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FIX SOCIETY, PLEASE: THREE PAPERS ON THE MENTAL HEALTH TREATMENT, SOCIAL SUPPORT RESOURCES, AND SUICIDOLOGY OF TRANSGENDER AND GENDER DIVERSE ADULTS

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DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Social Work at the University of Kentucky

By
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ABSTRACT OF DISSERTATION

FIX SOCIETY, PLEASE: THREE PAPERS ON THE MENTAL HEALTH TREATMENT, SOCIAL SUPPORT RESOURCES, AND SUICIDOLOGY OF TRANSGENDER AND GENDER DIVERSE ADULTS

Despite their frequent utilization of mental health resources, transgender and gender diverse (TGD) adults are more likely than their cisgender counterparts to attempt suicide. While this phenomenon may inspire a myriad of explanations, the present dissertation is interested in two exploratory ideas: namely, that 1) mental health professionals may be failing their TGD clients, and 2) traditional mental health paradigms may be myopically inadequate. Paper 1 addresses the first issue by considering TGD experiences of active discrimination by mental health professionals. In addition to investigating the prevalence of abuse, this paper analyzes how intersectionality of oppression plays a role in mental health discrimination. Results suggest that age, income, race/ethnicity, gender identity, and sexual orientation are significant predictors of discrimination, and certain populations (people of color, non-binary individuals, and those living in poverty) are particularly vulnerable to abuse. Paper 2, a content analysis, builds on the quantitative foundation of Paper 1, establishing themes associated with TGD-inclusive mental healthcare. Here, more direct links between ineffective providers and suicide attempts are realized. Competent providers are identified by their helpfulness, trustworthiness, and understanding of TGD issues, while incompetent providers inflate their expertise, conflate TGD experiences with LGB experiences, and manipulate their clients. Finally, Paper 3 introduces an alternative to pathologizing mental health paradigms: a model that pinpoints protective social support mechanisms. Regression results reveal that community support, acquaintance support, and family support, along with race, age, and income, are predictive of not attempting suicide. All three papers draw from one of the most expansive (N= 4,467) mental health surveys of TGD Adults: the 2017 Trans Mental Health Survey. Ultimately, the cumulative purpose of these papers is to inform mental health providers about iatrogenic and ameliorative practices involved in working with TGD clients. These papers also highlight the protective quality of social support: the significance of which must not be ignored in TGD suicide research or in clinical practice.

KEYWORDS: Transgender and gender diverse, social support, inclusive mental healthcare, mental healthcare discrimination, suicide attempts

Annie Snow

January 23, 2020

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Dr. Julie Cerel
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January 23, 2020
Date

DEDICATION

This dissertation is dedicated to the abbreviated life of Leelah Alcorn and her enduring dictate to fix society. This dissertation is also dedicated to my loving and supportive partner, Matthew, and my younger, suicidal self: thank you for persisting and for giving me the opportunity to actualize a few of my dreams.

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I am immensely grateful for my advisor, Dr. Julie Cerel, and her expertise, encouragement, and guidance. I am also indebted to Dr. Christopher Flaherty for his statistical prowess and Dr. Laura Frey for her instruction regarding content analysis. Additionally, I would like to thank the remaining members of my dissertation committee, Dr. Diane Loeffler, Dr. Christina Studts, and Dr. Sharon Rostosky, for their commitment to my academic growth. Last but not least, I want to acknowledge the dedicated staff at Trans Lifeline and the LGBTQ+ Task Force, and all the respondents who took the time to complete the Trans Mental Health Survey: their responses made this dissertation possible.

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Chapter 1: Introduction

On December 28, 2014, Leelah Alcorn, a transgender teenager, died by suicide. Immediately before her death, Alcorn posted the following message on her Tumblr blog: "My death needs to be counted in the number of transgender people who commit [*sic*] suicide this year. I want someone to look at that number and say 'that's fucked up' and fix it. Fix society. Please." (Merlan, 2014, para. 10). Years later, trans and gender diverse (TGD) individuals continue to face inimical social environments and elevated suicide rates: contemporary research suggests that TGD individuals attempt suicide at a rate of 41% compared to 5% of the general U.S. population (Williams, 2017; Haas, Rodgers, & Herman, 2014). TGD adults also report a higher lifetime prevalence of depression (44.0 %), anxiety (33.2%), and overall psychological difficulty (40.1%) (Bockting et al., 2013).

Despite the desideratum for quality psychological interventions, recent studies posit that incompetent therapists present a salient and ubiquitous barrier to TGD mental healthcare (Snow, Cerel, Loeffler, & Flaherty, 2019). The mental health community is further marred by the historical pathologizing of transgender identities (Ansara & Hegarty, 2012; Davy & Toze, 2018). Illustratively, "gender identity disorder" was only recently recategorized as "gender dysphoria" in the latest iteration of the Diagnostic Statistical Manual (DSM-V) (American Psychiatric Association, 2013). Beyond the iatrogenic effects of incompetent counseling, a few scholars have surmised that relying on disease-based models to elucidate TGD suicidality is facile and potentially transphobic (Ansara & Hegarty, 2012; Davy & Toze, 2018). Instead, one must also consider the noxious externalities of prejudice, gender-based violence, discriminatory

policies, familial rejection, and lack of social support. In other words, one must endeavor to "fix society" in order to fully address TGD suicides.

Background

Emerging research on TGD suicidology tends to eschew myopic disease-based models in favor of idiographic and sociological ratiocinations. Several studies emphasize the role of minority stress—a theory that explicates how marginalization and discrimination can lead to psychological distress (Meyer, 2003). More recently, Testa et al. (2015) developed a Gender Minority Stress and Resilience Measure (GMSR) which accounts for trans-specific stressors including external stimuli (gender-based victimization, rejection, discrimination, nonaffirmation of gender identity) and internal agitators (internalized transphobia, negative expectations for future events, nondisclosure). Testa et al. (2017) have also pioneered a working theory of TGD suicidality by combining GMSR with Thomas Joiner's (2005) interpersonal-psychological theory of suicide (IPTS).

IPTS is preeminent within the field of suicidology, eclipsing both clinical (Mann, Waternaux, Haas, & Malone, 1999) and cognitive (Wenzel & Beck, 2008) models of suicide. The theory suggests that failed belonginess and perceived burdensomeness, coupled with an acquired capability for self-harm, elevates suicidal risk (Joiner, 2005). Failed belongingness is defined broadly as social alienation, and perceived burdensomeness is characterized by intense feelings of worthlessness and self-hatred (Joiner, Van Orden, Witte, & Rudd, 2009). According to Joiner (2005), these two factors alone are insufficient catalyzers: one must also have an acquired capacity to self-injure.

Testa et al. (2017) argue that IPTS, with its emphasis on external (failed belongingness) and internal (perceived burdensomeness) stimuli, cumulates seamlessly with GMSR. In a recent study, Testa et al. (2017) introduce two mediation models: the first suggests that external gender minority stressors will lead to internal gender minority stressors, which will in turn result in increased suicidal ideation (SI). The second model proposes that internal gender minority stressors and SI are mediated by increases in IPTS factors (Testa et al., 2017). Pathway analysis revealed an "adequate" fit for the first model, and a post hoc test indicated variability across MTF (male to female) and FTM (female to male) groups and the direct relationships between external and internal stressors (Testa et al., 2017, p. 133). The fit for Model 2 was less ambiguous, although the authors of the study acknowledge its incompleteness.

In addition to these fledgling risk models, scholars have also posited that social support is paramount to suicidal resilience in TGD individuals. Within the theoretical framework of IPTS, social support serves to extenuate feelings of failed belongness (Joiner, 2005). On the surface, there appears to be empirical encouragement for this model: social support has long been recognized as protective factor in the general population (Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Gutierrez & Osman, 2008; Rutter et al., 2008), and burgeoning research suggests that it is a negative predictor of suicidal ideation and attempts for trans and gender diverse adults (Moody & Smith, 2013). Among the general population, studies indicate that social support is both proximally and distally related to lower instances of suicidality, serving as a direct protective factor and an auxiliary to other protective factors like self-esteem (Chioqueta & Stiles, 2007; Kleiman, Riskind, Schaefer, & Weingarden, 2012).

If social support mitigates feelings of failed belongness; ostensibly, mental health care attenuates the subjective perception of burdensomeness. However, nascent research suggests that for the TGD community, mental health interventions may do more harm than good. A recent systematic review revealed that TGD mental health consumers receive suboptimal care in the form of unknowledgeable, unnuanced, and unsupportive providers (Snow, Cerel, Loeffler, & Flaherty, 2019). Far from extirpating the deadly duo of burdensomeness and failed belongingness, it is possible that some mental health professionals exacerbate the very conditions they are trying to help mollify.

While TGD suicidology is growing both theoretically and methodologically, most studies are small, ungeneralizable, and occasionally specious. Few address suicide prevention (Moody & Smith, 2013). Consequently, there is an exigent need for robust research that prioritizes the lived experiences of TGD individuals, incorporates sophisticated data analysis, and produces wide-reaching results. What follows is an agenda to address these needs.

Research Agenda

This dissertation builds upon previously articulated themes surrounding TGD suicidology, drawing from one of the largest mental health surveys of TGD adults (N=4,467). The survey, conducted in 2017 by Trans Lifeline and The National LGBTQ Task Force, yields vital insights into a susceptible and relatively understudied population. The current three-paper dissertation adopts a transformative research lens which centralizes the experiences of marginalized communities and extrapolates power imbalances that exacerbate vulnerabilities (Jackson et al., 2018). In keeping with this

transformative aim, the following studies connect research outcomes to concrete actions intended to help "fix society."

The first paper, entitled *Mental Health Care and Active Discrimination in Transgender and Gender Diverse Populations,* is a compendious (N=3,267) study of participants' experiences with abusive mental health providers. This paper adds to existing, abecedarian research on the subject by considering the role of intersectionality (Bowleg, 2012). While scholars have suggested that TGD clients are at a higher risk for mental health discrimination (denial of service, harassment, misgendering, and assault), less is known about the confluence of TGD identities and how particular demographic factors lead to increased therapeutic jeopardy (Bell & Purkey, 2019; Shires & Jaffee, 2015). Importantly, this research pinpoints vulnerable TGD populations while exposing transphobic practices within the mental health field—practices that may result in adverse, and even suicidal, outcomes.

The second paper, entitled *A Safe Bet? Transgender and Gender Diverse Experiences with Inclusive Therapists* considers participants' (N=1,576) response to the following open-ended question: "Is there anything you would like to add about your experience with therapy?" Content analysis uncovered a previously unpublished facet of TGD mental health care: the quality of "affirming" treatment. While existing content analysis has historically relied upon small sample sizes, the present dataset affords a unique opportunity to assume a robust and often overlooked viewpoint in TGD mental health research: the perspective of those with lived experience (Grossoehme, 2014). Research results elucidate both helpful and harmful therapeutic practices, providing vital

information for mental health professionals who must endeavor to provide inclusive, life-giving care.

The final paper, entitled *Social Support and Suicidology in Transgender and Gender Diverse Adults,* addresses another neglected issue within TGD suicidology: suicide prevention. Prior to this dissertation, few studies involving social support, suicide, and TGD participants have been large enough to employ advanced statistical methods. The third paper accomplishes this objective, identifying protective social support networks so that therapists and community leaders can devise plans to facilitate these relationships. Notably, this paper highlights the experiences of suicide attempters instead of ideators. This distinction is strategic, for while most studies focus on suicidal ideation, only one-third of those who seriously contemplate suicide attempt to end their life (Nock et al., 2008). Thus, the results of this paper are more directly applicable to understanding suicidal behavior and the impact of social support in TGD adults.

Definition of Terms

Suicidology is the scientific study of suicide. The term was coined by American clinical psychologist Edwin S. Shneidman.

Suicidality refers to suicidal thoughts, plans, and attempts.

Transgender is an umbrella term which includes individuals whose assigned sex at birth does not reflect their gender identity. Transgender individuals may identify as male, female, both, neither, non-binary, or as a different gender entirely. Gender identity may be fixed or fluid; some transgender individuals elect to have gender-affirming surgery and others do not.

Gender Diverse refers to individuals whose gender presentation does not conform to traditional societal expectations.

Cisgender refers to individuals whose assigned sex at birth corresponds with their gender identity.

