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BLESSING OR BS? EXAMINING THE THERAPY EXPERIENCES OF TRANSGENDER AND GENDER NONCONFORMING CLIENTS OBTAINING REFERRAL LETTERS FOR GENDER AFFIRMING MEDICAL TREATMENT

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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 Education
at the University of Kentucky

By

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ABSTRACT OF DISSERTATION

BLESSING OR BS? EXAMINING THE THERAPY EXPERIENCES OF TRANSGENDER AND GENDER NONCONFORMING CLIENTS OBTAINING REFERRAL LETTERS FOR GENDER AFFIRMING MEDICAL TREATMENT

Transgender and gender nonconforming (TGNC) people who pursue gender affirming medical interventions, such as hormone therapy and surgery, are required to supply their physicians with referral letters from mental health professionals (Coleman et al., 2012). The process by which TGNC people are required to obtain referral letters before accessing gender affirming care is often referred to as *gatekeeping* in the TGNC literature (Budge, 2015; Cavanaugh, Hopwood, & Lambert, 2016). Despite implications that the current gatekeeping system may have for the relationship between TGNC clients and their therapists, few studies have examined TGNC individuals' experiences related to obtaining referral letters in therapy (Bess & Stabb, 2009; Elder, 2016). This study used semi-structured interviews and a grounded theory approach to qualitatively examine the experiences of 15 TGNC individuals who have obtained a referral letter for gender affirming medical intervention from their therapists. Thematic analysis revealed two core themes: (1) "blessings" that TGNC individuals experienced because of the referral letter requirement and (2) "bullsh*t" (or "BS") participants endured due to this requirement. Implications for psychotherapy practice and training, as well as healthcare policy, are discussed.

KEYWORDS: Transgender, TGNC, Gatekeeping, Referral Letters, Letters of Support, Therapeutic Relationship

Holly Brown

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Chapter One: Literature Review

The vast majority of transgender and gender nonconforming (TGNC) individuals either have engaged in psychotherapy or want to pursue psychotherapy (Grant et al., 2011; James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Based on the high rates of accessing therapy among this population, most therapists will likely work with at least one TGNC individual over the course of their careers (Budge, 2013). Despite the number of TGNC individuals seeking therapy, therapists report being underprepared to work with this population (O'Hara, Dispenza, Brack, & Blood, 2013; Zimmerman, 2015). TGNC clients notice this lack of training, and report encountering mental health providers who may be affirming but often require substantial education regarding their TGNC clients' identities and gender-related experiences before addressing TGNC clients' actual therapeutic needs (Benson, 2013; Bess & Stabb, 2009). To date, we know little about the experiences of TGNC clients in therapy or the relationships therapists build with their TGNC clients (Benson, 2013; Bess & Stabb, 2009; Elder, 2016). Additional research is needed to better understand how TGNC clients experience therapy, how they perceive their relationships with therapists, and how their therapeutic needs can be most effectively addressed. In this chapter, I use available literature to introduce relevant terminology, describe the current gatekeeping system of gender affirming healthcare and its history, discuss the theoretical framework I use to approach my research, summarize therapy experiences specific to TGNC individuals, and describe how previous research has considered the impacts of the gatekeeping system on TGNC clients.

Relevant Terminology

Transgender people are individuals whose gender identity, expression, or behavior is different from what society generally expects based on their assigned sex at birth. *Gender identity* is a person's internal sense of being a man, a woman, or a person with another gender. Because gender identity is internal, it is not necessarily visible to others (Bockting & Cesaretti, 2001). *Gender expression* is how a person expresses their gender to others, often through clothing, behavior, voice, and body characteristics (Hooks, 2015).

Transgender is an adjective and considered an umbrella term that describes a wide range of people with varying identities (Bockting & Cesaretti, 2001). Some transgender individuals are binary-identified, meaning that they identify as women or men. *Transgender women* are individuals who were assigned a male sex at birth and identify as women, and *transgender men* are individuals who were assigned a female sex at birth and identify as men (Budge, 2013).

Some transgender individuals identify as *nonbinary*, meaning that they may see themselves as having aspects of both masculine and feminine genders, may not identify with any gender, or may identify with a gender other than man or woman. Individuals who fit in this category may use a number of terms to describe their gender identities, including *genderqueer*, meaning neither identifying fully as a man or woman, *bi-gender*, meaning identifying fully with both masculine and feminine genders, or the broader term *gender nonconforming (GNC)*, which describes anyone whose gender expression is different from society's expectations based on their assigned sex at birth (Budge, 2013).

Often, people who fall into any of the categories above are described collectively as *transgender and gender nonconforming (TGNC)* individuals (Elder, 2016).

As the awareness of nonbinary gender identities increases, more Americans are using the third person pronoun *they* in singular contexts to acknowledge and include individuals of all genders. Traditionally, *they* has been reserved for plural antecedents, although its singular use is now common in American English in both formal and informal contexts (LaScotte, 2016). Singular *they* may refer to an individual whose gender is unknown, and is also often the pronoun used by GNC individuals who do not identify with *he* or *she* pronouns. In an effort to respect the diversity of gender, this manuscript will use singular *they* pronouns in all contexts except when referring specifically to individuals who use another pronoun.

Individuals who do not belong to the TGNC population are known as *cisgender* individuals, meaning that their gender identity and expression are congruent with what society generally expects based on their assigned sex at birth (Hooks, 2015). The vast majority of existing literature on psychotherapy focuses on the experiences and perspectives of cisgender clients. The lack of existing literature on TGNC individuals' experiences in therapy (Benson, 2013; Elder, 2016) is one of the motivations behind this dissertation study. More information is needed about how TGNC people experience therapy and about whether their needs as clients are being effectively met.

Gatekeeping

Gatekeeping is a term commonly used in the TGNC literature to describe the requirement that TGNC individuals obtain referral letters from therapists before accessing gender affirming medical interventions (Budge, 2015; Cavanaugh, Hopwood,

& Lambert, 2016). *Gender affirming medical interventions* are treatments or procedures that some TGNC individuals undergo to help them achieve a gender expression that better matches their gender identity (Coleman et al., 2012). Healthcare providers who offer gender affirming medical interventions to TGNC clients, such as hormone therapy and gender affirming surgeries, often require their patients to supply referral letters from mental health professionals before agreeing to offer services. These letters are used to confirm that TGNC individuals seeking gender affirming medical treatments meet the criteria for gender dysphoria, are prepared for the medical aspects of their transition, are aware of the potential risks and side-effects of gender affirming medical interventions (Budge 2015; Coleman et al., 2012), and are unlikely to regret their decision to have surgery (Benson, 2013; Bess & Stabb, 2009). Although many TGNC clients use therapy to address problems in living similar to cisgender clients, many also initiate therapy to obtain referral letters for gender affirming medical interventions (Benson, 2013; Budge, 2015; Hendricks & Testa, 2012).

Although many healthcare providers and insurance companies independently require referral letters before agreeing to provide or pay for gender affirming medical treatment, the gatekeeping system is also supported by professional organizations. Most notably, the World Professional Association for Transgender Health (WPATH) recommends that TGNC individuals seeking gender affirming surgery obtain referral letters in its Standards of Care (SOC) Version 7, a set of recommendations regarding TGNC healthcare that is considered the current gold standard for treatment with TGNC populations (Coleman et al., 2012). The SOC set forth recommendations that health professionals who work with TGNC individuals are encouraged to follow. However,

health professionals and insurance companies ultimately determine their own requirements for TGNC individuals who are looking to access or pay for gender affirming medical treatment. Requirements set by doctors and insurance companies may or may not align with the SOC.

The current SOC recommend that TGNC individuals obtain one referral letter for breast/chest surgery. Two referral letters are recommended for genital surgery, typically one from the TGNC individual's ongoing mental health provider and a second from another mental health provider who has an evaluative role with the TGNC individual. TGNC people may also need referral letters from their therapist to initiate hormone therapy, though according to the current SOC, physicians with behavioral health training are also qualified to assess patients' eligibility for hormone therapy (Coleman et al., 2012). The SOC recommend that mental health professionals have at least a masters-level degree or an equivalent specifically in behavioral health or counseling and be credentialed by a relevant licensing board to be considered competent for providing referral letters. Mental health professionals as defined in the SOC may be psychologists, psychiatrists, social workers, mental health counselors, marriage and family therapists, nurses, or family medicine practitioners (Coleman et al., 2012).

The SOC recommend that referral letters for surgery include the client's identifying characteristics such as sex assigned at birth, affirmed gender, and personal pronouns; assessment results and diagnoses for the client; information about therapy including length of treatment, types of evaluation, and therapy used; a clinical rationale for the client meeting criteria for surgery and why the therapist supports their request; assertion that informed consent for the surgery has been obtained; and assurance that the

referring therapist is available for continuing coordinated care. Beyond these suggestions for topics to cover in referral letters, there is no set standard for determining whether a client is eligible for gender affirming medical treatment. Therapists who provide referral letters are left to their own discretion on whether and when they will provide clients with referral letters (Budge, 2015; Coleman et al., 2012).

The current gatekeeping system is rooted in historical approaches to transgender healthcare. Demand for gender affirming healthcare in the United States first skyrocketed after Christine Jorgenson, the first transgender woman to receive gender affirming surgery in this country, made headlines in 1952. Following this demand, American medical centers focusing on transgender care sprang up throughout the country in the late 1960s and early 1970s. These clinics were largely university-based, research-focused institutions. Because of their research priorities, these clinics were very selective in the patients they accepted, and clients were required to go through rigorous, standardized gatekeeping procedures before they had any hope of receiving services. Such requirements often included significant therapy and personality testing, evaluations by multiple providers, approval from both their physician and the clinic's committee, and significant investments of time and money just to be examined with no guarantee of treatment (Denny, 1992).

Candidacy for gender affirming medical interventions was largely based on rigid gender roles, and often individuals were not considered for services if their behavior did not strikingly fit the stereotypes of their identified gender. Individuals were often only selected for gender affirming treatment if they were able to pass as a person of their identified gender prior to treatment. Some individuals report that, even when they

accessed hormone therapy, they were given lower doses of hormones than other patients if they did not fit the gender stereotypical molds that their providers were looking for (Denny, 1992).

In the 1960s and 1970s, gender affirming medical interventions were considered a last-ditch effort largely reserved for transgender people living socially disapproved lifestyles, such as individuals engaging in sex work, or for people who were highly suicidal. Individuals who showed signs of adjustment living as their assigned gender, such as pursuing an education or holding a job, were unlikely to be considered for treatment. These strict, stereotypical criteria for accessing gender affirming care not only had a dramatic impact on who was able to obtain medical treatment, but also on academic and cultural narratives about transgender people (Denny, 1992).

