    - Care-coordination with the criminal justice system
    - Care-coordination with the education system
    - Housing support
    - Insurance support
    - [write-in]

Is there anything else you would like to share about not accessing and/or receiving clinical social work services as a youth? [write-in]

*On a final page after this groups' survey questions:*

Thank you for completing the survey component of “Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area.”

Your responses are much appreciated and thoroughly valued!

## TRANSFIGURED TREATMENT

If you have become triggered or upset due the research material just encountered, please contact any of the following local agencies for further support:

- Berkeley Free Clinic: worker collective providing no-cost, limited medical and mental healthcare  
2339 Durant Avenue, Berkeley, CA 94704  
(510) 548-2570 or (800) 6-CLINIC  
Berkeleyfreeclinic.org
- St. James Infirmary: medical and mental healthcare by-and-for people with experiences in the sex trades  
1372 Mission St, San Francisco, CA 94103  
(415) 554-8494  
Stjamesinfirmary.org
- Tom Waddell Transgender Clinic: San Francisco Department of Public Health multi-disciplinary mental and medical healthcare provided to anyone who identifies as transgender  
230 Golden Gate Avenue  
(415) 355-7400  
<https://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransgenderHlthCtr.asp>
- Trans Lifeline: national hotline by-and-for transgender people to respond to the needs of our community  
(877) 565-8860  
Translifeline.org

Thank you again for your participation!

### Provider Participants:

- Which of the following services do you provide for transgender youth? Select all that apply.
  - Individual therapy
  - Group therapy
  - Family therapy
  - Psycho-Education
  - Care-coordination with the medical system
  - Care-coordination with the legal system

## TRANSFIGURED TREATMENT

- Care-coordination with the criminal justice system
- Care-coordination with the education system
- Housing support
- Insurance support
- [Write-In]

*For all services selected, the following questions will appear:*

- Is it a focus of your clinical work providing [X] service to:
  - Enhance your client’s sense of safety? (Y/N; [write-in])
  - Maintain trust in the clinical relationship? (Y/N; [write-in])
  - Connect your client to peer support? (Y/N; [write-in])
  - Collaborate with your client while developing goals of care? (Y/N; [write-in])
  - Empower your client to express their own opinions and choices? (Y/N; [write-in])
  - Respect your client’s gender? (Y/N; [write-in])
  - Employ a working knowledge of the way your client’s gender(s) interacts with their other identities and experiences? (Y/N; [write-in])
  - Employ a working knowledge of the way stigma, discrimination, and violence affect your client’s overall health? (Y/N; [write-in])
  - Interact with your client’s family (of origin or chosen)? (Y/N; [write-in])
  - Use language that is clinically-informed and client-affirming? (Y/N; [write-in])
- Do you consider yourself a “gender specialist”? (Y/N; [write-in])
  - *If Yes:* What are the specific clinical guidelines or protocols you follow in order to practice as a gender specialist? [write-in]
  - *If Yes:* What specific training have you received in order to practice as a gender specialist? [write-in]
  - *If Yes:* What professional support is available for gender specialists (e.g., professional peer networks, professional trainings, gender- and oppression-specific supervision)? [write-in]

## TRANSFIGURED TREATMENT

- In your professional opinion, how needed are the following services for transgender youth (ages 12-24) in the Bay Area? (1 is not needed; 5 is most needed)
  - Individual therapy (Likert)
  - Group therapy (Likert)
  - Family therapy (Likert)
  - Psycho-Education (Likert)
  - Care-coordination with the medical system (Likert)
  - Care-coordination with the legal system (Likert)
  - Care-coordination with the criminal justice system (Likert)
  - Care-coordination with the education system (Likert)
  - Housing support (Likert)
  - Insurance support (Likert)
  - [write-in] (Likert)
- How have you learned that the aforementioned services are those that are most needed for transgender youth? Select all that apply:
  - Client demand
  - Parent report
  - Clinical Research
  - Client satisfaction report
  - Personal belief
  - [write-in]
- Which services do you most frequently provide for transgender youth? (1 is never provided; 5 is regularly provided)
  - Individual therapy (Likert)
  - Group therapy (Likert)
  - Family therapy (Likert)
  - Psycho-Education (Likert)
  - Care-coordination with the medical system (Likert)
  - Care-coordination with the legal system (Likert)
  - Care-coordination with the criminal justice system (Likert)
  - Care-coordination with the education system (Likert)