Social support refers to the emotional and physical help accessible to those with individual and community relationships.

Transformative research is a strategy designed to improve the lives of marginalized individuals through the dissemination of praxis-focus information.

Conceptual Framework

Suicidality, Social Support, and Existentialism

Before suicidality was medicalized, it was an ancient topic of philosophical debate. "To be or not to be" was indeed the question: the only question, according to Albert Camus (1955), that truly mattered. Existentialists were especially preoccupied with suicide given their ethos that life is objectively meaningless (Stillion & McDowell, 1996). The pursuit of an authentic existence—creating meaning where there is none—became the defining feature of this particular school of thought. According to Martin Heidegger (1962), only when individuals face their own mortality and *uneigentlichkeit* (inauthenticity) can they begin to embrace their true self and accept their unique connection to the rest of society. In so doing, individuals avoid the sense of burdensomeness and failed belonginess characteristic of modern suicidal behavior.

When coupling Heidegger's philosophy with a sociological framework, it becomes clear why suicide may appear viable to TGD individuals. Pain and suffering aside, failure to achieve internal or external *eigentlichkeit* can result in extreme emotional

and social discomfort. Emile Durkheim (1951), in his seminal book on suicide, categorized the phenomenon into four types: 1) egoistic suicide 2) altruistic suicide 3) anomic suicide and 4) fatalistic suicide. According to Durkheim (2013), egoist suicides are the result of "excessive individualization," or a person's inability to assimilate into a particular environment. One can imagine, from an existentialist perspective, the plight of an individual attempting to achieve authenticity while being rejected by the rest of society. A transgender individual, for example, who is attempting to authentically live out their gender reality may very well be ostracized and abused by their family and their community. Suicide, in this case, far from being the result of an acute mental illness, is perhaps better described as an individual acting upon environmental and existential inducements. Within this paradigm, social support may act as a buffer for suicidal behavior and an indicator of *eigentlichkeit* achieved.

Mental Health and Poststructuralism

Whatever the source of their distress, TGD adults often seek professional mental health care for their depression, anxiety, and suicidal thoughts. In the present study, 88.7% (N=3267) of the respondents reported that they had seen a therapist at some point in their life and 84.6% (N=3592) had been diagnosed with a mental disorder. The latter figure is particularly alarming given the mental health community's checkered past.

In *History of Madness*, Michel Foucault (1965) recounts the advent of modern mental healthcare. During the Age of Reason, European society attempted to contain the undesirables or presumed "madmen" of the village in an effort to cure them of their idiosyncrasies. There were no empirical criteria to distinguish the mad from the unmad; instead, diagnoses were constructed using subjective, culturally defined standards.

Imprisoned and discarded, the "mad" had no say over their identity or their fate (Foucault, 1965).

During the nineteenth century, the dialogic of madness was a monologue largely promulgated by professed scientific experts. In 1851, Dr. Samuel Cartwright published an article in the well-respected *The New Orleans Medical and Surgical Journal* identifying two new mental health disorders*: Drapetomania*, an illness that caused black slaves to flee, and *Dysaethesia Aethiopica,* another mental disorder which caused slaves to exhibit a poor work ethic (Cartwright, 1851). During this time, women were also branded with the sex-specific label of *Hysteria*. Within this milieu, misogyny and racism masqueraded as science; any discursive contribution from the marginalized would have been dismissed outright as capricious and nonsensical (Ehrenreich & English, 1989).

According to some critics, mental health experts continue to silence and oppress the "other" while monopolizing the dialogue around mental health. Thomas Szasz, an iconoclast of the psychiatric community, has written prolifically about this subject, suggesting that the current mental health lexicon is an oppressive mischaracterization of the phenomenon. Szasz takes a positivist view by arguing that mental illnesses, unlike physical illnesses, cannot be scientifically tested or measured, nor can their pathologies be distinguished at the molecular level. As such, the term "mental illness" is philosophically errant, a category mistake (Szasz, 2011). Ironically, the voices of those who have been diagnosed with a mental health disorder are often lost within this debate.

Poststructuralism, with its focus on the mediumistic construct of language, offers a solution to this dilemma. Within this paradigm, truth-setters claim authority over certain scientific realities and certain social relationships (doctor/patient, teacher/student). The

truths established within these discursive fields operate as first premises—assumed and uncontested axioms. According to Foucault, these first premises are so readily accepted, that those who would seek to question them are effectively "marginalized and silenced" (Scott, 1988). Despite these risks, the work of poststructuralists includes challenging and deconstructing these false premises, many of which are presented as opposing binaries: man versus woman, difference versus quality, and madness versus sanity. Poststructuralism ultimately helps to facilitate a new and more inclusive discourse—one in which binaries are obliterated, and the tyranny of the "experts" is overthrown.

Conclusion

TGD adults are attempting suicide at alarming rates, despite their utilization of mental health services. This incongruity demands a critical analysis of mental health practices and the ways in which therapists are failing to meet the needs of their clients. In the absence of social support networks, mental health professionals may help fill a momentous gap in helping their clients realize a sense of belonginess and societal contribution. Similarly, strong social support systems may be a tenable substitute for professional care. Rather than relying upon pathologizing frameworks and positivist methodologies, the three papers comprising this dissertation seek to create a more inclusive discourse that privileges the existential experiences of TGD adults. This poststructuralist perspective allows for the transformative interpretation of data so that scholars, practitioners, and lay people alike can "help fix society."

Chapter 2: Mental Healthcare and Active Discrimination
in Trans and Gender Diverse Populations

Introduction

When confronted by life's troubles and associated malaise, many individuals turn to mental health professionals (MHPs) for succor and advice. According to one study, 42% of U.S. adults have seen a counselor at some point in their lives, while an additional 32% are amenable to the idea ("Americans Feel Good About Counseling," 2018). Ostensibly, MHPs are trustworthy and equipped to empathize with the most vulnerable of clients. However, emerging research suggests that transgender and gender diverse (TGD) individuals may be victimized by the very people entrusted with their wellbeing (McCann, 2015; McCullough et al., 2017). This abuse resembles the malfeasants committed by physicians and other medical personnel, of which there is no shortage of evidence. TGD adults have been denied medical treatment, verbally harassed, physically assaulted, and misgendered by doctors, nurses, and other clinical staff (Kenagy, 2005; Grant et al., 2011; Lambda Legal, 2010; Shires & Jaffee 2015). According to Lambda Legal (2010), 70% of TGD clients have reported some form of healthcare discrimination, compared to 56% of lesbian, gay, and bisexual (LGB) respondents.

Trans people of color are especially vulnerable to maltreatment, a reality that is perhaps best explained by the theory of intersectionality (Grant et al., 2011; Shires & Jaffee 2015). In short, intersectionality of oppression proposes that those with interlocking, marginalized identities are at increased risk for health disparities, structural inequalities, and systemic violence (Crenshaw, 1995; Bowleg, 2012). Tragically, this theory is actualized in the current rash of transphobic killings: in 2018, at least twenty-six

TGD individuals were murdered in the U.S., the majority of whom were Black trans women (Violence against the transgender community in 2018, n.d.).

In addition to race and ethnicity, other marginalized identities place TGD clients at increased risk for discrimination. According to Shires & Jaffee (2015), female-to-male (FTM) transgender clients who identify as queer are more likely to be mistreated by medical personnel, while older, wealthier TGD clients are less likely to be abused. Further studies propose a correlation between healthcare discrimination and masculine-presenting identities, Latinx persons, African Americans, the unemployed, sex workers, undocumented persons, and younger TGD adults (Kattari & Hasche, 2015; Grant et al., 2011).

The Present Study

Existing mental health literature reveals that MHPs have misgendered and verbally harassed their TGD clients, but less is known about TGD encounters with physically violent practitioners (McCann, 2015; McCullough et al., 2017). There is also scant evidence to suggest that TGD adults have been denied therapeutic services (Grant et al., 2011). The current study seeks to address these gaps in knowledge by focusing on four vehicles of active discrimination identified by Bell and Purkey (2019) and Shires and Jaffee (2015): harassment, assault, misgendering, and denial of service. Here, active discrimination is secerned from passive forms of therapeutic discrimination, which may include binary gender designations on intake forms and a lack of access to gender-inclusive restrooms. The present study also explores the role of intersectionality by investigating demographic correlates, including age, race/ethnicity, income, sexual orientation, and gender identity. Based on available research, the author hypothesizes that

participants belonging to marginalized groups (particularly young, queer, masculine-presenting people of color) will be more likely to experience negative outcomes.

Methods

Data Collection

The current study is a secondary data analysis of the Trans Mental Health Survey (2017), which was disseminated online by the LGBTQ Task Force and Trans Lifeline. Over a period of five months, participants were recruited via TGD listservs and at PRIDE events across the United States. The collection of responses yielded one of the most extensive, cross-sectional datasets of its kind: 4,467 TGD participants completed the 129-item survey. Respondents were not compensated for their participation and consented to share their results. The current secondary analysis met the criteria for exemption set by the University of Kentucky's institutional review board.

Sample Measures

Age. Participants were asked to indicate their birth year. From that data, a continuous variable was created for the participants' age at the time of the survey. For descriptive purposes, a categorical variable was also created using the Pew Research Center's (2019) generational designations: Generation Z, ages 18-20 (n=433, 15.3%); Millennials, ages 21-36 (n=1735, 61.5%); Generation X, ages 37-52 (n=415, 14.7%); Baby Boomers, ages 53-72 (n=234, 8.3%); Silent Generation, ages 72-100 (n=6, 0.2%).

Race/Ethnicity. Participants were asked, "What is your race/ethnicity (Check all that apply)?" Respondents were invited to endorse 29 possible designations, including "Asian," "African American," "Black," "White," "Western European," and "Jewish." These responses were coded into the following discrete categories: African

American/Black (n=36, 1.3%), Caucasian/White (n=1762, 62.4%), Asian/Pacific Islander (n=34, 1.2%), Indigenous (n=12, 0.4%), Latinx/Brown (n=46, 1.6%), and Other (n=933, 33%).

Income. Participants were asked to indicate their gross annual income using a nine-item ordinal scale. To increase statistical power, the first three items were consolidated to form a "low-income" category, which included participants who grossed less than $35,000 a year (n=1,776, 55.4%). The next two items were consolidated to form a "middle-income" category, which included participants who grossed between $35,000-$74,999 annually (n=825, 25.7%). The remaining four items were consolidated form a "high income" category which included participants who grossed over $75,000 a year (n=557, 17.4%).

Gender identity. Participants were asked the following open-ended question: "How would you describe your gender?" Responses included a myriad of unique designations which were subsequently consolidated into the following categories: masculine expressions (n=671, 24%), feminine expressions (n=865, 30.6%), non-binary (n=1,077, 38.2%), transgender unspecified (n=36, 1.3%), and other (n=154, 5.5%). "Masculine expressions" included individuals who indicated that they were FTM (female-to-male), transmasculine, transman, and male, among other designations. "Feminine expressions" included individuals who indicated that they were MTF (male-to-female), transfeminine, transwoman, and female, among other designations. "Non-binary" included individuals who indicated that they were genderqueer, gender-fluid, agender, and non-binary, among other designations. "Transgender unspecified" included responses in which a participant indicated that they were transgender or transsexual but

gave no further description. “Other” included individuals who responded with a shruggie (emoji denoting a shrug) or an otherwise inscrutable designation (e.g., “amazing”). A trans-identified coder helped in the production of these categories.

Sexual orientation. Participants were asked the following open-ended question: “What is your sexual orientation?” Like gender identity, this question solicited a wide-range of responses which were coded as follows: straight unspecified (n=172, 6.1%), gay unspecified (n=692, 24.5%), androphilic (n=38, 1.3%), gynophilic (n=353, 12.5%), bisexual/pansexual (n=1,088, 38.5%), ace umbrella (n=327, 11.6%), and other (n=153, 5.4%). “Straight unspecified” included individuals who indicated that they were heterosexual or straight, among other designations. “Gay unspecified” included individuals who indicated that they were gay or queer among other designations. “Androphilic” included individuals who, through their response, indicated that they were attracted to men or masculine-presenting people. “Gynophilic” included individuals who, through their response, indicated that they were attracted to women or feminine-presenting people. “Ace umbrella” included individuals who indicated that they were asexual or fell somewhere along the ace continuum. Finally, “other” included individuals who indicated that they were questioning, unsure, or otherwise undeterminable (e.g., “It is somewhere between bisexual and lesbian.”). A trans-identified coder helped in the production of these categories.