Although approaches to gender affirming healthcare have changed dramatically in the last few decades, TGNC people still face limited access to gender affirming care due to uninformed and even discriminatory practices among therapists, physicians, and other healthcare professionals (Gridley et al., 2016; White Hughto, Rose, Pachankis, & Reisner, 2017). The historical and contemporary rigidity around who can access gender affirming interventions leads many TGNC people to resort to self-medication for hormone therapy, at risk to their physical health (Denny, 1992). Those with the means and ability to navigate the gatekeeping system and access professional gender affirming medical care must obtain referral letters from mental health professionals, driving many TGNC individuals to therapy. This gatekeeping system was established based on limited empirical evidence as limited research exists on TGNC people, their experiences in and beyond therapy, and how they are affected by gatekeeping requirements. The lack of

empirical data on the gatekeeping system and how it affects TGNC people necessitates further study to better understand how this system affects the therapy experiences and lives of TGNC individuals.

Theoretical Framework

Although TGNC people have always been a part of human diversity and psychologists have worked with TGNC people for decades, conversations centered on TGNC individuals are still new in the larger culture, and there is limited existing empirical research on this population. With these givens, it is important to be clear about the theoretical foundation from which I am approaching this study and my overall approach to research with TGNC people. I aim to couch this dissertation in a transgender theory perspective, which promotes a holistic view of gender (Nagoshi, Nagoshi, & Brzuzy, 2014).

Feminist theory and queer theory, both theoretical forbearers of transgender theory, go beyond essentialist views of gender to address the impacts of socialization. However, Nagoshi and colleagues (2014) argue that none of these theories adequately explain the experiences of TGNC individuals. Social construction of gender alone does not explain the embodied experiences of TGNC individuals. In other words, the notion that socialization is the only influence that determines gender identity and expression does not explain how individuals come to possess TGNC identities. Instead, these scholars propose a transgender theory that defines the lived reality of gender as a complex experience that involves elements of social construction, self-construction, and embodied experience. Experienced gender includes elements of societal messages received about gender (social construction), personal understandings of gender and

gender presentation choices (self-construction), as well as physical experiences of gender (embodiment). While acknowledging the influences of social pressures, this theory recognizes the experiences of TGNC people who have come to acknowledge their transgender identities despite the influences of socialization (Nagoshi et al., 2014). Additionally, transgender theory makes room for both binary and nonbinary understandings of gender and acknowledges the fluidity with which some people may experience and express their gender identities (Nagoshi, Brzuzy, & Terrell, 2012).

Qualitative research supports the tension between socially constructed and embodied aspects of TGNC identities, which is highlighted in transgender theory. In an interview study with 11 TGNC individuals, participants shared motivations to pursue gender affirming medical procedures not only for their benefit, but also to match societal expectations of people with their gender in a way that they felt would help them be safer and more socially accepted. Participants in this study also discussed the impact of contextual factors on the fluidity of their gender presentation (Nagoshi et al., 2012). The negotiation of gender as an attribute that is personally embodied and experienced, as well as socially constructed, requires a flexible approach to understanding gender and the lived experiences of TGNC people. Cisgender people have different experiences with gender socialization, self-conception, and embodiment compared to their transgender peers. Because of this, it is important for cisgender researchers working with TGNC populations to carefully attend to participants' experiences and perspectives, rather than relying on their own assumptions.

Historically, researchers and health professionals have failed to prioritize the expressed needs and perspectives of TGNC individuals. Instead, the field of transgender

healthcare has placed more trust on the opinions of cisgender researchers and clinicians who claim expertise on transgender issues, rather than on the lived experiences of TGNC people themselves, even when those supposedly expert opinions are steeped in stereotypes and prejudices (Cavanaugh et al., 2016; Denny, 1992). Using a theoretical foundation that is derived inductively from the lived experiences of TGNC individuals is one way to ensure that further research on this population is trans-affirming and accurately reflects the lives of the people being studied. To honor this theoretical approach and to be consistent with practice guidelines for work with TGNC individuals (American Psychological Association [APA], 2015), I will use a number of safeguards in the methodology of this study to ensure that TGNC voices are represented accurately throughout the data collection and analysis processes. These safeguards will be discussed in more detail in Chapter 2.

TGNC Individuals in Therapy

Although the literature on this area is still in its early stages, a small number of studies have investigated how TGNC individuals experience therapy (Benson, 2013; Bess & Stabb, 2009; Budge, 2015; Elder, 2016; Hooks, 2015; Johnson, 2014; Rachlin, 2002; Scarpella, 2010). Available research has considered the reasons that motivate TGNC individuals to seek therapy, as well as the positive and negative aspects of TGNC individuals' therapy experiences. Current research findings will be discussed in detail in the following sections.

Reasons for seeking therapy. TGNC individuals engage in therapy for numerous reasons. Motivations for TGNC individuals pursuing therapy may or may not relate to their gender identities. Reasons that TGNC people pursue therapy that have

been recorded in the current literature include gender identity exploration, seeking support during transition, seeking referral letters for gender affirming healthcare, and reasons unrelated to gender. Below is a summary of what the current literature has to say on why TGNC individuals may seek therapy.

TGNC individuals may use therapy as a space to process their gender identity exploration. TGNC clients may be struggling with the competing demands of their innate experiences of self and the gendered expectations society places on them due to their assigned sex at birth. Consequently, the process of coming out to oneself and others as a TGNC person may be stressful, and TGNC clients may seek the support and empathy a therapist can offer during this potentially challenging period of their lives (Austin & Goodman, 2018; Bess & Stabb, 2009; Lev 2004).

TGNC individuals may seek therapy during their coming out and transition processes. This period of TGNC individuals' lives presents a number of potential losses and challenges that may induce distress. TGNC clients may want to focus on preparing to come out to certain people or in certain settings of their lives, grieving the loss of relationships with people in their lives who are not accepting, and building supportive social networks (Austin & Goodman, 2018; Bess & Stabb, 2009).

The transition process also presents a number of potential stressors for TGNC individuals. Many of these may come up in therapy. TGNC clients may seek therapy for support through life changes related to transition, as well as psychoeducation related to TGNC concerns such as accessing medical interventions and legal resources (Benson, 2013; Bess & Stabb, 2009; Rachlin, 2002). Therapy with TGNC clients can also serve as a place to help clients navigate the medical and social processes of transition, and even

specific concerns such as emotional changes that may result from hormone therapy (Budge, 2015).

The Standards of Care (SOC) recommend that TGNC individuals obtain referral letters from mental health professionals before accessing gender affirming medical interventions (Coleman et al., 2012). Referral letters are also often required by physicians providing gender affirming care and insurance companies who may assist with costs of gender affirming care. Because of this, many TGNC individuals may initiate therapy primarily or partially to obtain a referral letter for gender affirming medical services (Austin & Goodman, 2018; Benson, 2013; Budge, 2015; Hendricks & Testa, 2012).

Many TGNC individuals access therapy for problems in living that have nothing to do with their gender identity. Like cisgender clients, TGNC individuals may deal with stressors related to work, family, interpersonal relationships, psychological symptoms, and many other concerns—and these issues may be more salient to some TGNC clients than their gender identities. It is important for therapists working with TGNC clients to be mindful of this and to avoid pathologizing TGNC identities by assuming that gender identity will be a clinical focus in the therapeutic work these clients engage in (Austin & Goodman, 2018; Benson, 2013; Bess & Stabb, 2009; Rachlin, 2002).

TGNC therapy experiences. A great deal of conceptual writing focuses on therapy with TGNC clients (Austin & Craig, 2015; Budge, 2013; Carroll & Gilroy, 2002; Carroll, Gilroy, & Ryan, 2002; Goethals & Schwiebert, 2005; Hendricks & Testa, 2012), and several professional organizations have set forth guidelines about working with this population (APA, 2015; Burnes et al., 2010; Coleman et al., 2012). However, the current

body of research directly inquiring about TGNC clients' experiences in therapy is quite limited. Existing studies speak to positive experiences that this population has had with therapists, as well as negative and discriminatory experiences.

Positive experiences. Despite the discriminatory treatment that TGNC people face in society at large, many members of this population report having positive experiences in therapy (Bess & Stabb, 2009; Elder, 2016; Hooks, 2015; Rachlin, 2002). Available research suggests that TGNC people benefit most from therapy that is informed and affirming (Elder, 2016; Rachlin, 2002), but may still receive benefit even when their therapists are inexperienced with TGNC therapy issues (Rachlin, 2002). In an interview study looking at therapy experiences among 10 older, binary-identified TGNC people, participants noted that their therapy experiences have become increasingly TGNC-affirming in the last few decades (Elder, 2016).

Many TGNC people describe having positive, transaffirmative experiences in therapy. A sample of seven binary-identified TGNC people who were interviewed about their therapy experiences reported benefiting from opportunities to work with informed and affirming therapists who did not need a great deal of education on TGNC issues before addressing their clients' presenting concerns (Benson, 2013). TGNC individuals describe therapy as a place where they can talk freely about their gender experiences or address issues entirely unrelated to gender, depending on what their goals and priorities are (Elder, 2016). In an interview study about therapy experiences with seven binary-identified TGNC people, participants noted encountering therapists who explicitly support their decisions on gender-related medical interventions and do not force rigid definitions of masculinity or femininity on them (Bess & Stabb, 2009). Many therapists

who are affirming of TGNC clients themselves reject traditional gender roles and expression (Bess & Stabb, 2009) or openly identify as members of the LGBT community (Elder, 2016).

TGNC people report positive life changes because of therapy. Research suggests TGNC populations benefit most when their therapists are experienced in working with TGNC clients (Elder, 2016; Rachlin, 2002). In a survey study of 93 binary-identified transgender people, participants tended to have better therapy experiences with therapists who adhered to best practices for working with TGNC clients (Rachlin, 2002). With an experienced therapist, TGNC individuals report better rapport, greater progress in their gender exploration or transition, and higher satisfaction with therapy (Rachlin, 2002). The positive correlation between therapist experience and client satisfaction among TGNC clients was also found in a survey study with 149 TGNC people (Hooks, 2015). However, even when their therapists do not have adequate experience with gender issues, TGNC people still report experiencing positive life changes as a result of therapy (Rachlin, 2002). Although TGNC people can benefit from therapy despite pervasive issues with counselor preparedness to work with this population, the existing literature makes it clear that access to informed and affirming therapists is most beneficial for TGNC therapy clients.

Research is limited, but available evidence suggests that TGNC individuals are increasingly able to access gender affirming therapy. TGNC people report that therapists they encounter today are more open minded than in the past, and increasingly identify as allies and LGBT individuals themselves. Therapists TGNC individuals report encountering today are more accepting of clients' gender and sexual identities and are

more knowledgeable on updated language and literature related to TGNC individuals (Elder, 2016).

Negative experiences. Many TGNC research participants report positive experiences in therapy. However, this is not always the case. TGNC individuals also report negative therapy experiences including having difficulty finding knowledgeable and supportive therapists (Austin & Goodman, 2018), encountering a range of microaggressions from therapists (Johnson, 2014; Mizock & Lundquist, 2016; Scarpella, 2010), receiving abusive and unethical treatment from therapists (Elder, 2016), and being unfairly denied access to gender affirming medical interventions (Bess & Stabb, 2009; Elder, 2016).