## TRANSFIGURED TREATMENT

- Housing support (Likert)
- Insurance support (Likert)
- [write-in] (Likert)
- Why are the aforementioned services those that are *most* frequently provided? Check all that apply:
  - Insurance coverage
  - Time constraints
  - Clinical research indications
  - Licensed scope of practice
  - Client request
  - Parent request
  - Personal belief
  - Client demand
  - [write-in] (Likert)
- Why are the aforementioned services those that are *least* frequently provided? Check all that apply:
  - Insurance coverage
  - Time constraints
  - Clinical research indications
  - Licensed scope of practice
  - Client request
  - Parent request
  - Personal belief
  - Client demand
  - [write-in]
- Is there anything else you would like to share about providing services to transgender youth in the Bay Area? [write-in]

*On a final page after this groups' survey questions:*

Thank you for completing the survey component of “Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area.”

## TRANSFIGURED TREATMENT

Your responses are much appreciated and thoroughly valued!

If you have become triggered or upset due the research material just encountered, please contact any of the following local agencies for further support:

- Berkeley Free Clinic: worker collective providing no-cost, limited medical and mental healthcare  
2339 Durant Avenue, Berkeley, CA 94704  
(510) 548-2570 or (800) 6-CLINIC  
Berkeleyfreeclinic.org
- St. James Infirmary: medical and mental healthcare by-and-for people with experiences in the sex trades  
1372 Mission St, San Francisco, CA 94103  
(415) 554-8494  
Stjamesinfirmary.org
- Tom Waddell Transgender Clinic: San Francisco Department of Public Health multi-disciplinary mental and medical healthcare provided to anyone who identifies as transgender  
230 Golden Gate Avenue  
(415) 355-7400  
<https://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransgenderHlthCtr.asp>
- Trans Lifeline: national hotline by-and-for transgender people to respond to the needs of our community  
(877) 565-8860  
Translifeline.org

Thank you again for your participation!

Appendix B

2015-2016  
RESEARCH PROJECT PROTOCOL CHANGE FORM  
Smith College School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

**Transfigured Treatment: A Comparative Social Work Needs and Specialized Services Assessment of Transgender Youth and Gender-Specialist Providers in the Bay Area**

**Researcher: Lark Endean Nierenberg**

**Research Advisor: Diana Fuery**

.....  
Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. Two organizations which were initially approved for recruitment contact (Trans Thrive at Asian & Pacific Islander Wellness Center and San Francisco AIDS Foundation) have invited me to recruit participants in-clinic *this week on Tuesday and Wednesday*. Procedurally, I would meet potential participants in the common space of the clinics before and after evening support groups. Many of these potential participants do not have access to the Internet. I would thus offer recruitment flyers (previously approved), as well as my personal laptop on which participants may complete the brief survey. The survey, consent process, and risks inherent in the study have not changed. The only change is that I would recruit in-person, as invited to do so, and would offer a technological device on which participants may complete the survey.

- .....
- I understand that these proposed changes in protocol will be reviewed by the Committee.
  - I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
  - I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

**Signature of Researcher:** \_\_\_\_\_ 

**Name of Researcher (PLEASE PRINT):** Lark Endean Nierenberg **Date:** April 2, 2016

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at [LWyman@smith.edu](mailto:LWyman@smith.edu) or to Lilly Hall Room 115.

\*\*\*Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.