Active discrimination. Participants were asked, **“**Have you experienced any of the following from any of your therapist(s), past or current, or associated staff because of your

transgender identity? Choose all that apply." Possible responses included: denied equal treatment or service (n=358, 12.7%); verbally harassed or disrespected (n=462, 16.3%); physically attacked or assaulted (n=26, 0.9%); misgendered, or refused to use the correct name and pronouns (n=928, 32.9%); and no, I did not experience these negative outcomes (n=1,725, 61.1%). Among those who experienced discrimination, most encountered one form of abuse (n=722, 59.8%); 264 (21.8%) experienced two forms of active discrimination, 204 (16.9%) experienced three, and 17 (5.8%) encountered all four.

Analytic Procedure

In an effort to identify possible relationships between demographic markers and active discrimination**,** Pearson's chi-square analyses were conducted for each negative outcome: denied equal treatment or service, verbally harassed or disrespected, physically attacked or assaulted, and misgendered, or refused to use the correct name and pronouns. Independent samples t-tests were conducted for the continuous variable, age. These tests for independence supplement a binary logistic regression model that uses a dichotomous variable for negative outcomes: yes/no. This variable was created by combining active discrimination variables with the no active discrimination variable. While the logistic regression analysis provides a general model with significant demographic predictors, the univariate analyses provide a more detailed picture of negative outcomes and their demographic correlates. All data were analyzed using IBM SPSS version 26 software.

Results

Prior to analysis, all variables used were examined for missing data; these missing cases were dropped from both the chi-square the binary logistic regression analyses

(n=1,156). Respondents who endorsed both a negative outcome and "no, I did not experience these negative outcomes," were also eliminated.

Bivariate Analysis

Chi-square tests of independence were performed to examine the relationship between categorical demographic characteristics (income, race/ethnicity, gender identity, and sexual orientation) and active discrimination variables (denied service, harassed, assaulted, and misgendered. Post hoc analyses were conducted by identifying adjusted residuals (z-scores) in the contingency tables that were greater than 1.96. These z-scores were then multiplied by each other to create chi-square values, which were subsequently converted into p-values by using the Sig.ChiSq function in IBM SPSS (Beasley & Schumacker, 1995). To reduce the possibility of Type 1 error, the Bonferroni-adjusted p-value was tabulated for each contingency table. Ultimately, contingency table p-values were used as a baseline for significance when evaluating single-cell p-values. Complete results are displayed in Tables 2.1-2.4. Additionally, independent samples t-tests were conducted for age and active discrimination variables (see Table 2.5).

Denied service. Race/ethnicity was significantly associated with being denied equal treatment or therapeutic services. Specifically, post hoc tests revealed that being coded as an "other" race, X^2 (1, N =1,063) =12.96, p< .001 was positively associated with being denied service. Conversely, being white, X^2 (1, N =1,995) =12.25, p< .001 was negatively associated with being denied service. Income was also associated with being denied service: low-income was positively associated with being denied service, X^2 (1, N =1,776) =7.84, p = .005, while high income was negatively associated with being denied service X^2 (1, N =557) 8.41, p = .004.

Misgendered. Chi-square analyses revealed that being coded as an "other" race/ethnicity, X^2 (1, N =1,063)=21.16, p< .001; being low-income, X^2 (1, N =1776) =14.44, p< .001; identifying as non-binary, X^2 (1, N =1077) =53.29, p<.001, and being gay, X^2 (1, N =812) =20.25, p<.001 were all positively associated with being misgendered. Conversely, being white, X^2 (1, N =1,995) =18.49, p<.001; high income, X^2 (1, N =557)10.24, p = .001; feminine presenting X^2 (1, N =970) =60.84, p< .001; straight, X^2 (1, N =172) =10.24, p< .001; and gynophilic, X^2 (1, N =354) =21.16, p<.001 were all negatively associated with being misgendered. An independent samples t-test for age revealed a significant difference in age for those who were misgendered (M=28.35, SD=10.097, N=1018) compared to those who were not misgendered (M=32.79, SD=13.162, N=2181), t(3197)=9.525, p<.001.

Harassed. While harassment was significantly associated with race/ethnicity and gender identity, post hoc analysis using the Bonferroni-adjusted p-value did not uncover any statistically significant values between groups. However, post hoc analyses did reveal that being low-income X^2 (1, N =1776) =13.69, p< = .001 and being coded as an "other" sexual orientation, X^2 (1, N =172) =9.61, p = .002 were positively associated with harassment. Meanwhile, a high income was negatively associated with being harassed, X^2 (1, N =557) 7.84, p = .005.

Assaulted. Race, gender identity, and sexual orientation were all significantly associated with being attacked or assaulted. However, post hoc analysis using the Bonferroni-adjusted p-value did not uncover any statistically significant values for sexual orientation. Post hoc analysis did reveal that being African American/Black, X^2 (1, N =40) =21.16, p< .001, and being coded as transgender unspecified, X^2 (1, N =40)

=8.41, p= .004 were positively associated with being physically attacked or assaulted. Both Black/African American and transgender unspecified levels contained cells with fewer than five observations; thus, results should be interpreted with caution. Additionally, an independent samples t-test revealed a significant difference in age for those who were assaulted (M=36.26, SD=14.368, N=27) compared to those who were not assaulted (M=31.34, SD=12.418, N=3172), t(3197)=-2.048, p= .041.

Multivariate Analysis

A binary logistic regression model was constructed to determine which demographic characteristics (age, income, race/ethnicity, gender identity, and sexual orientation) are predictors of active discrimination (denied service, harassed, assaulted, and misgendered). Categorical variables were entered into the model using the "categorical covariates" function in IBM SPSS. This function creates dummy variables with a corresponding comparison group: in all instances, "other" served as the baseline category. The analysis was subsequently re-run using the largest category for race (Caucasian/White) as a baseline category. However, just like the original model, only the baseline category and "other" race were statistically significant. Given this replication and the tenuous model fit, no other baseline categories were considered for analysis.

Preliminary analysis of pairwise correlations suggested the presence of negligible multicollinearity among the independent variables that was not detected when observing VIF values. Overall, 1,207 (37.6%) respondents indicated that they experienced active discrimination, while 2,000 (62.4%) did not. Regression results indicated that the overall model fit was questionable (-2 Log likelihood =4023.902) but statistically reliable in distinguishing between active discrimination and not experiencing active discrimination

[X^2 (17) = 121.865, p< = .001]. The model correctly classified only 62.9% of the cases. Thus, while the main model significantly predicted the negative outcome, any further analysis is speculative and potentially specious Regression coefficients are reported in Table 2.6.

Discussion

Unlike medical practitioners, mental health professionals do not swear to the Hippocratic Oath; nevertheless, one may expect them to live up to their "professional" title and the ethical guidelines established by their respective disciplines. Like their medical counterparts, some MHPs cause real harm to TGD clients and engage in discriminatory practices. Active discrimination may include verbal harassment, misgendering, assault, and denial of services (Bell & Purkey, 2019; Shires & Jaffee, 2015).

The present study reveals that 12.7% (n=358) of respondents were denied equal treatment or mental health services, a figure that is consistent with the 2011 National Transgender Discrimination Survey, which reports a refusal frequency of 11% for TGD mental health clients (Grant et al., 2011). Over 16% (n=462) of respondents indicated that they had been verbally harassed or disrespected by a mental health professional or associated staff; this figure is slightly less than the reported 20-25% of TGD adults who were harassed by medical personnel (Lambda Legal, 2010; Grant et al., 2011). Unsurprisingly, less than one percent of the sample (n=26) reported being assaulted by their mental health provider, which is consistent with a prevalence of 2% among TGD medical clients (Seelman et al., 2017; Grant et al., 2011).

Although several studies acknowledge the pervasiveness of misgendering, no arrestive frequencies have been established for TGD experiences with mental health providers (McCullough et al., 2017; Grant et al., 2011). In the current study, over a third of the respondents (n=928) indicated that they had been misgendered by a mental health professional. While on the surface, misgendering may seem comparatively benign, the noxious effects of this recognized microaggression are well-documented and include increased mental health risks: a symptom exacerbated by the very professionals trained to treat it (McLemore, 2018).

The frequencies reported in this study appear to align with published research findings; however, the damage done by mental health professionals is not evenly distributed throughout the population. The theory of intersectionality suggests, and emerging studies confirm that marginalized individuals face increased discrimination from health care providers. The present exploratory study adds to these findings, highlighting subpopulations associated with discriminatory practices. Logistic regression results indicate that age, income, race/ethnicity, sexual orientation and gender identity are significant predictors of active discrimination. Chi-square analyses and independent samples t-tests provide a more intricate explanation of demographic factors and their relationship with adverse outcomes.

As predicted, people of color appear to be at increased risk for active discrimination. Respondents coded as an “other” race/ethnicity were associated with being denied service while African Americans were more likely to be assaulted. Although the latter relationship should be interpreted with caution given the small cell sizes, this result is supported by exigent literature (Grant et al., 2011; Shires & Jaffee

2015). Meanwhile, the variable White/Caucasian was associated with not being denied service or misgendered.

TGD clients coded as "low-income" also appear to be at an increased risk for negative outcomes, including harassment, misgendering, and being denied service. Presumably, individuals living in poverty may be denied service because they do not have insurance or cannot afford to pay out of pocket. However, the association between poverty, harassment, and misgendering is less perspicuous outside of an intersectionality paradigm. Remarkably, over half of the participants in this study grossed under $35,000 a year. While these arbitrary income categories do not delineate household size, current reports indicate that nearly 30% of TGD adults live in poverty (Badgett, Choi, & Wilson, 2019). Given the relationship between financial scarcity and active discrimination, this statistic is particularly alarming.

People of color and those earning less than $35,000 were not the only marginalized identities associated with misgendering. According to the present study, young, gay, and non-binary clients appear more likely to experience this type of discrimination. For non-binary individuals, this phenomenon may be due in part to the underutilization of personal pronouns like they/them and xe/xer. Non-binary individuals also tend to be younger, which may further explicate this particular association (Reisner & Hughto, 2019).

Limitations and Directions for Future Research

This study has several limitations; most involve how survey questions were asked. For instance, the bulky and nebulous "other" categories may be attributed to open-ended or "check all that apply" questions. Additionally, being denied service is a distinct

experience from being denied equal treatment; it would have been helpful to separate these phenomena in the questionnaire. Similarly, it would have been useful to distinguish between the harassment perpetrated by MHPs and the harassment committed by associated staff. Furthermore, the measure for active discrimination may have been incomprehensible to some participants since "no, I did not experience these negative outcomes" was a possible response to the question, **"**Have you experienced any of the following from any of your therapist(s), past or current, or associated staff because of your transgender identity?" While participants who endorsed the "no" option and a negative outcome were eliminated from the survey, these questions directly and indirectly complicate the analysis. One way to address some of these limitations would be to create fewer, larger categories (e.g., white/not white); however, given the intersectional focus of this paper, collapsing marginalized variables appeared either counterproductive or insuperable (e.g., gender identity).

Future research may address some of the deficiencies in this study by using robust and cogent categories. While the present study is representative of most generational cohorts, only seven participants were coded as belonging to the Silent Generation. Older TGD adults tend to be neglected in the literature, despite the fact that more trans and gender diverse adults are transitioning later in life (Bess & Stabb; Witten & Eyler, 2012). Given this oversight and the association between increased age and assault in this study, stratified studies of older TGD adults may be especially useful. In order to further explore the role of intersectionality of oppression, it may also be helpful to investigate potential interactive effects among demographic variables. Ultimately, given the paucity of research in this area, any scholarly contribution would be welcome.

Concluding Thoughts

TGD individuals face discrimination on all fronts: from bathrooms to the battlefield. The last place they should expect abuse is at a healthcare facility or in a therapist's office. Mental health practitioners should evaluate the way they treat their TGD clients, paying particular attention to those with intersecting, marginalized identities. While it may seem expedient to refuse a poor, black trans person, it is likely discriminatory. Similarly, habitually misgendering a non-binary person may be considered abusive. For practitioners committed to providing the best care for their clients, these practices cannot continue.