Some research suggests that TGNC people may have limited access to therapists in their community who are knowledgeable about TGNC individuals' therapy needs and who are affirming of TGNC people. A recent study surveyed 65 TGNC people asking about their experiences with therapists and healthcare providers. Among the 56 participants who had been to therapy in this sample, 26% of respondents reported having a difficult time locating a therapist with knowledge about transgender people, and 19% of respondents reported difficulty finding a trans affirming therapist (Austin & Goodman, 2018).

TGNC people report experiencing a variety of microaggressions from their therapists. Microaggressions in therapy such as expressing disapproval, invading bodily privacy, and pathologizing gender identity are associated with weaker therapeutic alliances and higher rates of premature termination for TGNC clients. However, the effects of microaggressions were less severe when therapists acknowledged their

microaggression perpetration, compared to when TGNC clients had to point out microaggressions themselves, in a sample of 255 TGNC people who were surveyed online about encountering microaggressions in therapy (Johnson, 2014). In an interview study on therapy relationships with 12 transgender women, participants reported other microaggressive experiences in therapy such as therapists expressing discomfort with a client's gender identity, failing to acknowledge a client's gender because they did not fit their therapist's narrow definition of a transgender person, and focusing on other issues when participants wanted to address gender identity concerns (Scarpella, 2010). Therapists' attending to client needs also impacts whether TGNC clients benefit from therapy. A recent grounded theory study with 45 TGNC adults found TGNC individuals received less benefit from therapy when their therapists overemphasized or underemphasized gender, as well as when their therapists overemphasized or underemphasized their gatekeeping role (Mizock & Lundquist, 2016).

TGNC people also report instances in which mental health providers abused their power in even more dramatic ways. Examples of mistreatment in therapy were described by 10 older TGNC people in a recent qualitative study and included being subjected to physical restraints, overmedication, involuntary hospitalization, sexual advances, refusal of treatment, and attempts by therapists to change TGNC individuals' sexual orientations or gender identities (Elder, 2016). Some TGNC individuals also report encountering therapists who were reluctant to write letters for gender affirming procedures (Elder, 2016) or unfairly denied access to gender affirming treatment (Bess & Stabb, 2009).

Existing studies provide useful information about TGNC clients' experiences in therapy and provide a starting point for empirical inquiry. An important way to advance

research in this area is to look at specific components of TGNC individuals' experiences in therapy, particularly aspects of therapy that are unique to TGNC client populations. This study adds to research on therapy with TGNC populations by addressing the gatekeeping aspects of therapy with TGNC clients.

Letter Writing

The Standards of Care (SOC) recommend that TGNC individuals obtain a referral letter from a mental health professional or obtain approval from a physician with behavioral health training before accessing hormone therapy, recommend one letter from a mental health professional to access chest masculinizing or feminizing surgery, and recommend two letters from mental health professionals to access genital surgery (Coleman et al., 2012). This system of encouraging TGNC individuals to work with mental health professionals before receiving gender affirming medical care is often referred to as gatekeeping (Budge, 2015). Although the SOC's recommendations are considered the gold standard for TGNC healthcare among much of the medical community, individual doctors and insurance companies are free to set their own requirements that may be more or less strict than the recommendations set forth in the SOC. Below, I discuss the rationale, advantages, and disadvantages of the current gatekeeping system.

Benefits of referral letters. There are a number of stakeholders who arguably benefit from the current gatekeeping system. Some scholars have argued that TGNC individuals benefit from the current system because it encourages them to process their transition experiences with a mental health professional; allows them an opportunity to process questions, hopes, and fears related to surgery; and ensures that they receive

information about the risks associated with transition (Bess & Stabb, 2009; Coleman et al., 2012).

The SOC note that recommending referral letters from mental health providers ensures that TGNC people seeking gender affirming care receive thorough informed consent about the process, risks, and benefits related to transition and the treatment they seek (Coleman et al., 2012). Proponents of the current gatekeeping system also argue that it protects physicians and mental health professionals from lawsuits with inadequately informed or prepared patients who theoretically might regret their gender affirming treatment (Bess & Stabb, 2009). Therapists also arguably benefit in the form of increased clientele, as needing a referral letter for medical interventions may motivate TGNC individuals to pursue therapy (Budge, 2015).

Potential harms of referral letters. Although many therapists support the current referral system, others argue that it may have potential harms. These harms are most likely to impact the most vulnerable stakeholders: TGNC individuals in need of gender affirming medical interventions. Some potential harms of referral letters include the necessity of therapists taking on a gatekeeping role, the possibility of therapist bias in deciding whether to provide referral letters, and the reduction of trust between TGNC clients and their therapists. These concerns may have implications for the therapeutic relationship and ultimately the benefit that TGNC clients receive from therapy.

Therapists as gatekeepers. Many TGNC individuals have called for a transgender healthcare system in which TGNC individuals are allowed to self-refer for gender affirming treatment (Bess & Stabb, 2009; Denny, 1992). In recent literature, this is often called an *informed consent* model of treatment (Cavanaugh et al., 2016). In

contrast, the current SOC recommendation, that TGNC people obtain referral letters from mental health professionals before accessing certain treatments, places therapists in a gatekeeping role. Adding this component to the therapist role may shift power dynamics in therapeutic relationships between TGNC clients and their mental health providers, and negatively affect the experiences that TGNC clients have in therapy (Budge, 2015).

Apart from work with TGNC clients, there are few instances in which therapists are responsible for giving clients referrals for medically necessary interventions. Unlike most other health and psychological concerns therapists may act as gatekeepers for, such as access to medication for attention-difficulties, access to gender affirming medical treatments has implications for the autonomy, personhood, safety, and marginalization of TGNC clients. Gender affirming medical treatment can dramatically change the gender presentation of TGNC individuals (Coleman et al, 2012), impacting how they experience themselves and how they can publicly define and present themselves. Because they affect TGNC individuals' gender presentations, gender affirming medical interventions affect how other people view and treat TGNC people, considering that TGNC people report increases in experienced harassment when their gender presentation is more androgynous (Cavanaugh et al., 2016). TGNC people also report high rates of distress while waiting to access gender affirming medical care. TGNC individuals attempt suicide at rates much higher than cisgender populations (Grant et al., 2011; James et al., 2016), and this disparity may be partially attributable to these stressors. This means that gender affirming treatment has significant implications for the marginalization and even physical safety of TGNC people. Additionally, requiring therapists' approval before TGNC clients can access gender affirming medical care invalidates and pathologizes

TGNC identities by implying that TGNC people are not capable of self-determining what gender affirming medical treatments are appropriate for them.

Other research casts doubt on the preparedness of therapists to competently work with TGNC clients, much less act as fair and unbiased gatekeepers to gender affirming healthcare access. A survey study of doctoral clinical psychology students revealed that the majority of trainees did not have any courses in their program specific to transgender or LGBT issues, did not receive any supervision on clinical work with transgender clients, did not have any practicum experience working with transgender clients, and were unaware of WPATH's SOC (Zimmerman, 2015). Another study surveyed 87 trainees in accredited counseling and counseling psychology programs, finding that neither length in the program nor practicum experience correlated with trainees' self-rated competency for working with transgender clients. The authors concluded that these findings suggest counseling and counseling psychology graduate programs are not adequately training counselors to work with transgender client populations (O'Hara et al., 2013). These training program issues extend to other mental health professions. In a recent survey of TGNC social work students, participants reported transphobic behavior among faculty in their programs, a lack of course content and readings on transgender issues, course content that pathologizes TGNC experiences, and experiences of being pressured to educate faculty and other students about transgender issues (Austin, Craig, & McInroy, 2016).

Therapist trainees may also encounter roadblocks when looking outside of their graduate programs for information on how to effectively work with TGNC clients. Cisgenderist language is still common in psychological literature about transgender

people, especially in clinically focused literature and research conducted by or associated with some of the most prolific psychological researchers on transgender issues (Ansara & Hegarty, 2011). Further, the current TGNC therapy literature offers little guidance on how to effectively and reliably assess clients' readiness for gender affirming medical treatment (Budge, 2015; Coleman et al., 2012). The prevalence of inadequate graduate training on TGNC issues coupled with limitations in the existing TGNC therapy literature reduce the likelihood that therapists will be able to act as fair and reliable gatekeepers for gender affirming medical intervention.

Bias in the referral process. Because the referral process leaves ample room for therapists' subjectivity, some TGNC clients may be denied referral letters despite the potential to benefit from gender affirming medical treatment. A few existing studies have highlighted this issue, giving voice to TGNC individuals who report that some healthcare professionals have based referral decisions on biases such as racism and cisnormative beauty standards (Denny, 1992; Elder, 2016). Accounts of early gender affirming medical treatment in the United States during the late 1960s and early 1970s even include examples of providers who used their own level of sexual interest in potential patients to determine who was eligible for services (Denny, 1992). These examples highlight the potential abuses that may stem from placing therapists in the position of determining when and if their TGNC clients are eligible for gender affirming medical treatment.

Trust between TGNC people and psychologists. Because of the exploitation that can and has occurred in the referral process, and the unpreparedness of many therapists to work with TGNC clients, many TGNC individuals report distrust toward the field of psychology and skepticism about therapy's usefulness for them (Bess & Stabb, 2009;

Cavanaugh et al., 2016; Denny, 1992). Conversely, some scholars suspect that TGNC individuals shift narratives about their experiences to present themselves as good candidates for gender affirming treatment (Beauchamp et al., 2016; Bess & Stabb, 2009; Cavanaugh et al., 2016; Denny, 1992; Singh, Hwahng, Chang, & White, 2017). For example, Singh and colleagues (2017) present a case illustration in which an African-American transgender woman avoided disclosing a number of important life experiences, including experiences of violence victimization and participation in underground economies, because she was pursuing a referral letter for hormone therapy and felt pressure to present herself as psychologically healthy. Similarly, Cavanaugh and colleagues (2016) speculated that GNC individuals pursuing gender affirming medical treatment might inaccurately frame their gender and transition goals in binary language to fit therapists' stereotypes about transgender people and increase their chances of obtaining referral letters. Unfortunately, the current gatekeeping system for gender affirming healthcare demands and is reinforced by these types of deception (Denny, 1992).

No research has looked at how the current gatekeeping system affects the relationship between TGNC clients who are pursuing gender affirming medical treatment and their therapists. Given the heightened power differential that gatekeeping creates, the ways in which the authority given to gatekeepers can be misused, and the lack of trust the current gatekeeping system creates between TGNC therapy clients and therapists, it seems likely that gatekeeping related to TGNC healthcare may have serious implications for the therapeutic alliance between a TGNC client and their therapist. It is widely known that the therapeutic alliance is a significant predictor of client outcomes in

psychotherapy (Horvath, 2001). Consequently, the gatekeeping function of therapy with TGNC clients seeking referral letters for gender affirming medical treatment may contradict therapy's intended purpose: improvement of clients' well-being. Research is needed to assess whether this perturbing possibility is actually experienced by TGNC therapy clients.