Table 2.1

Prevalence of Denied Service in TGD Adults

	No		Yes			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2820	88.0	385	12.0	16.31	.006
African American/Black	36	90.0	4	10.0		
Caucasian/White	1787	89.6	208	10.4		
Asian / Pacific Islander	34	82.9	7	17.1		
Indigenous	12	100.0	0	0.0		
Latinx / Brown	47	87.0	7	13.0		
Other	904	85.0	159	15.0		
Income	2278	88.0	380	12.0	10.52	.005
Low Income	1537	86.5	239	13.5		
Middle Income	731	88.6	94	11.4		
High Income	510	91.6	47	8.4		
Gender Identity	2804	88.0	383	12.0	3.13	.537
Transgender Unspecified	32	80.0	8	20.0		
Masculine Expressions	687	87.5	98	12.5		
Feminine Expressions	853	87.9	117	12.1		
Non-Binary	1078	88.7	138	11.3		
Other	154	87.5	22	12.5		
Sexual Orientation	2808	88.0	384	12.0	4.56	.601
Straight Unspecified	176	90.3	19	9.7		
Gay Unspecified	709	87.3	103	12.7		
Androphilic	40	88.9	5	11.1		
Gynophilic	361	88.3	48	11.7		
Bisexual / Pansexual	1047	88.4	137	11.6		
Ace Umbrella	331	88.3	44	11.7		
Other	144	83.7	28	16.3		

Table 2.2

Prevalence of Misgendering in TGD Adults

	No		Yes			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2185	68.2	1020	31.8	21.33	.001
African American/Black	27	67.5	13	32.5		
Caucasian/White	1415	70./9	580	29.1		
Asian / Pacific Islander	28	68.3	13	31.7		
Indigenous	8	66.7	4	33.3		
Latinx / Brown	39	72.2	15	27.8		
Other	668	62.8	395	37.2		
Income	2155	68.0	1003	31.8	16.73	<.001
Low Income	1162	65.4	614	34.6		
Middle Income	581	70.4	244	29.6		
High Income	412	74.0	145	26.0		
Gender Identity	2172	68.0	1015	31.8	74.79	<.001
Transgender Unspecified	26	65.0	14	35.0		
Masculine Expressions	537	68.4	248	31.6		
Feminine Expressions	755	77.8	215	22.2		
Non-Binary	736	60.5	387.3	39.5		
Other	118	67.0	56.1	33.0		
Sexual Orientation	2176	68.0	1016	31.8	43.76	<.001
Straight Unspecified	153	78.5	42	21.5		
Gay Unspecified	502	61.8	310	38.2		
Androphilic	32	71.1	13	28.9		
Gynophilic	319	78.0	90	22.0		
Bisexual / Pansexual	800	67.6	384	32.4		
Ace Umbrella	250	66.7	125	33.3		
Other	120	69.8	52	30.2		

Table 2.3

Prevalence of Harassment in TGD Adults

	No		Yes			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2707	84.5	498	15.5	13.44	.020
African American/Black	36	90.0	4	10.0		
Caucasian/White	1711	85.8	284	14.2		
Asian / Pacific Islander	38	92.7	3	7.3		
Indigenous	9	75.0	3	25.0		
Latinx / Brown	42	77.8	12	22.2		
Other	871	81.9	192	18.1		
Income	2665	84.4	493	15.6	14.95	.005
Low Income	1461	82.3	315	17.7		
Middle Income	712	86.3	113	13.7		
High Income	492	88.3	65	11.7		
Gender Identity	2691	84.4	496	15.6	15.89	.014
Transgender Unspecified	30	75.0	10	25.0		
Masculine Expressions	655	83.4	130	16.6		
Feminine Expressions	844	87.0	126	13.0		
Non-Binary	1021	84.0	195	16.0		
Other	141	80.1	35	19.9		
Sexual Orientation	2696	84.5	496	15.5	10.90	.028
Straight Unspecified	172	88.2	23	11.8		
Gay Unspecified	672	82.8	140	17.2		
Androphilic	39	86.7	6	13.3		
Gynophilic	357	87.3	52	12.7		
Bisexual / Pansexual	1006	85.0	178	15.0		
Ace Umbrella	319	85.1	56	14.9		
Other	131	76.2	41	23.8		

Table 2.4

Prevalence of Assault in TGD Adults

	No		Yes			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	3178	99.2	27	0.8	25.40	<.001
African American/Black	37	92.5	3	7.5		
Caucasian/White	1984	99.4	11	0.6		
Asian / Pacific Islander	41	100	0	0.0		
Indigenous	12	100	0	0.0		
Latinx / Brown	53	98.1	1.9	1.0		
Other	1051	98.9	12	1.1		
Income	3131	99.1	27	0.9	5.90	.052
Low Income	1757	98.9	19	1.1		
Middle Income	1045	99.0	8	1.0		
High Income	329	100	0	0.0		
Gender Identity	3160	99.2	27	0.8	9.84	.043
Transgender Unspecified	38	95.0	2	5.0		
Masculine Expressions	781	99.5	4	1.0		
Feminine Expressions	960	99.0	10	1.0		
Non-Binary	1206	99.2	10	0.8		
Other	175	99.4	1	0.6		
Sexual Orientation	3165	99.2	27	0.8	13.61	.034
Straight Unspecified	195	100	0	0.0		
Gay Unspecified	809	99.6	3	0.4		
Androphilic	43	95.6	2	4.4		
Gynophilic	405	99.0	4	1.0		
Bisexual / Pansexual	1174	99.2	10	0.8		
Ace Umbrella	370	98.7	5	1.3		
Other	169	98.0	3	2.0		

Table 2.5

Group Differences in Age for Active Discrimination

	No		Yes				
Variable	*M*	*SD*	*M*	*SD*	*t*(3197)	*p*	Cohen's *d*
Denied Service	31.27	12.60	32.20	11.20	-1.38	.167	0.08
Harassed	31.43	12.71	31.07	10.86	0.59	.554	0.03
Misgendered	32.79	13.16	28.35	10.10	9.53	<.001	0.38
Assaulted	31.34	12.42	36.26	14.37	-2.05	.041	0.37

Table 2.6

Summary of Logistic Regression Analysis Predicting Active Discrimination

Variable	*B*	*SE*	*OR*	95% CI	Wald statistic	*p*
Age	0.15	0.00	0.99	[0.98, 0.99]	17.90	<.001
Income	0.20	0.06	0.82	[0.73, 0.92]	12.31	<.001
Race/Ethnicity (Other)					18.26	.003
African American/Black	0.38	0.34	0.69	[0.35, 1.34]	1.21	.271
Caucasian/White	0.33	0.08	0.72	[0.61, 0.84]	17.08	<.001
Asian/Pacific Islander	0.25	0.34	0.78	[0.40, 1.52]	0.53	.468
Indigenous	0.35	0.59	1.42	[0.45, 4.50]	0.35	.554
Latinx/Brown	0.20	0.30	0.82	[0.45, 1.48]	0.45	.501
Sexual Orientation (Other)					17.37	.008
Straight Unspecified	0.39	0.23	0.68	[0.43, 1.06]	2.92	.088
Gay Unspecified	0.09	0.18	1.10	[0.77, 1.56]	0.26	.609
Androphilic	0.45	0.37	0.64	[0.31, 1.30]	1.53	.215
Gynophilic	0.33	0.20	0.72	[0.49, 1.07]	2.68	.101
Bisexual / Pansexual	0.14	0.17	0.87	[0.62, 1.22]	0.67	.414
Ace Umbrella	0.27	0.20	0.76	[0.52, 1.13]	1.86	.172
Gender Identity (Other)					16.89	.002
Transgender Unspecified	0.33	0.36	1.39	[0.68, 2.82]	0.81	.367
Masculine Expressions	0.01	0.18	0.99	[0.70, 1.41]	0.00	.974
Feminine Expressions	0.26	0.18	0.77	[0.54, 1.09]	2.18	.140
Non-Binary	0.14	0.17	1.15	[0.82, 1.60]	0.65	.421

Note. CI = confidence interval for odds ratio (*OR*).

Chapter 3: A Safe Bet? Transgender and Gender Diverse Experiences with Inclusive Therapists

Introduction

For some transgender and gender diverse (TGD) individuals, securing a capable mental health provider is a risky endeavor (Snow, Cerel, Loeffler, & Flaherty 2019). A mounting body of qualitative and quantitative literature evinces the subpar experiences of TGD clients and highlights uncertain therapeutic outcomes (Bess & Stabb 2009; McCann, 2015; Mizcock & Lundquist, 2016). A participant in the present study describes their chances in this gamble:

> My experience with accessing therapy…is like flipping a coin. I have a 50% chance of finding someone I can trust and work with who accepts all parts of my identity (gender, sexuality, kink, trauma) and a 50% chance of someone who will reiterate dangerous social norms, misgender me (or expect me to teach and prove the existence of trans folks to them), and leave me feeling more suicidal than when I arrived.

Unlucky clients may encounter three manifestations of incompetence: uneducated providers who are clueless about TGD identities, unnuanced providers who focus too much or too little on these identities, or unsupportive providers who are overtly hostile and abusive (Snow et al., 2019). Unsurprisingly, mistreated clients are often reluctant to continue therapy (McCullough et al., 2016). Evidence of therapeutic ineptitude and related service avoidance is particularly troubling, considering the high frequency of suicidal thoughts and behaviors within the TGD population (Haas, Rodgers, & Herman, 2014).

In recent years, researchers and practitioners alike have acknowledged the need for trans-affirming protocols and culturally competent training. In 2015, the American

Psychological Association answered with the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People,* and organizations like Fenway Health have established replicable models for inclusive psychological care. Contemporaneous research suggests that more practitioners are accepting of trans identities, and LGBTQ+ training appears to enhance therapists' attitudes, knowledge and skills, regardless of their religious affiliation or years of clinical experience (Pepping, Lyons, & Morris, 2018; Alessi, Dillon, & Kim, 2014). TGD clients have also reported salubrious encounters with trans affirmative and LGB-identified providers (Elder, 2016; Hunt, 2014; Benson, 2013; Bess & Stabb, 2009).

The Present Study

Ostensibly, therapists who advertise as "trans-friendly" and those who identify as LGBTQ+ themselves would provide reliable, expert care. However, small incipient studies suggest that LGB-identified therapists are not axiomatically trans-competent, and TGD clients have indicated feeling misunderstood and even oppressed by LGB practitioners (McCullough et al., 2016; Elder, 2016; Dispenza, Watson, Chung, & Brack, 2012). These recent, competing reports raise the following question: Are inclusive and LGBTQ+ identified providers a "safe bet" for TGD adults? If not, who is? The present content analysis addresses this critical issue.

Methods

Data Collection

The current study draws from 1,576 open-ended responses recorded in the Trans Mental Health Survey (2017). This national, online survey is one of the largest of its kind (N=4,467), representing trans and gender diverse adults of varying ages, ethnicities,

socioeconomic backgrounds, sexual orientations, and gender identities. Participants were recruited at PRIDE events, via TGD listservs, and across various social media outlets. The majority of respondents identified as a millennial (58%), white/Caucasian (62.2%), and outside the gender binary (59.9%). An overwhelming margin indicated that they had visited a therapist in the past or were currently seeing a social worker, counselor, or psychologist (88.7%). Participants sought counseling for a variety of reasons, including general mental health concerns and transition-related care. Demographic frequencies are provided in Table 3.1.

Data Analysis

Participants were asked a series of Likert scale questions relating to their experiences with mental health professionals. These questions included, "How difficult has your search been to find an adequate therapist (be it currently or in the past)?", "Do you feel like you can trust your therapist?", and "Have you had to educate your therapist(s) about transgender issues? Respondents were then asked, "Is there anything you would like to add about your experiences with therapy?" After eliminating "no" responses, 1,576 open-ended responses remained. Given the one-item nature of this analysis, these comments include those of participants who did not complete the entire Trans Mental Health Survey (n=554).

In keeping with conventional content analysis protocol, hypotheses were not established a priori, and codes emerged inductively during data analysis (Hsieh & Shannon, 2005). Researchers employed both manifest and latent analysis techniques. First, manifest analysis was used to achieve greater trustworthiness. This particular approach requires the researcher to adhere closely to the text, so that codes reflect the

explicit content of the respondents (Bengtsson, 2016). Latent analysis was subsequently used to identify barriers to care established in a preexisting systematic review. These barriers include a fear of being pathologized, an objection to common therapeutic practices, incompetent mental health professionals (including unknowledgeable unnuanced, and unsupportive providers), and affordability factors (Snow et al., 2019).