Although some existing research has considered TGNC therapy clients' experiences with the current gatekeeping system, this work has occurred in the context of broader studies about TGNC individuals' experiences in therapy (Bess & Stabb, 2009; Elder, 2016). Empirical studies have yet to specifically examine how TGNC individuals' therapy experiences are impacted by the gatekeeping system. This gap in the literature is concerning, given that there is little empirical justification for recommendations in the SOC that create the current gatekeeping system for gender affirming medical care (Coleman et al., 2012). Existing guidelines on when and how TGNC people can access gender affirming care seem to be based more on tradition and stereotypes held by healthcare professionals, rather than on the expressed perspectives and needs of the population these guidelines are intended to protect. This system mandates that TGNC people wishing to pursue the most commonly sought gender affirming medical interventions obtain a stamp of approval from psychologists or other mental health providers who, as currently available research shows, are collectively underprepared to work with TGNC clients in a culturally responsive way (Austin et al., 2016; Benson, 2013; O'Hara et al., 2013; Zimmerman, 2015). Despite the many requirements that have been placed on TGNC people by healthcare professions, these professions—including psychology—have made little effort to investigate how TGNC people experience the

demands they must meet before accessing gender affirming care, or to assess whether the current gatekeeping system of gender affirming healthcare is a useful safeguard or simply a barrier to treatment.

Contributions to Counseling Psychology Research and Practice

Based on a review of the existing literature about TGNC individuals' experiences in therapy and the current gatekeeping system, it is apparent that a gap exists in the literature regarding TGNC individuals' experiences of the current gatekeeping model for accessing gender affirming medical care and how the process of gatekeeping impacts TGNC people's experiences with therapists. Although some existing research has touched on TGNC individuals' experiences with the gatekeeping process while exploring broader therapy experiences (Bess & Stabb, 2009; Elder, 2016), there is a lack of research directly examining how this system impacts TGNC individuals' therapy experiences. To address this gap in the literature, I examined the experiences of TGNC individuals who have obtained a referral letter from their therapist related to gender affirming medical interventions by posing the research question: *"How does the referral letter requirement impact therapy experiences and overall transition processes for TGNC clients?"* Data addressing this question has the potential to inform effective and culturally competent approaches to therapy with TGNC people.

The following chapters provide the elements of my dissertation research study. Chapter 2 provides information about the design and methodology of this study, including a rationale for the use of grounded theory methodology. Details regarding the targeted sample, participant recruitment, data collection, data management, and data

analysis are also included. Chapter 3 contains the research results from the dissertation study, and Chapter 4 provides a discussion of these results.

Chapter Two: Methodology

This study sought to address the research question: "*How does the referral letter requirement impact therapy experiences and overall transition processes for TGNC clients*?" I chose qualitative methodology using a grounded theory approach to address this research question because it allows for exploration of an area with little existing research, can be used to inductively generate theory based on participant perspectives and experiences, and facilitates a collaborative research approach consistent with ethical guidelines for conducting research with TGNC people (APA, 2015). Given the limited empirically-acquired information on how TGNC clients experience the gatekeeping process, it is premature to test hypotheses related to this phenomenon, because theory does not exist to appropriately ground quantitative research hypotheses. A discovery-oriented approach through qualitative methodology was chosen as most likely to richly represent the experiences of the TGNC individuals who participated in this study, and to provide a broader context in which future quantitative work can be grounded.

Grounded Theory

There are a limited number of empirical studies addressing transgender psychotherapy clients' therapy experiences, and no research specifically on transgender clients' experiences with the gatekeeping process. Because of this, there is not an evidenced-based theory about this phenomenon already in existence that a study such as this one can seek to verify. Consequently, an inductive qualitative approach that seeks to develop rather than confirm a theory, such as a grounded theory approach (Charmaz, 2006; Glaser & Strauss, 1967), is most appropriate for this study. Grounded theory

methodologies have been used in other recent qualitative studies on transgender individuals with similar rationales (Aaron & Rostosky, 2018; Levitt & Ippolito, 2014).

Inductive. Grounded theory relies on an inductive process to generate theory—creating theory based on collected data rather than trying to fit data into deductively created theories (Glaser & Strauss, 1967). This form of qualitative research ensures that generated theories reflect the collected data. This type of approach is especially important when studying vulnerable populations whose experiences have been absent or misrepresented in previous research, including transgender individuals (Bess & Stabb, 2009; Elder, 2016; Hale, 2009; Vincent, 2018). An inductive process prioritizes the experiences of members of the studied population, rather than relying too heavily on researcher assumptions (Charmaz, 2006; Charmaz, 2014; Glaser & Strauss, 1967).

Context-based. In contrast to phenomenology and other qualitative methods that use *bracketing*, a method of attempting to set aside preconceived notions about studied phenomena (Creswell, 2007), researchers who use grounded theory are encouraged to use their guiding interests as points of departure for research. Although researchers are cautioned that their preconceptions about phenomena are only starting points and should be abandoned when faced with data that contradicts them, initial ideas about and interests related to phenomena are considered an asset rather than an impediment in grounded theory approaches (Charmaz, 2006; Charmaz, 2014). Consequently, my research approach was informed by therapy work with TGNC clients, trainings and literature on how to effectively work with TGNC client populations, and interactions with TGNC individuals in numerous roles including peer, colleague, aspiring ally, and friend. Perspectives with which I approached this study included valuing the autonomy of TGNC

people regarding their self-definitions, being aware of barriers TGNC people are confronted with in accessing gender affirming care, and being aware of the need for cisgender allies to vocally affirm TGNC people in both personal and professional environments.

Collaborative. Although not a requirement of grounded theory approaches, this methodology allows collaboration between researchers, participants, and the studied population. It was my aim to involve the TGNC community as much as possible in the design of this study and its interview protocol. Given the abuses that have occurred in the past by researchers working with the TGNC community (Denny, 1992; Vincent, 2018), and the fact that I am approaching this study from the lens of someone who is not a member of the TGNC community, it would be irresponsible and unethical to conduct this research without seeking to attend to, incorporate, and acknowledge the perspectives of TGNC individuals as much as possible (Vincent, 2018). This goal is in line with the APA's guidelines for work with TGNC populations, which mentions the importance of using collaborative approaches in research with the TGNC community (APA, 2015). I pursued this goal by seeking and attending to input from members of the TGNC community about my ideas and plans for this study and for the interview protocol. I also used member checks (Charmaz, 2006; Charmaz, 2014) to ensure a collaborative approach with research participants, who had the option to review their interview transcripts for accuracy and to review and provide feedback on the preliminary categories my research team generated based on their interviews. These strategies were attempts to acknowledge the expertise and authority of TGNC people to the greatest extent possible in a dissertation study about TGNC experiences being conducted by a cisgender researcher.

The Current Study

The purpose of this study was to collect and analyze accounts of TGNC individuals' experiences with the gatekeeping process, especially how it impacted their relationships with therapists and their transition processes. To accomplish this, I used grounded theory qualitative methodology (Charmaz, 2006; Charmaz, 2014; Glaser & Strauss, 1967). In the following sections I describe strategies for participant recruitment, research materials, data collection, and the data analysis process.

Participant recruitment. Eligible participants included people over the age of 18 who identified as TGNC individuals, had prior therapy experience, had obtained a referral letter for transition related medical services from a mental health professional, and had seen the mental health professional who wrote their letter for therapy within the past year. I sent information about the study and my contact information to regional and national LGBTQ and transgender-specific listservs and social media outlets. When sharing information with social media groups I was not already a part of, I contacted a page administrator (Vincent, 2018) to request permission to post my university internal review board approved study announcement and contact information. Some administrators posted the information themselves, and some asked me to join the group and post the information personally. I also used *snowball sampling*, a recruitment strategy that asks members of the studied population to refer individuals from their networks (Sadler, Lee, Lim, & Fullerton, 2010). This involved asking participants, individuals who were screened but did not meet study criteria, and individuals who came across my research announcement to share a flier about the study and my contact

information with others who they believed were eligible and potentially interested in research participation.

Sample size. In grounded theory approaches, researchers aim to gather data until saturation is reached. *Saturation* occurs when enough data is collected that no new information or patterns emerge. At this point, grounded theory experts argue gathering further data will not lead to new insights regarding the studied phenomena. Achieving saturation ensures that data that address the research question are sufficient to produce theory (Charmaz, 2006; Charmaz, 2014).

No known studies have explored TGNC individuals' experiences with obtaining referral letters from therapists for gender affirming medical treatment, so I was not sure what sample size would be sufficient to adequately inform theory development. Most existing qualitative studies on TGNC individuals' therapy experiences have used sample sizes of 10 or fewer participants (Benson, 2013; Bess & Stabb, 2009; Budge, 2015; Elder, 2016). Considering the small sample sizes in previous qualitative research about TGNC individuals' experiences in therapy, I planned to interview 10-15 participants. Ultimately, I completed interviews with 15 participants. Given that qualitative researchers have been able to develop theory related to transgender therapy experiences with smaller sample sizes than the one obtained for this study, theoretical saturation was plausible with a sample of 15 participants.

Participants. A total of 15 self-identified transgender adults participated in this study. Female-affirmed individuals accounted for 46.67% of participants, male-affirmed individuals accounted for 40% of participants, and nonbinary individuals accounted for 13.33% of participants. Additional demographics are outlined in ***Table 2.1***.

***Table 2.1* Participant Demographics** *pseudonyms

Name*	Gender	Pronouns	Race/ Ethnicity	Age	Sexual orientation	State	Environment	Education	Therapist Age	Therapist Gender
Alex	gender nonconform-ing, trans-masculine	ze/hir	White	33	queer	NY	urban	PhD student	33	cisgender woman
Bryce	trans male	they/them	White	23	Pan-sexual	CO	urban	GED	early-mid 50s	transgender woman
Cameron	trans-masculine nonbinary	they/them	White	19	queer	KY	urban	college sopho-more	40	cis woman
Gina	transgender female	she/her	Multiracial (Polynesian and White)	49	lesbian	CA	urban	some college	40	cisgender woman
Jim	transgender man	he/him	White	22	bisexual	TX	urban	college senior	mid 40s	cisgender woman
Karen	transgender female	she/her	White	55	lesbian	MN	rural	some college	60	cisgender woman
Liz	transgender MTF	she/her	White	49	none	NC	urban	Associates	33	cisgender woman
Mary	female	she/her	White	53	bisexual	NC	rural	some college	45-55	cisgender woman
Moore	trans man	he/him	African American	34	queer	NY	urban	some college	40s	cisgender man
Sebastian	male	he/him	African American	20	hetero-sexual	KY	urban	college first year	32-33	cisgender man
Space	FTM	he/him	Black	19	straight	MA	rural	college senior	28-30	cisgender woman
Stella	demigirl/ trans woman	she/her	Multiracial (self-identified as Black in interview)	25	lesbian (attracted to women and nonbinary people)	MI	urban	college sopho-more	late 40s to mid 50s	cisgender woman
Trish	female	she/her	White	41	hetero-sexual	WA	urban	Associates	early-mid 60s	cisgender woman
Victoria	female	she/her	Multiracial (South Asian and White)	26	lesbian	KY	urban	GED	mid 40s	cisgender woman
Vincent	trans man	he/him	White	27	queer	MI	urban	Master's student	therapist 1: 30s-40s; therapist 2: late 50s	both cisgender woman

Compared to previous studies on TGNC therapy experiences, I was able to recruit a relatively diverse sample, with individuals who have a range of gender identities, racial identities, ages, and geographic locations. Interviewing participants with a range of identities allowed me to obtain a range of perspectives. Interestingly, despite their other areas of diversity, the majority of participants in this sample worked with cisgender women therapists.

Materials. Materials used in this study included the interview protocol, which was semi-structured and designed to elicit in-depth descriptions of individuals' therapy experiences and experiences obtaining referral letters for gender affirming medical treatment from therapists. Two audio recorders were used to facilitate verbatim transcription of participants' interviews.

Interview protocol. The interview protocol was developed based on a literature review of TGNC therapy experiences and my research question. I also sought feedback from the TGNC community while developing and refining my interview protocol (Vincent, 2018). I consulted several individuals in the TGNC community for input on the interview protocol's content, phrasing, and length, using feedback to revise the interview protocol through multiple iterations. I also revised the protocol based on feedback from my dissertation committee and pilot testing. The protocol was pilot tested with two volunteers from the TGNC community who met most of the study criteria. Pilot interviews were recorded, and afterward volunteers offered feedback related to the wording of questions, length of the interview, and the interview process. Following pilot interviews, I rephrased questions to improve protocol clarity about what transition steps participants had taken and why participants considered transition important. Pilot

interviewees also provided feedback about interview pacing and effectiveness of follow-up questions that was helpful when I began completing interviews with research participants. After revisions from pilot testing, I finalized the interview protocol based on additional feedback from my dissertation co-chairs.

The protocol included demographic questions and open-ended questions. Open-ended questions addressed topics such as the participants' experiences in therapy, relationship with their therapist, and how needing their therapist to provide a referral letter for gender affirming medical care affected their therapy and transition experiences. These questions were designed to elicit personal accounts of my participant's experiences seeking referral letters and their perceptions of the gatekeeping process in therapy at large. Questions in the interview protocol included: "How did needing a referral letter for gender affirming medical treatment affect your decision to go to therapy?" "In what ways did needing a referral letter affect your experience with your therapist?" "Thinking about work with the therapist who wrote your letter, how helpful was your therapy experience, overall?" "How did needing a referral letter affect your experience in therapy overall?" "How did needing a referral letter affect your transition process?" "What are your thoughts and feelings about the requirement that you get referral letters from a therapist before receiving gender affirming medical treatment?" The interview protocol's semi-structured format allowed for follow-up questions and probes based on participant responses. The full interview protocol is shown in Appendix A.

Audio recorders. Two digital audio recorders were used to record participant interviews. One audio recorder served as the primary recording device, and the second audio recorder served as a safeguard in case of electronic failure. I stored confidential

materials that could potentially link participants to the study inside a lockbox, which was stored in a locked filing cabinet in my personal office. These included two digital recorders and interview notes with identifying information such as names, demographics, and contact information.

Data collection procedures. I was contacted by approximately 80 individuals who were interested in participating in the study through email and social media. I answered questions from interested individuals online and screened for study eligibility with a few basic demographics including gender-identity, age, race, and region to ensure a range of perspectives was included in my participant sample. Individuals who met pre-screening criteria completed a brief phone screener (i.e., time since receiving last letter, time since last appointment with therapist), were given details about the study, and scheduled a time with me for their phone interview. Eligible participants were provided information about the study length, content, and compensation. Individuals who were still interested in completing an interview scheduled an interview time. After scheduling several interviews with mostly White women, I began making additional efforts to recruit individuals with diverse gender and racial identities, including posting my research advertisement on the pages of additional intersectional social media groups and using snowball sampling with the specification that I was particularly looking for perspectives from People of Color and nonbinary individuals. I conducted interviews in two waves, one in which I scheduled interviews with the first eligible individuals who contacted me, and one in which I used targeted recruitment to schedule interviews with participants whose identities would add balance to the perspectives represented in my sample. Once a participant was scheduled for an interview, I emailed the informed consent form to them

(see Appendix B). Each participant had an opportunity to ask questions about the informed consent information over the phone, and verbal informed consent was obtained prior to beginning the telephone interview. Written informed consent was waived given that this study occurred via telephone.

After obtaining verbal informed consent, I administered the interview protocol, which included additional demographic questions as well as questions about participant therapy experiences. To protect participant confidentiality, I used pseudonyms to refer to participants in their interview transcripts and in all of my subsequent writing related to their interview quotes. Some participants chose their own pseudonym, while others asked me to pick a pseudonym for them. Pseudonyms I selected were chosen at random. Interviews had a semi-structured format and lasted between one and two hours depending on how detailed participants' responses were. After interviews I mailed each participant a $50.00 check to compensate for their time, as well as their mental and emotional labor (Vincent, 2018).

After each interview was completed, I uploaded the audio recording onto a password protected computer and manually transcribed each interview verbatim. I read over transcriptions to check for accuracy, and also emailed each transcription to the corresponding participant in case they wanted to check it for accuracy. To protect confidentiality, transcripts were password protected before being emailed to participants. Participants had a two-week window to respond with any potential changes to their transcript. Two participants responded after receiving their transcript, and neither of them reported any inaccuracies or requested changes.

Data analysis. Transcripts were coded using grounded theory methodology by a small research team consisting of myself and three other counseling psychology graduate students with previous experience in LGBTQ research. Research team members included a cisgender, bisexual woman; a cisgender, heterosexual woman; a cisgender, gay man; and an agender, pansexual person with lived experience as a member of the TGNC community.

Initial coding. Initial coding began once 12 interviews had been completed. Prior to beginning initial coding, the research team met to discuss the process of initial coding and to practice recommended strategies for line-by-line initial coding (Charmaz, 2006; Charmaz, 2014). Research team members labeled each line of participants' transcribed responses based on the content participants shared. When using grounded theory methodologies, labels or codes are not generated from preconceived ideas, but from what emerges from the data itself, and may be revised repeatedly to best capture the data (Charmaz, 2006; Charmaz, 2014). This meant that each team member read through all interview transcripts and labeled each line with a code that the team member believed captured the main idea the research participant was conveying in that line of their transcript.

Focused coding. Once all four research team members independently completed initial coding, we met to compare observations from our experiences with initial coding and discuss recommended processes for focused coding. When using grounded theory methodologies, focused coding involves condensing the initial codes based on the most frequent and meaningful ideas that came up during initial coding (Charmaz, 2006; Charmaz, 2014). Each research team member coded the initial 12 interviews during

focused coding, as well as three additional interviews I completed during the focused coding process. Once research team members had independently completed focused coding, we met to consolidate and organize the codes we had created.

Category generation. When using grounded theory methodology, the final step of the coding process involves sorting and organizing codes to lay the groundwork for a theory of the studied phenomena (Charmaz, 2006; Charmaz, 2014). Our research team met over the course of two 3-hour meetings to collaboratively consolidate our focused codes and begin organizing them into categories. During our first focused coding meeting, the research team agreed that we were not getting new coding ideas based on the most recent interviews and had achieved saturation. After our second meeting, I generated definitions for the categories we had created based on our group discussion and sent them to other members of the research team for review. I edited the definitions based on research team members' feedback.

Memo writing. An analytical tool commonly used in grounded theory methodology is *memo writing*, or taking ongoing notes on interviews, codes, and ideas that come to light throughout the research process (Charmaz, 2014). I kept a notebook for memo writing beginning with the initial pilot testing stages of the study. I used the notebook to record methodological decisions, observations following interviews, and reflections during the data analysis process. I also encouraged other research team members to engage in memo writing and share points from their memos throughout the data analysis process. We shared observations and written memos during data analysis meetings to more deeply inform the data analysis process.

Trustworthiness. Multiple steps were taken to ensure the *trustworthiness* of this study, or the rigor with which I and my research team worked to ensure that participants' perspectives, rather than researcher bias, informed the data analysis (Morrow, Castañeda-Sound, & Abrams, 2012). Given the limitations of existing research about TGNC populations—which has a long history of pathologizing TGNC identities and experiences (Bess & Stabb, 2009; Denny, 1992; Elder, 2016), and the lack of trust that many TGNC individuals have toward mental health professionals due to this history (Denny, 1992), trustworthiness is an especially important priority for new studies with TGNC individuals.

Reflexivity. One method for ensuring the trustworthiness of a qualitative study is *reflexivity*. This is the process of reflecting on personal biases, interests, and assumptions that might influence my approach to research inquiry (Charmaz, 2014). Using a reflexive stance during this study allowed me to consider personal assumptions that could prevent me from accurately conveying participants' experiences in my data collection and analysis (Hale, 2009). This involved recognizing my motivations for this study (Hale, 2009; Vincent, 2018), which included the lack of research on TGNC clients' experiences in therapy and my professional identity as a counseling psychologist-in-training who values holistic approaches to research and practice that account for individuals' lived experiences, strengths, and perspectives.

Reflexivity also included personal reflection; discussing concerns about potential biases with my dissertation committee, research team, and TGNC community members; working to reach a consensus with research team members regarding category generation; and inviting feedback throughout the research process. As a cisgender person

studying a community that I am not a part of, reflecting on my motivations and assumptions about this research and being responsive to feedback is especially important in ensuring that my findings reflect the realities of my research participants, not my own assumptions (Hale, 2009). For example, my dissertation committee pointed out some leading questions in an early draft of my interview protocol, which likely stemmed from my assumptions that participants would perceive that the referral letter requirement negatively affected their therapy experiences. This feedback allowed me to create a final interview protocol of non-leading, open-ended questions. It also increased my awareness of how personal assumptions might affect my approach to this study and motivated me to mindfully attend to participants' positive experiences related to obtaining referral letters during data collection and analysis.

Constant comparative method. Throughout the analysis process, I made revisions to the generated categories list and its organization using the *constant comparative method*. This involved comparing data to data, data to codes, codes to categories, and back again (Charmaz, 2014). After generating categories based on our coding of participants' data, I led a reiterative process to ensure that the generated categories meaningfully addressed my initial research question and effectively conveyed participants' experiences. The research team reviewed the preliminary categories and their organization over two rounds of editing. During this process, we discussed points from participants' interviews and earlier codes to help us make collaborative decisions about category revisions. I then sent the categories to my dissertation co-chairs for review. After receiving feedback from my co-chairs, I reorganized the categories our research team had generated to more effectively and parsimoniously answer my research

question. With these reorganized categories, I went back through participants' interview data to compare emerging understandings of the data to the original transcriptions and coding. Once I had solidified category definitions, I sent the revised categories to my research team to review. I made further edits to the categories and their definitions based on feedback from research team members. I then submitted preliminary categories to research participants for member checks.

Member checks. Research participants were emailed with an invitation to review initial categories and provide feedback on how accurately the generated categories fit with their experiences. Participants had a two-week window to provide feedback. This was an additional step to ensure that TGNC research participants' voices were privileged throughout the research process, and to minimize the effects of researcher bias on the study's results. Similar safeguards have been used in other qualitative studies with this population (Aaron & Rostosky, 2018; Bess & Stabb, 2009; Elder, 2016). Two participants provided feedback on categories, and neither of the responding participants recommended any changes.