Researchers followed a four-step analysis process involving decontextualization, recontextualization, categorization, and compilation: meaning units were identified, original responses were re-read alongside the established meaning units, and categories were identified and compiled into a cogent palimpsest (Bengtsson, 2016). The present manuscript spotlights categories related to respondents' experiences with inclusive providers: a salient theme that emerged during the manifest analysis process. Inclusive providers include mental health professionals who advertise themselves as a) TGD inclusive or friendly, b) those who have knowledge or experience working with TGD clients, and/or c) gender therapists. Mental health professionals who identify as queer or TGD were also coded as inclusive.

Positionality Statement

All research requires a modicum of reflexivity, particularly content analyses sensitive to researcher bias. Although manifest analysis seeks to eschew bias by adhering to respondents' exact words, a certain level of interpretation is central to any form of research. For that reason, it is necessary to disclose that the author is a white, middle class, cisgender, queer, non-disabled woman. The author grew up in the southern United States, spent several years living abroad in Europe, and currently resides in the Pacific Northwest. She has studied trans and gender diverse populations since 2017 resulting in

four prior publications. The author maintains a poststructuralist worldview and, through her research, attempts to foreground the lived experiences of a diverse and often ignored population.

Results

Survey participants recounted diffuse and complicated histories with a myriad of mental health professionals. A soupçon (n=36) described only positive therapeutic relationships, while far more interacted with unknowledgeable (n=160), unnuanced (n=26), or unsupportive (n=181) mental health providers (Snow et al., 2019). A significant number (n=281) annotated a spectrum of experiences ranging from "horrific to helpful" and "abusive to very good" among other polarities.

The Professional Gamble: High Stakes, Poor Odds

In response to suboptimal encounters, or in an effort to avoid them, 94 participants intentionally selected inclusive mental health professionals, including the following respondent: "I specifically sought out therapists with lgbtq* experience or from the community because of a fear of not being treated well as a result of my identity." In total, 316 participants indicated that they had experience with an inclusive therapist. Of those respondents, 150 labelled their experience(s) as mostly positive while 83 participants labelled their experience(s) as largely negative.

Non-beginner's luck. Participants who represented their provider in positive terms (e.g., "great," "awesome," "lifesaver") were also apt to describe themselves as "lucky" or "fortunate" for having found them. Nevertheless, this was often not a case of beginners' luck: 51 participants revealed that they had a negative therapeutic experience prior to

finding a competent, inclusive counselor. Many were sedulous in their pursuit, spending years, traveling miles, and paying hundreds out of pocket for a chance at quality care.

Winners of this therapeutic gamble celebrated their provider for being a) understanding, b) safe and trustworthy, and c) helpful and supportive. These competent mental health professionals were not only cognizant of TGD identities; they were also teachable, recognizing the expertise of their client and the validity of their lived experience. One respondent explains, "My first two therapists were not at all friendly towards me. My current therapist is an angel. I can trust her, she is knowledgeable of most transgender issues, and willing to learn from my experiences."

Competent, inclusive providers were also characterized as safe and trustworthy. Notably, while respondents described feeling comfortable with trans-friendly providers, they only indicated feeling safe with trans-identified providers. As one participant relates, "Current therapist identifies as genderqueer and uses they/them pronouns, and I feel very safe with them, but that is very much an exception to my broader experience with therapists, both before and after coming out as trans."

In addition to being understanding, safe and trustworthy, competent providers were also categorized as helpful and supportive. Respondents explained that their therapist fully supported their gender identity, helped them access resources and navigate challenging relationships. According to one respondent,

> The therapist I see now has helped me greatly with connecting with trans resources and figuring out what being nonbinary means to me, and discussing coming out to family, work…I am really lucky now to have an incredibly queer friendly therapist, and a trans support group.

Losing outcomes. While two-thirds of the respondents experienced success with their inclusive provider, the remaining third were not as fortunate. In addition to exhibiting general hallmarks of incompetence, some inclusive providers inflated their expertise, conflated LGB experiences with TGD experiences, and manipulated their clients. Participants disclosed that although providers advertised themselves as trans-friendly or trans-competent, they were often uninformed, especially in their understanding of non-binary identities. As one respondent elucidates:

> So many local therapists advertise being familiar or comfortable with trans people, and I have always had to be the one teaching them. This is already unacceptable, but they're almost invariably expensive, too. Meaning I waste money getting inadequate and exhausting therapy. My therapist was relatively aware and accepting of binary transness, but fought me hard when i suggested i'm nonbinary.

Incompetent, inclusive providers were also likely to conflate LGB experiences with TGD experiences. This was especially true for queer-identified therapists. One participant explains:

> My therapist is a lesbian, and sometimes tries to blanket Trans experience under her experience as a Gay person. She's just trying her best to show she gets it on some level, but sometimes I really do feel like screaming you DONT GET IT. You don't face the same hatred I face out there.

Finally, incompetent providers were manipulative, using harmful gatekeeping practices to ensure their client's return. Some therapists were also acquisitive, collecting information from TGD clients in order to expand and bolster their practice. As one

participant recounts, “My last therapist had claimed to specialize in transgender care, yet was using her patients as a guide for each other. I.e. Ask me for advice for another patient and vice versa when it came to transition questions.” Another respondent described feeling like a notch in their therapist’s belt:

> [It’s] like they're counting their trans clients so they can say "I've served X # of trans folks!" Except I basically never feel served. I'm rarely misgendered, because I live in a place where I can seek out providers who work to not do such stupid things (but even they are few and far between in the big cities), but I have never experienced real, competent care.

Counting the Cost

The stakes are invariably high for those in search of an inclusive mental health professional. In addition to basic service expenses, survey participants indicated that they wagered time, distance, and convenience all for mercurial outcomes. While previous studies have acknowledged the financial burden of therapy, scholars have questioned why TGD consumers pay out of pocket for services that may be covered by their insurance or by Medicaid (Shiphard, Green, & Abramovitz, 2010). The present study reveals that TGD clients often prioritize competence over affordability, choosing out-of-network providers who are experienced with trans issues. As one respondent explains,

> I have a therapist who is also nonbinary, which has been my best therapeutic relationship. However, I must pay out of pocket for this. If I depended on the VA or medicaid to find a therapist, I know I would have to educate them on my identity, which would create even more barriers for me.

A few participants were forced to abandon treatment when the cost became insuperable, while others spent an exorbitant amount of time trying to locate an inclusive, in-network provider. According to one participant, “It took years to find a therapist who both took Medicaid and was supportive of my trans identity. Once I did, though, they were incredibly helpful and assisted me in finding resources to transition.”

When TGD consumers finally identified an inclusive provider, they frequently had to travel out of town for treatment. This hindrance often depleted clients’ diminishing stores of time and money. In response, some clients turned to online resources or phone therapy. While more convenient, remote counseling is not without its complications, as one respondent articulates:

> When I was younger, I had terrible experiences with therapists. Now, my issue is lack of access. Here in Iowa, there are no trans therapists of color. I have to see someone remotely, which is not as good because the one therapy modality that works best for me includes bodywork. I am making do by working with a personal trainer and then having therapy right after, but it means my partner and I can't save much money.

For trans people of color, and for other TGD clients with intersecting identities, locating a culturally competent provider was often scabrous. Those with acute mental health diagnoses also found it difficult to find an inclusive therapist who was practiced enough to meet their therapeutic needs. One participant explains,

> The therapist I have now is OK. But I think very soon I won't be able to afford appointments at all, even with sliding scale. And I am frustrated in that she is white, and there's a lot she doesn't "get" about my needs as a

> biracial trans person. I feel like I have to choose - either someone who gets me as a trans person, or who gets me as a biracial person.

A few respondents navigated this challenge by juggling multiple therapists: a feat that demands even more time and money.

Discussion

Far from being a "safe bet," there is a chance that inclusive providers may inflate their expertise, conflate LGB experiences with TGD experiences, and manipulate their clients. For some, the stakes are life-or-death: two participants attempted suicide immediately following a negative encounter with a trans-identified therapist, and several more reported feeling suicidal after an iatrogenic session. One respondent described this gamble as a "Russian roulette wheel" adding, "I've had respectful therapists with little trans related knowledge and disrespectful therapists with a wealth of knowledge." For those fortunate enough to find a competent mental health professional, the financial burden, travel commitment, and time investment may be unsustainable.

Moving forward, it is imperative that mental health providers attenuate the risks associated with their treatment practices. While emerging research supports the efficacy of cultural competency training, more research is needed to determine if prevailing modalities prepare therapists to meet the needs of their TGD clients. Moreover, although trainings exist, they are not habituated or standardized across institutions (Hanssman, Morrison, & Russian, 2008). Trans competency should be included in all educational curricula, and different training approaches should be investigated to establish a threshold for best practices.

Study results may also serve as a caution to queer and TGD therapists: those who identify as LGBTQ+ should not substitute their lived experience for a robust and nuanced education. Before advertising their services as TGD inclusive, all therapists should be aware of their professional limitations, possess a willingness to learn, the ability to create lenitive spaces, and the competency to provide tangible assistance. Addressing systemic challenges to care is less perspicuous. Perhaps if counseling programs and licensing boards required extensive TGD education, more therapists would be prepared to offer trans-competent care, increasing accessibility for potential clients.

Limitations and Directions for Future Research

While the present study is unique in its prodigious sample size, it is not immune to common limitations involving content analysis of a secondary dataset. Assiduous techniques were used to most accurately reflect the language and intent of the respondents; nevertheless, it is possible that certain meanings were inscrutable. It is also essential to acknowledge that open-ended responses are likely to solicit extreme, polarizing answers; thus, neutral experiences may be underrepresented in this sample (O'Cathain & Thomas, 2004). At the very least, this study serves as a desideratum for future, replicative research, providing instructions for clinicians, and giving voice to a euphony of TGD experiences.

Concluding Thoughts

For too many TGD clients, mental healthcare is a crapshoot. The odds may slightly improve for those fortunate enough to identify an inclusive provider, but there are no guarantees. The viability of expensive, time-consuming, remote therapy is even more uncertain. Given how vulnerable TGD individuals are to suicide and precipitant mental

health issues, it would behoove practitioners to accelerate their understanding of TGD issues (Haas et al., 2014).

Table 3.1

*Demographic Characteristics of Participants (*N=*1,576*)

Characteristic	*n*	%
Generation (age at time of survey)		
Generation Z	144	10.3
Millennials	895	63.9
Generation X	231	16.5
Baby Boomers	124	8.8
Silent Generation	3	0.2
Race/Ethnicity		
White	805	57.5
Not White	595	42.5
Income		
Low Income	748	53.4
Middle Income	472	33.7
High Income	152	10.9
Gender Identity		
Masculine Expressions	333	23.8
Feminine Expressions	376	26.9
Non-Binary	584	41.7
Other	103	7.3
Sexual Orientation		
Straight	53	3.8
Gay	367	26.2
Bisexual/Pansexual	486	35.4
Ace Umbrella	186	13.2
Other	296	21.1

Chapter 4: Social Support and Suicidality in Transgender and Gender Diverse Adults

Introduction

Transgender and gender diverse (TGD) individuals attempt suicide at a rate of 41% compared to 5% of the general U.S. population (Williams, 2017; Haas, Rodgers, & Herman, 2014). In response to this staggering differential, researchers have attempted to pinpoint idiomatic risk factors for this vulnerable population, focusing on both individual (e.g., internalized transphobia, depression) and structural (e.g., public opinion, discriminatory policies) correlates (Perez-Brumer, Hatzenbuehler, Oldenburg & Bockting, 2015; Maguen & Shipherd, 2010). Scholars have also speculated about potential protective factors. According to the newly-established interpersonal-psychological theory of suicide (IPTS), social support serves to mollify feelings of failed belongingness: one of the central precursors to suicide (Joiner, 2009). Still, to date, only two published studies have addressed protective factors and suicidal behavior in TGD adults, and there is no available literature involving U.S. adults (Moody & Smith, 2013; Moody, Fuk, Peláez, & Smith, 2015).

Within the general population, social support has long been recognized as a protective factor (Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Gutierrez & Osman, 2008; Rutter, 2008) and an auxiliary to other protective factors like self-esteem (Chioqueta & Stiles, 2007; Kleiman, Riskind, Schaefer, & Weingarden, 2012). Extant literature also suggests that social support is a protective against suicide for LGB youth and adults (D'Augelli, Grossman, Hershberger, & O' Connell, 2001; Fenaughty & Harré, 2003). In their pioneering study, Moody et al. (2013) proposes that the same phenomenon holds true for TGD adults. Presumptively, social support markers for this population

include formal mechanisms (mental health practitioners, community resources, support groups, crisis lines) and informal mechanisms (friends, partners, family members) (Moody et al., 2015). Notably, Canadian participants in Moody & Smith's (2013) study of 133 TGD adults indicated that they received less social support from family than they did from friends. Nevertheless, familial support, rather than friend support, was significantly associated with lower rates of suicidal behavior (Moody & Smith, 2013). In a study of risk and protective factors in suicidal, TGD youth, family support also emerged as the strongest protective predictor in a series of multivariate models (Veale, Peter, Travers, & Saewyc, 2017).

In addition to serving as a protective factor, the converse of social support may be viewed as a risk factor for suicide. While risk factors are not requisite corollaries of protective factors (Gutierrez & Osman, 2008), research suggests that for LGBTQ+ individuals, the absence of social support is associated with suicidal thoughts and behaviors (Perez-Brumer et al., 2015; Maguen & Shipherd, 2010). Tangentially, social alienation has been identified as a risk factor for other negative outcomes, including homelessness and mental illness within the TGD community (Seibel et al., 2018; McDowell, Hugto, & Reisner, 2019). Thus, a lack of social support may be both directly and indirectly linked to TGD suicides.

The Present Study

In order to establish much-needed suicide prevention protocols for TGD adults, scholars should be aware of how social support and its absence function as respective protective and risk factors (Gutierrez & Osman, 2008). While the literature surrounding potential risk factors is growing, there is a dearth of literature related to protective factors.

Consequently, the current study seeks to fill a considerable gap in research by exploring social support predictors of not attempting suicide. Social support factors include formal mechanisms (community support and group support) and informal mechanisms (acquaintance support, friend support, family support, and chosen family support.

This study also explores the relationship between certain demographic variables and social support factors in an effort to identify which subpopulations are at greater risk for societal alienation. To the researcher's knowledge, this is the first study to explicitly study these associations in connection with TGD suicide attempts. This is also one of the first studies to include community support, group support, and acquaintance support as social support markers. Based on nascent TGD research, the author hypothesizes that familial support will emerge as a salient, negative predictor of suicides.

Methods

Data Collection

In 2017, the LGBTQ Task Force collaborated with Trans Lifeline to produce the first Trans Mental Health Survey. This online, cross-sectional survey was advertised on social media and at PRIDE events across the United States. In order to participate in the study, respondents needed to be at least 18 years old, reside in the U.S. and identify as TGD. From June 2017 to October 2017, 4,467 TGD adults participated in the study, making it one of the largest of its kind. As the name suggests, the Trans Mental Health Survey canvased topics related to mental health diagnoses, treatment, and experiences with suicide: both as an attempt survivor and as a loss survivor.

Sample Measures

Demographic characteristics. For detailed frequencies, refer to Table 4.1. Participants were asked to specify their birth year; for descriptive purposes, a categorical variable was created using the Pew Research Center's (2019) generational designations. These categories include: Generation Z, ages 18-20; Millennials, ages 21-36; Generation X, ages 37-52; Baby Boomers, ages 53-71; and Silent Generation, ages 72-100. In addition, a continuous variable was created for participants' age at the time of the survey. Participants were also asked to designate their gross annual income using a nine-item ordinal scale. To increase statistical power, the first three items were consolidated to form a "low-income" category, which included participants who grossed less than $35,000 a year (n=1776, 55.4%). The next two items were consolidated to form a "middle-income" category, which included participants who grossed between $35,000-$74,999 annually (n=825, 25.7%). The remaining four items were consolidated form a "high income" category which included participants who grossed over $75,000 a year (n=557, 17.4%). Respondents were additionally invited to endorse 29 possible race/ethnicity designations. These responses were coded into the following discrete categories: white and not white.

For gender identity and sexual orientation, participants were asked open-ended questions. Gender responses were consolidated into the following categories: masculine expressions, feminine expressions, non-binary, and other. "Other" denotes participants who only indicated that they were transgender or transsexual or whose expressed identify was inscrutable to the researcher (e.g., "I just am"). Sexual orientation was coded as follows: straight unspecified, gay unspecified, bisexual/pansexual, ace umbrella, and other. "Other" includes those who were androphilic, gynophilic, unsure, questioning, or

undefinable (e.g., “impossible to answer”). A trans-identified coder helped in the production of these categories.

Social support factors. For detailed frequencies, refer to Table 4.2. Formal support mechanisms involve community support (Do you feel you have community support for your transgender identity?) and group support (Do you currently attend any kind of support group for self-care?). Responses for community support included “yes” and “no.” Responses for support group included “yes, I attend one in real life,” “yes, if you consider social media an online support group,” “yes, I attend an online support group (i.e. that is not social media),” and “no.” The three “yes” responses were consolidated to create a dichotomous variable.

Informal support mechanisms encompass acquaintance support (Do you currently feel supported in terms of your gender identity by the people in your life?), friend support (Do you have friends that you consider your main source of social and emotional support?), family support (Do you feel like your parents, siblings, and/or other family members are a source of support for you?), and chosen family support (Do you feel like your chosen family (people whom you consider family) is a source of social and emotional support for you?) Responses for acquaintance support included “yes,” “no,” and “I have not come out.” The last response was eliminated prior to analysis. Responses for friend support included “yes, primarily in real life,” “yes, primary online,” and “no.” The two yes responses were consolidated to create a dichotomous variable. Responses for family support included “yes” and “no,” and responses for chosen family support included “yes,” “no,” and “not applicable.” The last response was eliminated prior to analysis.

Recent suicide attempts. Participants were asked, "Have you attempted to end your life in the last year?" There were 385 (13.6%) "yes" responses and 2,448 (86.4%) "no" responses.

Analytic Procedure

First**,** demographic chi-square analyses were conducted for formal and informal support variables: community support, support group, acquaintance support, friend support, family support, and chosen family support. Demographic chi square analyses were also conducted for past year suicide attempts. To reduce the possibility of Type 1 error, the Bonferroni-adjusted p-value was calculated for each contingency table. Post hoc analyses were conducted by identifying adjusted residuals (z-scores) in the contingency tables that were greater than 1.96 (Beasley & Schumacker, 1995). To detect p-values for individual variables, z-scores were multiplied to create chi-square values which were subsequently converted into p-values by using the Sig.ChiSq function in IBM SPSS (Beasley & Schumacker, 1995). Finally, binary logistic regression analysis was used to establish the relationship between support variables, demographic variables, and not attempting suicide. All data were analyzed using IBM SPSS version 26 software.

Results

Demographic Markers and Social Support

Formal support mechanisms. Chi-square tests of independence were performed to examine the relationship between demographic characteristics (income, race/ethnicity, gender identity, and sexual orientation) and each social support factor (community support, support group, acquaintance support, friend support, family support, and chosen family support). Complete results are displayed in Tables 4.3-4.8. Additionally,

independent samples t-tests were conducted for age and social support markers (See Table 4.9).

The relationship between community support and income, gender identity, and sexual orientation were all significant. However, post hoc analyses using the Bonferroni-adjusted p-value did not reveal any significant relationships for specific income and gender identity categories. Post hoc tests did reveal a positive association between being gay and experiencing community support, X^2 (1, N =812) = 23.04, p < .001; and a negative association between an "other" sexual orientation and experiencing community support X^2 (1, N =626) =21.16, p < .001. There was not a significant relationship between race/ethnicity and community support; furthermore, an independent samples t-test did not reveal a significant association between age and community support.

Chi-square results indicated a significant association between support groups for self-care and race/ethnicity, sexual orientation, and gender identity. Specifically, post hoc tests revealed that there was a negative relationship between being white and utilizing a support group, X^2 (1, N =1995) =7.29, p= .007; and a positive relationship between not being white and utilizing a support group X^2 (1, N =1210) =7.29, p= .007. Post hoc results also indicated that there was a negative relationship between masculine expressions and utilizing a support group, X^2 (1, N =785) =9.61, p = .002.; and a positive association between being bisexual/pansexual, X^2 (1, N =1184) =10.89, p< .001 and utilizing a support group. There was not a significant relationship between income and self-care support groups; furthermore, an independent samples t-test did not reveal a significant association between age and support groups.

Informal support mechanisms. The relationship between acquaintance support and income, gender identity, and sexual orientation were all significant. However, post hoc analyses using the Bonferroni-adjusted p-value did not reveal any significant relationships for specific income categories. Post hoc tests did reveal a positive association between masculine expressions and experiencing acquaintance support, X^2 (1, N =785) = 7.84, p = .005; and a negative association between being non-binary and experiencing acquaintance support, X^2 (1, N =1216) =14.44, p < .001. Additionally, there was a positive association between being gay and experiencing acquaintance support, X^2 (1, N =812) =18.49, p < .001. There was not a significant relationship between race/ethnicity and community support. An independent samples t-test for age revealed a significant difference in age for those who had acquaintance support (M=31.98, SD, 12.165 N=2465) and those who did not have acquaintance support (M=29.58, SD=13.465, N=513), t(2976)4.000, p<.001.

The relationship between friend support and income, gender identity, and sexual orientation were all significant. Post hoc analyses revealed that low income was negatively associated with friend support, X^2 (1, N =1776) =15.21, p< 001; while middle income was positively associated with friend support, X^2 (1, N 825) =10.24, p =.001. Post hoc analyses also revealed that being non-binary was positively associated with friend support, X^2 (1, N =1216) =18.49, p< .001. Additionally, post hoc analyses revealed that being gay was positively associated with friend support, X^2 (1, N =812) =14.4, p< .001; while "other" sexual orientations were negatively associated with friend support, X^2 (1, N =626) =20.25, p< .001. Race/ethnicity was not significantly associated with

friend support; furthermore, an independent samples t-test did not reveal a significant association between age and acquaintance support.

The relationship between family support and income, gender identity, and sexual orientation were all significant. There was a positive relationship between family support and having a high income, X^2 (1, N =557) =9, p = .002. There was also a positive relationship between family support and masculine expressions of gender identity, X^2 (1, N =785) =13.69, p < .001; and a negative association between family support and being non-binary, X^2 (1, N =1216) =7.84, p = .005. Additionally, there was a positive association between having family support and being straight, X^2 (1, N =195) =12.96, p< .001. Race/ethnicity was not significantly associated with friend support; furthermore, an independent samples t-test did not reveal a significant association between age and family support.

Finally, the relationship between chosen family support and gender identity and sexual orientation were significant. Chosen family support was positively associated with being non-binary, X^2 (1, N =1216) =12.96, p < .001; and negatively associated with feminine expressions of gender, X^2 (1, N =970) =22.09, p< .001. Additionally, chosen family support was positively associated with being gay X^2 (1, N =812) =13.69, p < .001; and negatively associated with being an "other" sexual orientation, X^2 (1, N =626) =12.25, p = .005. Race/ethnicity and income were not significantly associated with chosen family support. Furthermore, an independent samples t-test did not reveal a significant association between age and family support.

Demographic Markers and Suicide

Chi-square tests of independence were performed to examine the relationship between demographic characteristics (income, race/ethnicity, gender identity, and sexual orientation) and recent suicide attempts ("Have you attempted to end your life in the last year?"). Complete results are displayed in Table 4.10. Additionally, independent samples t-tests were conducted for age (See Table 4.11).