Theoretical sorting. Following member checks, I worked with one of my co-chairs to complete *theoretical sorting*. This involved examining the links between categories and reorganizing categories to create a clearer and more parsimonious representation of participants' experiences in light of my research question (Charmaz, 2014). This process included reviewing multiple drafts of my dissertation results, experimenting with alternative approaches to organizing categories, and meeting over the course of two sessions to sort and combine categories to parsimoniously capture participants' experiences with obtaining referral letters.

Conclusion

Qualitative methodology using grounded theory facilitated exploration of TGNC individuals' experiences related to obtaining referral letters from therapists for gender affirming medical treatment. This methodology enabled exploration of experiences that have not been considered in the current academic literature and allowed for in-depth consideration of context. Grounded theory structured the analysis to allow for a deeper understanding of participants' letter seeking experiences. This was the first known research study to use grounded theory to explore TGNC individuals' experiences obtaining referral letters for gender affirming medical treatment in therapy. The strengths of this qualitative methodology far outweigh its limitations when exploring such a little-known topic, making the qualitative methodology of grounded theory the best framework to address this study question. In the next chapter, I provide a detailed description of the research results.

Chapter Three: Results

This chapter presents the findings from the systematic analyses of the rich data participants provided during their interviews. Participants' experiences and perspectives are illustrated through quotes transcribed directly from their interviews. Participants' quotes are presented verbatim except for minor changes to promote flow and/or grammar, or to protect the privacy of individuals named by participants. Additions are represented by brackets ([]) and signal any modification to participants' transcripts, while ellipses (…) note any omission of words or phrases to improve the flow and brevity of quotes. Following quotes, participants' pseudonyms and pronouns are provided.

Thematic Analysis

Participants shared a range of experiences and perspectives related to how needing to obtain referral letters affected their experience in therapy and their transition process as a whole. During analysis, two broad themes emerged from participants' experiences with the referral letter process. To some participants, the letter was a "blessing" in disguise, that ultimately led them to a beneficial therapeutic experience and support during their transition process. Other participants described the requirement that they obtain referral letters as "BS," or an infringement on their autonomy that reduced the benefit they received from therapy and ultimately made transition more challenging to access. These themes and sub-categories are described below.

Blessings. Fourteen participants identified ways they benefitted from the process of obtaining referral letters.

"It was really a blessing in disguise. Because, you know, who really wants—I don't know. Me, if I don't have to focus on myself, all the better for me. But being forced to talk about feelings, talk about what's going on and how I process things, how I relate to other people, how I like to disassociate a lot, and not by changing personalities but by

just shutting down from being a sexual assault victim survivor. So my go to is to shut down. So if I can, I don't like having to deal with things upfront… So for me having to deal with life scenarios, life situations, dealing with situations that need to be dealt with, especially with gender, yeah it's been huge. If I didn't have to, I don't think I would be the quality of person that I am today if I hadn't been required to get my letters," (Karen, she/her).

Blessings participants received because of the referral letter process included connecting with a supportive therapist, benefitting from obtaining their referral letter, and propelling transition forward.

Connecting with a supportive therapist. Thirteen participants felt that the letter requirement motivated them to connect with a therapist and ultimately to receive the benefits of engaging in therapy. Supportive therapists provided participants with positive therapy experiences by acting as a gateway to transition, providing resources and advocacy, promoting self-exploration, using the letter as a tool to affirm clients' genders, and integrating letters into the therapy process.

Acting as a gateway. Two participants shared experiences of working with therapists who valued their autonomy and explicitly assured participants that they would support their pursuit of gender affirming medical treatment. In these cases, participants' therapists acted as gateways to gender affirming medical treatment, rather than gatekeepers. Participants with this experience reported feeling that it positively impacted their relationship with their therapist.

"[The letter] was something that was always on the table. I think she just wanted to know that I was mentally ready and less like convince her that I'm so trans. She didn't need anything like that, she was just, are you here for this? Are you ready for this? And I think that was really helpful because it was respectful to me and my gender to not be like gatekeepy or anything like that. She was very much like I want to make sure that you're ok. And that you're ready for this. And I was like, that's good. That makes me so happy... Cause I feel like for a lot of trans people, they are playing a game with their therapist and that makes it hard to get the things you need from a therapist," (Stella, she/her).

Providing resources and advocacy. Seven participants felt that the letter requirement led them to connect with a therapist who served as a resource and advocate during their transition process. Participants with this experience noted that their therapist was a person they could come to when they wanted to discuss the details of their transition. These participants saw their therapist as someone who was knowledgeable about the transition process and what steps participants needed to take, and someone who could provide advocacy and emotional support during transition.

"[The letter requirement is] positive because … there's a lot of trans people who don't have someone to talk to. Maybe they do, maybe they don't. Most people you know don't get to explain everything, how they want to identify or what they want to do physically, with everyone on such a personal level. There's only so much you can tell people, so I think the positive of it is how a therapist, like they're usually your best advocate. And they're there to help you, you know, emotionally and stuff like that," (Sebastian, he/him).

Promoting self-exploration/certainty about transition. Six participants (40%) noted that seeking a referral letter gave them the opportunity to explore their gender and transition in therapy. For these participants, the process of obtaining referral letters allowed them to feel certain about their decision to move forward in pursing gender affirming medical treatment.

"I think that [the letter requirement is] reasonable to be honest. I really think that it's on the therapists to work with people enough to determine, you know, what their motivations are and whether they're healthy enough or not to make these choices. So, I appreciate the process because I don't want to be working strictly off my emotions thinking that I'm right, and want to be able to work through the process and figure out for myself is this really right for me, too… I'm a left and a right brain person, so I can deal with both. And I try to use them in the best situations depending on what they are. And when it comes to this I'm driving very heavily by my emotions. But I also want to make sure from an intellectual perspective that it all makes sense and this is a good thing to do," (Gina, she/her).

Using referral letter to affirm. Four participants felt affirmed by their therapist as a result of receiving their referral letter. Participants with this experience felt that providing a letter was one way their therapist communicated acceptance of their gender

and support for their decision to move forward with gender affirming medical treatment. For example, Bryce (they/them) noted that the letter was "*affirming in regard to self, mentally. Just you know, kind of like hey you, this is who you are and, you know. It's accepted here and you can move forward with your transition because it's who you are.*"

Integrating letter into therapy process. Sixty percent of participants (n = 9) felt their process of obtaining a referral letter was smoothly integrated into their larger therapy process, rather than something that detracted from it. Participants with this experience felt they could present themselves authentically in therapy without worry about how it would affect obtaining their referral letter. They also tended to have therapists who clearly expressed willingness to provide referral letters when participants decided it was the right time to pursue gender affirming medical treatment. Participants also noted that receiving their letter felt like a natural step in their therapy process. As Gina (she/her) noted, "*the letters just seemed to come as, by nature of the process. All I had to do was go and see her and do what I need to do. So the letters were more of an after effect of the process rather than the goal.*"

Benefiting from letter. Eight participants shared ways in which completing the referral letter process and receiving their referral letter benefitted them. Participants discussed how giving their therapist information about their gender history to include in the letter helped them feel more confident in their gender identity. Participants experienced excitement over having the letter as a tangible representation of their gender. They also experienced a sense of accomplishment once they had obtained their letter. Benefits of the referral letter process included having a tangible representation of transition that they could use to validate their gender and choice to pursue gender

affirming care in a range of contexts including social, medical, legal, and intrapsychic scenarios.

"At the end of that process, you're gonna feel so good about having somebody else stamp their name on how you feel. It's not inside you anymore, not getting out. It's out there in the world. Somebody supports you. Somebody backs you up. Somebody's got your back. With those letters, that's how it felt for me. The positive aspect of that is that … I can prove who I am. And that was impossible to do otherwise. If there was a positive thing to come out of that, it's that I can parade that around forever and show it to the judge, show it to anybody. It's admissible in court," (Trish, she/her).

Propelling transition forward. One third of participants (n = 5) felt that their referral letter process and work with their letter writing therapist sped up their transition. Participants with this experience described their therapist challenging them to take their next transition steps and in some cases offering to write a referral letter before participants felt they were ready for it. Participants with this experience also noted that their therapist provided their referral letter in a timely manner after agreeing to write it.

"I knew that I had no reason to say no anymore. Like I had no reason to say this is too hard. And [my therapist] was definitely kind of the slap in the face, quit dragging your feet, you want this, just do the thing. And that's when we came to the realization that I was dragging my feet because I didn't want to be told I couldn't have it. Because [my therapist] is also a fucking wizard. And once we realized that, that's when I was like yeah, you'll give me that letter. She was like, sweet," (Vincent, he/him).

Despite initial frustration and fear related to the referral letter requirement, almost all participants (n = 14) shared ways that the process of obtaining their referral letter benefitted them. Benefits of the referral letter process included getting connected with a therapist, benefiting from obtaining their referral letter, and being challenged to move their transition forward. Although almost all participants experienced blessings due to the referral letter requirement and process, most participants also dealt with negative experiences related to the letter, which will be discussed in the following section.

BS. Most participants (n = 13) described ways in which they were negatively impacted by the referral letter requirement. Three participants (20%) specifically described the referral letter requirement as BS. As an example, Mary (she/her) stated, *"for someone such as myself, who is an adult, who knows the consequences, and doesn't have any other issues, I think it's absolutely asinine… Asinine, ridiculous, bullshit. I'll let you fill in the blanks there."* A stark contrast to the blessings that participants reported receiving due to the referral letter process, the BS participants endured due to the referral letter requirement included challenges to the therapeutic relationship, reduced benefits from therapy, additional oppressive experiences, and further barriers to transition.

Challenges to the therapeutic relationship. Forty percent of participants (n = 6) shared ways in which the letter requirement negatively impacted their relationship with their therapist. Participants with this experience discussed fear of rejection by their therapist, an increased power differential between themselves and their therapist, and feeling that their therapist was making them go through the letter process to avoid liability rather than to meet their needs.

Fear of rejection. One third of the participants (n = 5) in this sample worried that their therapist might reject their request for a referral letter. This fear caused participants distress and created challenges as participants worked to build trusting, open relationships with their therapists.

"It scared me to ask her for something, in that she could say no. And I built my trust with this person. This person knows all about my deepest darkest secrets. And to possibly face rejection from her made me afraid to ever see her again. Because how can I go back to this therapist who would deny me something that's life saving? I prepared myself for the worst. I've read all the stories, I've talked to people whose therapist had said no,

you're too unstable. How can I continue that relationship? It's such a strange power dynamic that, frankly, is unethical," (Vincent, he/him).

Increased power differential. Twenty percent of participants (*n* = 3) felt that their need for a referral letter increased the amount of power their therapist had in the therapeutic relationship. Participants with this experience described the increased power differential as a barrier to establishing a strong therapeutic alliance, and noted that this power differential existed in the therapeutic relationship whether their therapist identified with the gatekeeping role or not.