The relationship between recent suicide attempts and all five demographic variables were significant. Specifically, post hoc analyses revealed that being white was negatively associated with a recent suicide attempt, X^2 (1, N =1995) =7.84, p =.005; while being not-white was positively associated with a recent suicide attempt, X^2 (1, N =1210) =7.84, p =.005. Post hoc analyses also revealed that being low-income was positively associated with a recent suicide attempt, X^2 (1, N =1776) =42.25, p< .001; while being middle income, X^2 (1, N =825) =16, p <.001, and high income, X^2 (1, N =557) =15.21, p =.001, were negatively associated with a recent suicide attempt. Additionally, post hoc analyses revealed that being non-binary, X^2 (1, N =1216) =9.61, p= .002, and gay X^2 (1, N =812) =12.96, p< .001, were negatively associated with a recent suicide attempt. An independent samples t-test for age revealed a significant difference in age for those who had not attempted suicide recently (M=31.78, SD, 12.508 N=2524) and those who had attempted suicide recently (M=27.43, SD=11.202, N=400), t(2924)21.974, p< .001.

Social Support and Suicide

A binary logistic regression model (see Table 4.12) was constructed to assess the likelihood of a TGD individual not attempting suicide. To adjust for demographic covariates, standard simultaneous regression was used: demographic variables were

entered into Block 1 and social variables were entered into Block 2. Categorical variables were entered into the model using the "categorical covariates" function in IBM SPSS. This function creates dummy variables with a corresponding comparison group.

Block 1 produced a statistically significant model for prediction (X^2 = 122.179, p< .001) that correctly classified 86.6% of the cases. The Hosmer and Lemeshow test indicated a good model fit (X^2 = 4.256, p= .833) for the demographic covariates (age, race/ethnicity, income, sexual orientation, and gender identity).The inclusion of social support variables (community support, support group, acquaintance support, friend support, family support, and chosen family support) in Block 2 produced another significant model for prediction (X^2 = 84.704, p< .001). While the Hosmer and Lemeshow test indicated a good model fit (X^2 = 6.897, p= .548), the addition of social support variables did not improve the Block 1 prediction rate of 86.6%.

In the final model, all five demographic covariates were significant predictors, along with three social support variables. For each year increase in age, an individual was less likely to attempt suicide (*OR*=1.032, p< .001). White individuals were one and half times more likely to not attempt suicide (*OR*=1.533, p=.001), while low-income individuals were more likely to attempt suicide (*OR*=.378, p<.001. When using low-income as the baseline category, middle income individuals were over one and a half times more likely to not attempt suicide (*OR*=1.735, p=.001) while high-income individuals were over two and a half more times likely not to attempt suicide (*OR*=2.768, p<.001). The baseline categories for sexual orientation and gender identity were also significant.

Among the six social support predictors, only half were statistically significant: community support, acquaintance support, and family support. Those who indicated that they had community support for their gender identity were over one and a half times less likely to attempt suicide (*OR*=1.677, p<.001). Similarly, those with acquaintance support were nearly one and a half times less likely to attempt suicide (*OR*=1.403, p=.04). Finally, unlike chosen family support, family support proved to be a significant predictor in the final model (p= .027) Those who responded "yes" to family support were over one times less likely to attempt suicide (*OR*= 1.359).

Discussion

As hypothesized, family support emerged as a prominent protective factor, along with acquaintance and community support. The last two predictors are particularly noteworthy, given that suicidologists have yet to utilize these social support variables in TGD research. By moving beyond friends and family and including a variety of support factors, this study helps fill a considerable gap in the literature and cements an expansive foundation for future research. With this precedent in place, scholars may find that a lack of informal support is offset by formal support mechanisms, namely, the community at large. This is especially encouraging for studies like the present one, where more participants are likely to report community support (n=2277, 71%) and acquaintance support (n=2468, 77%) than they are to report family support (n=1321, 41%).

In addition to this panoramic conceptualization of social support, the present study considered the role of several demographic factors. Logistic regression analyses suggest that white and older TGD individuals are less likely to attempt suicide, while low-income TGD adults are at an increased risk. Meanwhile, chi-square analyses indicate

that being gay and non-binary is associated with not attempting suicide. Additional chi-square analyses appear to corroborate the impervious quality of being gay: a sexual orientation that was positively associated with acquaintance support and community support, two of the significant predictors in the final logistic regression model. Surprisingly, while being non-binary was associated with not attempting suicide, this specific gender identity was negatively associated with two significant protective factors: family support and acquaintance support.

Given the paucity of equivalent research, it is difficult to expound on the intersection between demographic variables, social support, and suicide attempts found in this study. It is well-established that for cisgender individuals, being gay or lesbian is a risk factor for suicide (Silenzio, 2007; Haas et al., 2011). Regrettably, few studies recognize or report the sexual orientation of TGD participants: an oversight that must be rectified in order to confirm, contradict, and otherwise elucidate this apparent paradox. Similarly, more TGD studies should specify the gender identity of respondents instead of conflating trans and gender diverse experiences. Toomey et al. (2018) attempted to do just that by delineating participants' gender identities; their study of TGD youth found that compared to female-identified adolescents, non-binary individuals who were assigned male at birth were less likely to attempt suicide. Replicative research will help establish which gender identities are protective and why.

Limitations and Directions for Future Research

The present study is sensitive to challenges inherent in cross-sectional analysis. Given these disadvantages, the author chose to observe recent suicide attempts (suicide attempts occurring within the past year) as opposed to lifetime attempts. Perhaps more

problematic is the way in which certain demographic questions were asked and how these variables were subsequently coded. For instance, "gay unspecified" is appropriately named: the category lacks specificity, which problematizes the analysis. While historically, "gay" referred to male-identified persons who were attracted to other male-identified persons, the term is more commonly used as a catch-all for same-sex attraction. Because sexual orientation was an open-ended question, it is not clear if respondents meant the former or the latter. For this reason, the author speculates that male-to-male attraction may be overrepresented in the variable.

It is also worth noting that for both acquaintance support and community support, respondents were explicitly asked if they felt supported in terms of their gender identity. The other social support variables in the study represented more general forms of support. This distinction may be critical when interpreting results, and future surveys should employ consistent nomenclature. Finally, for the sake of statistical comprehensibility, the present study focused on participants who were already "out" to family and friends. Future research should consider the relationship between social support and suicidality for TGD individuals who are still closeted.

Concluding Thoughts

Protective factors are not peripheral to suicide research. Nevertheless, when concerning TGD populations, the subject has been largely ignored until quite recently. The present study of U.S. respondents is one of the first to identify familial, acquaintance, and community support as potentially protective against suicide attempts. Replicative and exploratory studies are sorely needed to establish suicide prevention measures for this vulnerable population.

Table 4.1

*Demographic Characteristics of Participants (*N=*4,467*)

Characteristic	*n*	%
Generation (age at time of survey)		
Generation Z	433	15.3
Millennials	1735	61.5
Generation X	415	14.7
Baby Boomers	234	8.3
Silent Generation	6	0.2
Race/Ethnicity		
White	1995	62.2
Not White	1210	37.8
Income		
Low Income	1776	55.4
Middle Income	825	25.7
High Income	557	17.4
Gender Identity		
Masculine Expressions	785	24.5
Feminine Expressions	970	30.2
Non-Binary	1216	37.9
Other	216	6.7
Sexual Orientation		
Straight	195	6.1
Gay	812	25.3
Bisexual/Pansexual	1184	36.9
Ace Umbrella	375	11.7
Other	626	19.5

Table 4.2

*Social Support Characteristics of Participants (*N = *3,207)*

Characteristic	Yes		No	
	n	%	*n*	%
Formal Support Mechanisms				
Community Support	2,277	71	918	29
Group Support	1,449	45	1,753	55
Informal Support Mechanisms				
Acquaintance Support	2,468	83	517	17
Friend Support	2,757	86	443	14
Family Support	1,321	41	1,871	59
Chosen Family Support	2,602	92	220	8

Table 4.3

Prevalence of Community Support in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2,276	71.3	917	28.7	3.64	.056
White	1,440	72.5	547	27.5		
Not White	836	69.3	370	30.7		
Income	2,241	71.0	905	29.0	8.38	.015
Low Income	1,229	69.0	542	31.0		
Middle Income	595	72.0	228	28.0		
High Income	417	76.0	135	24.0		
Gender Identity	2,266	71.4	909	28.6	10.28	.016
Masculine Expressions	582	74.3	201	25.7		
Feminine Expressions	675	70.0	289	30.0		
Non-Binary	871	71.9	341	28.1		
Other	138	63.9	78	36.1		
Sexual Orientation	2,268	71.3	912	28.7	34.85	<.001
Straight Unspecified	137	70.3	58	29.7		
Gay Unspecified	630	78.0	178	22.0		
Bisexual / Pansexual	841	71.2	340	28.8		
Ace Umbrella	261	70.4	110	29.6		
Other	399	63.8	226	36.2		

Table 4.4

Prevalence of Group Support in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	1,447	45.2	1,753	54.8	7.041	.008
White	865	43.4	1,128	56.6		
Not White	582	48.2	625	51.8		
Income	1,433	45.0	1,720	55.0	2.03	.362
Low Income	806	45.0	967	55.0		
Middle Income	361	44.0	462	56.0		
High Income	266	48.0	291	52.0		
Gender Identity	1,441	45.3	1,741	54.7	14.044	.003
Masculine Expressions	318	40.6	466	59.4		
Feminine Expressions	449	46.4	519	53.6		
Non-Binary	587	48.3	628	51.7		
Other	87	40.5	128	59.5		
Sexual Orientation	1,444	45.3	1,743	54.7	20.431	<.001
Straight Unspecified	75	38.5	120	61.5		
Gay Unspecified	333	41.1	478	58.9		
Bisexual / Pansexual	581	49.1	602	50.9		
Ace Umbrella	186	49.6	189	50.4		
Other	269	43.2	354	56.8		

Table 4.5

Prevalence of Acquaintance Support in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2467	83.0	516	17.0	.075	.784
White	1,541	83.0	319	17.0		
Not White	926	83.0	197	17.0		
Income	2,437	83.0	505	17.0	6.943	.031
Low Income	1,348	81.0	311	19.0		
Middle Income	662	85.0	114	15.0		
High Income	427	84.0	80	16.0		
Gender Identity	2,456	83.0	512	17.0	17.478	.001
Masculine Expressions	654	86.0	106	14.0		
Feminine Expressions	780	85.0	143	15.0		
Non-Binary	864	80.0	226	20.0		
Other	158	81.0	37	19.0		
Sexual Orientation	2,457	83.0	515	17.0	21.026	<.001
Straight Unspecified	160	85.0	29	15.0		
Gay Unspecified	675	88.0	94	12.0		
Bisexual / Pansexual	884	80.0	212	20.0		
Ace Umbrella	272	81.0	64	19.0		
Other	466	81.0	111	19.0		

Table 4.6

Prevalence of Friend Support in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2756	86.2	442	13.8	.019	.889
White	1,718	86.2	274	13.8		
Not White	1,038	86.1	168	13.8		
Income	2,716	86.0	436	14.0	15.55	<.001
Low Income	1,488	84.0	282	16.0		
Middle Income	738	90.0	87	10.0		
High Income	490	88.0	67	12.0		
Gender Identity	2,741	86.2	439	13.8	19.32	<.001
Masculine Expressions	665	84.9	118	15.1		
Feminine Expressions	812	83.8	157	6.2		
Non-Binary	1,087	89.5	127	10.5		
Other	177	82.7	37	17.3		
Sexual Orientation	2,746	86.2	439	13.8	31.65	<.001
Straight Unspecified	162	83.5	32	16.5		
Gay Unspecified	734	90.6	76	9.4		
Bisexual / Pansexual	1,018	86.1	164	13.9		
Ace Umbrella	329	87.7	46	12.3		
Other	503	80.6	121	19.4		

Table 4.7

Prevalence of Family Support in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	1320	41.4	1870	58.6	.018	.894
White	824	41.5	1,163	58.5		
Not White	496	41.2	707	58.8		
Income	1,839	59.0	1,304	41.0	9.087	.011
Low Income	1,056	60.0	710	40.0		
Middle Income	490	60.0	332	40.0		
High Income	293	53.0	262	47.0		
Gender Identity	1,313	41.4	1,859	58.6	17.523	.001
Masculine Expressions	368	47.1	413	52.9		
Feminine Expressions	403	41.7	563	58.3		
Non-Binary	465	38.3	748	61.7		
Other	77	36.3	135	63.7		
Sexual Orientation	1,314	41.4	1,863	58.6	17.389	.002
Straight Unspecified	104	53.6	90	46.4		
Gay Unspecified	333	41.3	474	58.7		
Bisexual / Pansexual	495	41.9	686	58.1		
Ace Umbrella	134	35.8	240	64.2		
Other	248	39.9	373	60.1		