"Even somebody like [my therapist] who right from the beginning is like I don't want to be a gatekeeper, in the end you are a gatekeeper, right? She might not want to be a gatekeeper and she might choose not to be a gatekeeper, but she is the one who gets to make that choice. Like I still need her to write the letter. I can't make a choice about that, so I think it's probably not that great for establishing a relationship with a therapist," (Alex, ze/hir).

Protecting professionals over clients. One participant felt that her therapist put her through the letter writing process to avoid legal liability in case she later regretted her decision to transition. She felt the letter requirement was in place to protect her therapist rather than to benefit her.

"If she had given me the letter in the first session and something went wrong, for lack of a better expression, then she'd be opening up herself to liability. Versus waiting three to six months, giving the letter, saying well I know I can document I did this, I did this, I did this, I did this. And that's why. So it gives them more time to document and to protect themselves in the event that treatment hits the air conditioner. Because, yes, they've got to protect their own livelihood just like we want to protect our own…That leaves all the clients on the short end of the stick. But that's a legal thing versus an actual treatment thing. And it's sad when legal matters interfere with real treatment matters," (Liz, she/her).

Reduced benefits of therapy. One third of participants (*n* = 5) described the referral letter requirement as reducing the benefits they received from therapy. Negative experiences that reduced the benefit participants received from therapy included having

to go to therapy but not benefitting from it, having to defend their mental health status, and encouraging ineffective use of therapy.

Having to go to therapy but not benefitting from it. Two participants shared that therapy was not a beneficial experience for them. Individuals with this experience also expressed frustration that they felt they had to attend therapy due to the letter requirement. For example, Space (he/him) said:

"I don't really feel like I need therapy. I guess I like therapy and I do enjoy talking to therapists. But most times I feel like I'm just going in circles about my life, that I already know is the way it is, and I don't really want to do that. So I can just do it without the copayment and just figure it out myself, you know?"

Defending mental health status. Twenty percent of participants (n = 3) felt pressure to minimize their stressors or psychological problems in living when working with their letter writing therapist. Participants in this situation expressed fear that being open about their stressors or problems in living might cause their therapist to believe they were not mentally stable enough to obtain referral letters for gender affirming medical treatment.

"In some ways [needing the letter] made me a little bit reluctant to talk about some things because I thought it might affect not getting it… If they ask how does this make you feel, how does that make you feel, you wanna make it sound like you were less affected than you were about various things. Because you're like wait a minute, that put them over here, going away from the letter instead of going toward it," (Liz, she/her).

Encouraging ineffective therapy use. Two participants felt that the referral letter requirement encourages TGNC people to use therapy ineffectively—focusing on the letter rather than other therapy goals, and terminating therapy after obtaining a letter rather than basing termination on when therapy goals are met.

"I think it forces people to bounce from therapist to therapist. Which, yeah, I don't think that's terribly healthy, honestly. I think that if somebody, I think it creates this sort of dependence on therapists to just get your letter and just get out. Which I think even people who don't have any diagnoses or think that they're ok could definitely benefit

from therapy. It's more preventative than anything else. But if all you have to go on is your experience with your therapist trying to get letters, how the hell are you supposed to build a long term customer relationship if you just want to go in, get the letter, and get out? Cause I know, when my dysphoria got bad, and I am a very driven person, if I have a goal I'm going to get it. I wanted those fucking letters. I know that's how I would treat my therapist. As a means to an end. Which is horrible. There's no way I would be the kind of person I am today without regularly attending therapy, getting scrips for meds, there's no way," (Vincent, he/him).

Additional oppressive experiences. Two thirds of participants (n = 10) shared ways in which the letter requirement added to the oppression they experience in society as transgender individuals. Oppressive experiences related to the letter requirement included feeling stigmatized, having limits placed on personal autonomy, having to prove their identity as a transgender person, and feeling pressure to conform to stereotypes about their gender.

Feeling stigmatized by requirement. Four participants felt stigmatized by the referral letter requirement. Participants with this perspective felt that the letter requirement is othering and makes TGNC identities seem like a mental illness. For example, Cameron (they/them) said:

"Yeah. I think the main thing is it medicalizes trans identity. And makes, I think it like kinda in a way makes people see being trans as more of a mental illness, because trans people are required to go to a therapist. And I think a lot of people already think that being trans is a mental illness, which is just upsetting on so many different levels... So I think it kind of reinforces that in a lot of different people's minds."

Limiting personal autonomy. Eight participants shared frustrations related to the referral letter and how this requirement limits their personal autonomy. Participants with this perception felt that the referral letter process disregarded their capacity for making decisions about their healthcare and was demeaning.

"If you ask any transgender person, they're going to tell you that they think the counseling part is ridiculous. You know, it's something that should be our choice. Something that, you know, it's kind of like if you were to talk to gay people, and they

were to tell you that in order to be gay I had to go to this counselor and get a letter getting permission to be gay," (Liz, she/her).

Having to prove trans identity. Two participants felt that part of their role in therapy was to prove their gender identity to their therapist as a requirement of getting their referral letter. Participants experienced this role as frustrating and invalidating. As an example, Trish (she/her) stated that it was

"terrible that I have to basically convince somebody that this is who I am. Because that's what it felt like for so many years, and the reason why it was so hard to come to that conclusion to see someone. Because that was my immediate reaction, was that, you know, I'm going to spend my life convincing people of who I am. And normal people don't have to do that."

Conforming to stereotypes. Twenty percent of participants (*n* = 3) felt pressure to conform to stereotypes related to their gender or to accepted narratives about transgender people. Participants expressed worry that not conforming to gender roles would negatively affect their ability to obtain referral letters.

"I'm pretty sure I was just like, yeah I'm a trans man, I hate everything girly. You know what I mean. I think I probably overgeneralized masculine stereotypes at first, and even now I feel, I feel like generally masculine. But like a lot of people I go to the goth club with my friends sometimes, and we'll paint our nails and do our eyeliner because it's the goth club. And like, I do collect dolls … but I know that was just like something I was very reluctant to talk about… So I'm afraid to share hobbies that are gender nonconforming even still, I think a little bit. Just because I don't want it to be misread as like, oh no we let you be a man but you're actually not good enough at being a man to be a man. Which I think is a little bit how it seems sometimes. Not necessarily particularly like [my therapist] but just in general. There's this sense that we can only let you be a valid masculine person if you promise not to be like, you know, not a good enough one… And so I think I do feel that a little bit sometimes in talking to [my therapist], but that's not necessarily her fault so much as it speaks to a societal issue," (Jim, he/him).

Barriers to transition. Two thirds of participants (*n* = 10) felt that their transition process was slowed down or made more difficult due to the referral letter requirement or their individual process of obtaining a referral letter. Barriers to transition created by the referral letter requirement included having to jump through hoops in order to access

transition, experiencing delays in obtaining referral letters from therapists, being denied referral letters, and decreasing the accessibility of transition.

Jumping through hoops. Twenty percent of participants (*n* = 3) perceived the need to get letters and their consequential therapy experience as a barrier they had to overcome to access transition. Participants with this experience expressed frustration that the letter was yet another requirement they had to meet to access transition. In some cases, the letter requirement also caused participants to delay transition. As Mary (she/her) stated, *"I had to have [therapy], so it was very helpful. It would have been nice if I didn't have to jump through all of those hoops… I just, like I said, it really irks the hell out of that we have to jump through hoops to get surgery when we're adults."*

Delays in obtaining letter. One third of participants (*n* = 5) shared experiences related to having to wait to obtain a referral letter. Two participants asked for a letter and were told it was too soon in their work with their therapist. In these cases, their therapists were willing to write a letter but wanted participants to attend therapy for a certain length of time first. Two participants shared that they waited to ask for their letter because they expected their therapist would want to see them multiple times before agreeing to write one, or because they feared their therapist would delay writing their letter if they brought it up too often. For example, Liz (she/her) said, *"I asked about it at the first one and then I asked about it—I didn't ask about it at every single appointment. I was afraid that it would annoy her to the point of her going, well you want to keep asking, I'll just keep holding off, you know."*

Four participants had to wait for their letter after their therapist agreed to write one. This included waiting several weeks after their therapist agreed to write a letter.

"He told me that it would probably take up to a couple of months only because they're really swamped down there. I believe they're like one of the only places that you can get a referral letter without going, without having such a hard time of over pricey therapists and things like that… So it pretty much was just based on how swamped they were at the time," (Moore, he/him).

Being denied letters. Two participants shared experiences with past therapists where they had asked for a letter and were refused. For participants in this situation, being denied a letter was part of the reason they chose to find another therapist.

"The first [therapist] I saw a couple of months before going in there, I was afraid to, and she seemed very unwilling to help me with the trans stuff. I would go there and kind of talk about what I was feeling, what I was going through. Usually like family issues would come up a little bit. You know, I would talk about it and it would be like, yeah, I appreciate the help. But also I definitely want to have space to talk about the trans thing, too. And it just felt like every time I started to bring the trans thing up, they would just dismiss it. Despite it being, it was the primary reason that I was trying to meet with them," (Jim, he/him).

Decreasing accessibility of transition. Eight participants discussed ways in which the referral letter requirement can make transition less accessible. Participants discussed the added expenses and time demands that attending therapy to obtain referral letters placed on their transition process, and the difficulty they faced finding and accessing affirming therapists.

"Trans people have a tendency to be less wealthy than average and insurance is a problem because a lot of times insurance doesn't cover transition related treatments… It could be that there are some people out there that don't necessarily need therapy for anything, trans related or not, and are still required to go to therapy anyway and go through the expense anyway (Victoria, she/her).

Although participants shared many ways that working with their referral writing therapists was beneficial for them, they also noted aspects of the referral letter requirement and process that negatively impacted them. Negative experiences, or "BS," participants endured due to the referral letter requirement included decreased therapeutic alliance with their therapist, reduced benefit from therapy, additional oppressive

experiences, and added barriers to overcome in their transition process. Both participants' positive and negative experiences are important to keep in mind when holistically considering participants' therapy experiences related to referral letters.

Conclusion

This chapter summarizes the analyses of stories from 15 TGNC individuals who have obtained referral letters from their therapists for gender affirming medical treatment. Participants shared a range of experiences and perspectives related to how needing referral letters affected their therapy experiences and transition processes. The next chapter will consider the implications of the themes distilled from participants' experiences, and implications of these themes for therapy practice, training of therapists, and TGNC healthcare policy. Strengths and limitations of the current study, as well as recommendations for future research, will also be discussed.

Chapter Four: Discussion and Conclusions

Participants' experiences related to needing and obtaining referral letters shed light on how the referral letter requirement affects TGNC people's therapy experiences and transition processes. Almost all participants shared both ways they benefitted from the letter requirement (n = 14), and ways the requirement negatively affected them (n = 13). The findings from this research project help expand our knowledge of TGNC individuals' experiences in therapy and experiences with accessing gender affirming healthcare.