Table 4.8

Prevalence of Chosen Family Support in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	2,601	92.2	220	7.8	.72	.397
White	1,647	92.5	133	7.5		
Not White	954	91.6	87	8.4		
Income	2,570	92.0	218	8.0	.06	.967
Low Income	1,436	92.0	121	8.0		
Middle Income	676	92.0	59	8.0		
High Income	458	92.0	38	8.0		
Gender Identity	2,586	92.2	219	7.8	24.34	<.001
Masculine Expressions	647	92.8	50	7.2		
Feminine Expressions	749	88.5	97	11.5		
Non-Binary	1,016	94.5	59	5.5		
Other	174	93.0	13	7.0		
Sexual Orientation	2,592	92.2	218	7.8	19.99	.001
Straight Unspecified	162	92.0	14	8.0		
Gay Unspecified	688	95.4	33	4.6		
Bisexual / Pansexual	965	92.0	84	8.0		
Ace Umbrella	291	92.1	25	7.9		
Other	486	88.7	62	11.3		

Table 4.9

Group Differences in Age for Social Support

	Yes		No				
Support Measure	*M*	*SD*	*M*	*SD*	*t*(3207)	*p*	Cohen's *d*
Community Support	31.47	12.28	31.15	12.62	0.66	.670	0.03
Group Support	31.62	12.74	31.19	12.20	0.97	.234	0.03
Acquaintance Support	31.98	12.17	29.58	13.47	4.00	<.001	0.19
Friend Support	31.26	12.19	32.13	13.89	-1.36	.174	0.07
Family Support	31.59	12.47	31.19	12.39	0.88	.633	0.03
Chosen Family Support	31.42	12.02	33.03	15.33	-1.86	.064	0.17

Table 4.10

Prevalence of Suicide Attempts in TGD Adults

	Yes		No			
Variable	*n*	%	*n*	%	$X^2(1)$	*p*
Race/Ethnicity	401	13.7	2,528	86.3	7.96	.005
White	224	12.3	1,598	87.7		
Not White	177	16.0	930	84.0		
Income	396	13.7	2,494	86.3	43.00	<.001
Low Income	286	17.0	1,365	83.0		
Middle Income	69	9.0	671	91.0		
High Income	41	8.0	458	92.0		
Gender Identity	398	13.7	2,517	86.3	9.67	.022
Masculine Expressions	109	15.1	613	84.9		
Feminine Expressions	137	15.4	754	84.6		
Non-Binary	123	11.1	982	88.9		
Other	29	14.7	168	85.3		
Sexual Orientation	400	13.7	2,518	86.3	20.32	<.001
Straight Unspecified	17	9.6	161	90.4		
Gay Unspecified	70	9.7	651	90.3		
Bisexual / Pansexual	172	15.5	939	84.5		
Ace Umbrella	61	17.8	281	82.2		
Other	80	14.1	486	85.9		

Table 4.11

Group Differences in Age for Suicide Attempts

	Yes		No				
Measure	*M*	*SD*	*M*	*SD*	*t*(2924)	*p*	Cohen's *d*
Recent Suicide Attempt	27.43	11.20	31.78	12.51	-6.55	<.001	0.37

Table 4.12

Summary of Logistic Regression Analysis Predicting No Suicide Attempt

Variable	*B*	*SE*	*OR*	95% CI	Wald statistic	*p*
Age	0.03	0.01	1.03	[1.02, 1.05]	22.24	<.001
Race (White)	0.43	0.13	1.53	[1.19, 1.97]	11.16	.001
Sexual Orientation (Other)					14.70	.005
Straight Unspecified	0.30	0.33	1.36	[0.71, 2.59]	0.85	.356
Gay Unspecified	0.25	0.22	1.29	[0.84, 1.98]	1.35	.246
Bisexual/Pansexual	-0.26	0.18	0.77	[0.54, 1.10]	2.11	.146
Ace Umbrella	-0.45	0.23	0.64	[0.40, 1.01]	3.73	.054
Gender Identity (Other)					21.76	<.001
Masculine Expressions	-0.12	0.28	0.89	[0.52, 1.52]	0.19	.660
Feminine Expressions	-0.33	0.27	0.72	[0.42, 1.22]	1.48	.223
Non-Binary	0.42	0.27	1.53	[0.90, 2.60]	2.44	.118
Income (High)					27.49	<.001
Low Income	-0.97	0.22	0.38	[0.25, 0.58]	19.19	<.001
Middle Income	-0.40	0.25	0.67	[0.41, 1.10]	2.50	.114
Community Support	0.52	0.15	1.68	[1.26, 2.23]	12.56	<.001
Group Support	-0.18	0.13	0.83	[0.65, 1.07]	1.98	.159
Acquaintance Support	0.34	0.17	1.40	[1.02, 1.94]	4.20	.040
Friend Support	0.06	0.20	1.06	[0.72, 1.57]	0.09	.762
Family Support	0.31	0.14	1.36	[1.04, 1.78]	4.91	.027
Chosen Family Support	0.38	0.21	1.46	[0.96, 2.21]	3.14	.077

Note. CI = confidence interval for odds ratio (*OR*).

Chapter 5: Conclusion

Historically, the U.S. mental health system has pathologized transgender and gender diverse identities, imposing spurious diagnoses and nocuous "fixes" (Ansara & Hegarty, 2012; Davy & Toze, 2018). In recent years, some researchers and mental health professionals have begun to acknowledge that it is society, not the TGD community, that needs fixing. The three papers comprising this dissertation highlight just a few social problems afflicting vulnerable TGD adults and offer some potential solutions. Specifically, Paper 1 addresses active discrimination in mental healthcare spaces, calling particular attention to intersectional oppression. Paper 2 foregrounds the best and worst practices of "inclusive" mental healthcare, and finally, Paper 3 identifies social support markers as protective against suicide attempts.

First, Paper 1 proposes that certain marginalized populations are associated with misgendering, denial of services, harassment, and assault. Univariate results revealed that TGD clients of color, gay and non-binary individuals, and those who are low-income are particularly susceptible to maltreatment. While the logistic regression model was tenuous, results indicated that age, income, race/ethnicity, gender identity, and sexual orientation were all significant predictors of active discrimination. Jointly, these outcomes expose an exigent healthcare travesty that needs fixing: mental health professionals must be aware of their own biases and endeavor to treat all clients with care and respect. Furthermore, replicative studies are needed to establish which TGD populations are at increased risk for mental healthcare discrimination.

Paper 2 explores a previously uncharted region of TGD mental healthcare: clients' experiences with inclusive providers. While inclusive mental healthcare is an

ostensive “fix” for unspecialized treatment, content analysis suggests that affirming providers are not axiomatically competent: some providers inflate their expertise, conflate TGD experiences with LGB experiences, and manipulate their clients. Conversely, competent providers are identified by their helpfulness, trustworthiness, and understanding of TGD issues. In addition to promulgating best practices, this study also acknowledges the existence of systemic barriers to quality care. The fixes for these macro issues are inherently daunting and include free or affordable mental healthcare and increased access to services.

Finally, Paper 3 addresses the suicide epidemic within the TGD community (Haas et al., 2014). While most research is concerned with identifying risk factors, this study is one of the few to consider potential protective factors: namely, formal and informal social support mechanisms. Regression results revealed that one formal mechanism (community support) and two informal mechanisms (acquaintance support and family support) were predictive of not attempting suicide. Additionally, particular demographic characteristics (being white and older) were shown to be protective. Chi-square analyses provide a more intricate assessment of demographic characteristics and social support/suicide outcomes. Of particular interest is the association between being gay, having community support and acquaintance support, and not attempting suicide. More confounding, but just as interesting, is the association between being non-binary, not experiencing acquaintance or family support, and not attempting suicide. Clearly, more research is needed to establish both risk and protective factors along with suicide prevention protocols—a “fix” that cannot come too soon. The present study is an initial step in this direction.

Collective Implications

Collectively, these three exploratory studies help inform mental health practitioners and set a precedent for future research. These studies also articulate a common theme: the TGD experience is not homogeneous, and specific subpopulations are more likely to struggle in a broken society. In all three papers, financial insecurity posed a pertinent barrier to effective mental healthcare and social support resources. Being low-income was also the only negative predictor of not attempting suicide. Given that 30% of TGD adults live in poverty (Badgett, Choi, & Wilson, 2019), it behooves researchers, practitioners, policymakers, and citizens alike to establish and enact appropriate solutions.

Although long-term solutions may appear quixotic, collective action could defeat the cyclical force of poverty and oppression. To this end, researchers must entertain more comprehensive frameworks of TGD suicidality, perfecting and replicating exploratory studies. Furthermore, clinical licensing boards and educational institutions must demand that would-be practitioners are TGD literate, while current mental health professionals should commit to further education. Finally, policymakers and individual citizens must privilege the experiences of the least advantaged, promoting legislation that makes mental healthcare (among other social services) more affordable and accessible. In so doing, community members can help fulfill the charge of Leelah Alcorn to "fix society, please" (Merlan, 2014, para. 10).

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EDUCATION

May 2017	*Western Kentucky University* Graduate Certificate in Gender and Women's Studies
May 2007	*University of Kentucky* M.A. in International Relations
May 2005	*Georgetown College and Oxford University* *summa cum laude* B.A. in English

PEER-REVIEWED PUBLICATIONS

Snow, A., Cerel, J., Loeffler, D., & Flaherty, C. (2019). Barriers to mental health care for transgender and gender non-conforming adults: A systematic review of the literature. *Health & Social Work*, *44*(3).

Aboussouan A.B., **Snow A.,** Cerel J., & Tucker R.P. (2019). Non-suicidal self-injury, suicide ideation, and past suicide attempts: Comparison between transgender and gender diverse veterans and non-veterans. *Journal Of Affective Disorders*, *259*, 186-194.

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Carter, S.P., Cowan, T., **Snow, A.,** Cerel, J., & Tucker, R.P. (2019). Health insurance and mental health care utilization among adults who identify as transgender and gender diverse. *Psychiatric Services.* Advanced online publication. https://doi.org/10.1176/appi.ps.201900289

CONFERENCE PRESENTATIONS

Tucker, R. Aboussouan, A. **Snow, A.,** Staklo, IV., & Cerel, J. (2019). Risk Factors for Suicide in Transgender and Gender Non-Conforming Adults: New Correlates and How They can be Applied to Prevention Efforts. Paper presented at the annual American Association of Suicidology conference. Denver, CO.

Snow, A., Cerel, J., Rodriguez-Roldan, V., Chaubal., N. & Martela., G. (2019). Surviving Stigma: Transgender Adults and Suicide Exposure. Paper presented at the annual Society for Research in Social Work (SSWR) conference. San Francisco, CA.

Snow, A., Cerel, J., Rodriguez-Roldan, V., Chaubal., N. & Martela., G. (2018). Speaking Out: Transgender Adults as Suicide Loss Survivors. Paper presented at the annual American Association of Suicidology conference. Washington D.C.

Snow, A. (2017). Exploring Precipitants to Suicide in LGB Adults. Poster presented at the annual American Association of Suicidology conference. Phoenix, AZ.

Snow, A. (2014): Measuring Outside the Lines: Assessing Creativity in the Classroom. Paper presentation at the annual Lilly Conference on College Teaching. Traverse City, MI.

TEACHING EXPERIENCE

2016-2019	Graduate Instructor, University of Kentucky
2013-2015	Undergraduate Instructor, University of Kentucky

HONORS AND AWARDS

2016-2017	Esther Fund Memorial Scholarship, Western Kentucky University
2005-2007	Vince Davis Memorial Fellowship, University of Kentucky
2002-2005	Dean's List, Georgetown College
2005	Scholastic Achievement Key Award, Alpha Gamma Delta Foundation
2005	Phi Sigma Alpha, National Honor Society in Political Science
2004-2005	National Dean's List
2004	Kentucky Intercollegiate Press Association Article Award Winner
2004	Phi Kappa Phi, National Honor Society
2003	Belle of the Blue Overall Scholarship Winner, Georgetown College
2003	Sigma Tau Delta, International Honor Society in English
2003	Omicron Delta Kappa, National Leadership Honor Society
2002	Outstanding Student in American Government, Georgetown College
2002	Alpha Lambda Delta, National Honor Society