Previous research on TGNC individuals' therapy experiences has looked broadly at therapy (Bess & Stabb, 2009: Elder, 2016; Johnson, 2014) rather than investigating how specific experiences, such as obtaining referral letters, impact TGNC clients. Additionally, guidelines for providing gender affirming medical care (Coleman et al., 2012) have been set in place without research considering how referral letter requirements affect TGNC individuals. Existing studies have failed to address how the referral letter requirement affects TGNC individuals' experiences in therapy and their transition processes. Research findings from the current study address these important questions.

Regarding results, two core themes emerged related to participants' experiences with obtaining referral letters. Frequently described experiences were the "blessings" participants received from the referral letter process (e.g., support, guidance, and advocacy) and the "BS" participants had to endure because of the referral letter process (e.g., limited autonomy, pressure to prove their gender identity, and additional barriers to transition). The three main sub-categories that emerged under blessings included

connecting with a supportive therapist, benefitting from the letter, and propelling transition forward. The four main sub-categories under BS were harming the therapeutic relationship, reducing therapy benefits, adding to oppressive experiences, and creating barriers to transition.

Gateways and Gatekeepers

Participants' experiences highlighted how the referral letter can act as an initial barrier to the therapeutic alliance and, depending on therapist behaviors, can be a factor that deteriorates clients' relationships with their therapists. Some participants experienced the referral letter requirement as creating an adversarial relationship with their therapist. In this case, participants felt mandated to attend therapy and perceived a need to game the referral letter system to access the gender affirming healthcare they needed. In some cases, needing a referral letter requires TGNC individuals to engage in involuntary therapy, which is also known to reduce the quality of the therapeutic relationship (Sotero, Major, Escudero, & Relvas, 2016), which is a robust predictor of clients' therapy outcomes (Horvath, 2001). Based on the experiences of participants in this sample, the referral letter requirement, involuntary participation in therapy due to the referral letter requirement, and negative experiences related to seeking referral letters in therapy may not only harm TGNC clients' relationships with their therapists, but also reduce the benefit TGNC clients receive from attending therapy.

However, experiences some participants shared suggest that their therapists played a key role in determining how participants experienced obtaining referral letters for gender affirming medical treatment, and the impact of this requirement on the therapeutic relationship. Participants tended to describe the letter requirement as a

blessing when their therapist acted as a gateway to transition. This included behaviors such as affirming their client's gender, clearly expressing willingness to provide letters, and supporting their client in moving forward with transition. Conversely, participants tended to describe the letter requirement as BS when sharing experiences of working with therapists who acted as gatekeepers. This included making clients feel the letter gave their therapist extra power in the relationship, creating an environment where clients felt they needed to present their experiences a certain way to obtain letters, and taking longer than necessary to provide letters. These findings echo previous grounded theory research finding that therapists emphasizing their gatekeeping role can lead to negative therapy experiences for their TGNC clients (Mizock & Lundquist, 2016), and previous qualitative research finding that supportive mental health professionals can help their transgender clients access positive healthcare experiences (Ross, Law, & Bell, 2016).

Many participants expressed frustration with how the referral letter requirement contributed to systemic barriers to transition, including difficulty accessing affirming therapists, fewer resources as a result of attending therapy, and limitations placed on their autonomy. Some participants' difficulty finding affirming therapists echoes previous research findings on TGNC people's therapy experiences (Austin & Goodman, 2018). Additionally, most participants experienced aspects of the referral letter requirement as oppressive. However, participants who noted these issues also shared ways they had benefitted from the referral letter process when their therapist acted as a gateway rather than a gatekeeper. Participants who disagreed with the referral letter requirement often still had positive therapy experiences when their therapist acted as a gateway to gender affirming medical treatment, providing support and affirmation as they navigated what

participants considered a flawed system. This finding supports previous calls in the transgender therapy literature for therapists to shift from roles as gatekeepers to advocates for their TGNC clients (Singh & Burnes 2010).

Practice Implications

These findings suggest therapists play a key role in determining how their TGNC clients experience the process of obtaining referral letters for gender affirming medical treatment. Although clients may experience the referral letter process as oppressive and anticipate that it will create another barrier to transition, therapists have the opportunity to act as a valuable support and resource for clients who are seeking gender affirming medical treatment. Therapists' efforts to act as a gateway for TGNC clients seeking gender affirming healthcare can mitigate the oppressive experiences TGNC clients may associate with the referral letter requirement and help TGNC clients benefit from their therapy experiences.

This study sheds light on many ways therapists can act as gateways rather than gatekeepers with their TGNC clients, and findings from this study align with existing guidelines and recommendations in the TGNC psychology literature (APA, 2015; Cavanaugh et al., 2016; Elder, 2016). Therapists should work to create an affirming environment for clients who are pursuing gender affirming medical treatment by trusting clients' experiences of their genders rather than asking clients to provide evidence for their gender identity or otherwise seeking to evaluate clients' appropriateness for gender affirming medical treatment. Participants in this study reported better therapy experiences when their therapist clearly stated their willingness to provide a letter early in treatment, and when their therapist accepted participants' need to transition and took on a

supportive rather than gatekeeping role in therapy. Based on this finding, therapists are encouraged to use informed consent approaches when working with clients who are interested in pursuing gender affirming medical treatment, and to advocate that other healthcare professionals and organizations transition to using informed consent models rather than gatekeeping approaches to gender affirming medical care. The current gatekeeping system asks therapists to step into an evaluative role with their TGNC clients when choosing whether or not to write referral letters for gender affirming medical treatment. By contrast, informed consent models of TGNC healthcare allow individuals to self-refer for gender affirming medical treatment, putting the power of choice into TGNC individuals' hands. Informed consent models of treatment allow therapists and other healthcare professionals to provide the education necessary to help clients make informed decisions about their gender affirming healthcare, while respecting clients' autonomy and ability to make their own decisions (Cavanaugh et al., 2016). Therapists are also encouraged to take opportunities to make therapy accessible to TGNC clients, which may include providing sliding scale services to reduce the financial burden TGNC therapy clients face. Participants' experiences of enduring financial burden to obtain gender affirming therapy and referral letters echoes previous research in which TGNC participants discussed financial burdens of therapy (Elder, 2016).

Training Implications

These findings suggest that TGNC individuals are less negatively impacted by the referral letter requirement and have more positive therapy experiences overall when their therapists are affirming and knowledgeable about TGNC experiences and gender affirming care. However, existing research indicates that graduate programs are not

effectively training therapists to provide knowledgeable service and support to TGNC therapy clients (Austin et al., 2016; O'Hara et al., 2013; Zimmerman, 2015). This is concerning, considering the high probability that most therapists will encounter TGNC clients during the course of their careers (Budge, 2013).

There are a number of steps that graduate programs can take to ensure that they produce therapists who are adequately equipped to provide competent services to TGNC clients. This includes educating trainees about gender identity, gender affirming healthcare, social and legal transition steps, discriminatory experiences faced by TGNC individuals, and factors that contribute to the well-being of TGNC people. Training should include instruction about existing recommendations for what to include in referral letters for gender affirming medical treatment (Budge, 2015; Coleman et al., 2012), as well as information about the referral letter requirement's potential risks to TGNC clients and the importance of recognizing client autonomy (Cavanaugh et al., 2016). Training programs are encouraged to provide opportunities for therapists-in-training to work with TGNC client populations in practicum settings, and to ensure that students working with TGNC clients are receiving adequate, transaffirming supervision. Training programs are especially encouraged to address the history of overpathologization of TGNC identities among healthcare and psychology professional communities (Denny, 1992), and to direct trainees to attend to the strength, resilience, and capacity for self-determination among their TGNC clients.

Policy Implications

This study highlights how the referral letter requirement can harm the therapeutic alliance, decrease the benefit that TGNC individuals receive from therapy, add to the

oppressive experiences that TGNC individuals endure, and add barriers to transition. However, existing guidelines for TGNC healthcare recommend that doctors working with TGNC patient populations require referral letters from patients seeking to access gender affirming medical treatment (Coleman et al., 2012). Future iterations of guidelines for providing health services to TGNC populations should take into consideration the negative effects that referral letter requirements may have on TGNC individuals and the additional barriers these recommendations create to transition. Physicians and insurance companies should also consider these factors when setting letter requirements in place for the TGNC patients they serve.

Strengths, Limitations, and Directions for Future Research

A notable strength of this study was its diverse sample. This study is one of few in the existing TGNC therapy literature to look at a range of perspectives across gender, age, race, and region. The comparable number of transgender women (n = 7) and transgender men (n = 6) was particularly notable, as much of the existing literature on transgender people tends to largely oversample transgender women (Benson, 2013; Bess & Stabb, 2009; Scarpella, 2010). The inclusion of some nonbinary participants (n = 2) was an important addition to the existing literature, considering that most studies on transgender psychology tends to limit samples to binary-identified transgender people (Benson, 2013; Bess & Stabb, 2009; Elder, 2016; Rachlin, 2002). Additionally, the significant number of participants who identified as People of Color (n = 6) is a step forward, given that most studies on transgender psychology substantially oversample White individuals (Bess & Stabb, 2009; Elder, 2016; Rachlin, 2002).

Although this study provides an important starting point, there are many ways in which future research can extend the literature on transgender therapy experiences and psychologists' role in the gatekeeping process for gender affirming medical care. Most notably, this study is missing the perspective of therapists who write referral letters for their clients' gender affirming medical procedures. Future studies should address therapists' experiences with this process, ways they have been able to use referral letters to support clients, and ways in which the referral letter process has inhibited their ability to effectively support clients. Future qualitative researchers might consider the benefit of interviewing client and therapist dyads who have been through the letter writing process, to obtain a more complete picture of how the referral letter process affects the therapeutic relationship and therapy experience from both client and therapist perspectives. Research on the experiences of TGNC individuals who have received gender affirming care through informed consent methods of treatment would help researchers and therapists better understand how this emerging approach to TGNC healthcare impacts the transition processes and well-being of TGNC people. Future studies might also consider attempting to sample a range of TGNC people who have obtained referral letters from therapists who identify as members of the TGNC community or cisgender men. Their experiences may differ from TGNC individuals who work with cisgender women therapists, as did most participants in this sample.

Qualitative methodologies do not allow for population generalizability. However, this study lays groundwork for future quantitative studies that could provide generalizable data to aid in understanding TGNC therapy clients as a population. Potential quantitative inquiries for future researchers to address include examining the

relationship between when TGNC clients receive referral letters and ratings of their therapeutic alliances and treatment outcomes, as well as the relationship between the presence of gender affirming therapist behaviors and client ratings of therapeutic alliance and treatment outcomes.

This research study provided an important step forward in understanding how TGNC individuals' therapy experiences are impacted by the process of obtaining referral letters for gender affirming medical care, particularly by highlighting how therapist behaviors can affirm and support TGNC clients while navigating the letter requirement system. The findings presented in this study can provide guidance to therapists seeking to improve their TGNC clients' therapy experiences while pursuing gender affirming medical care, and can help therapists mitigate some of the oppressive experiences their clients may encounter in the gatekeeping process.

Conclusion

An analysis of TGNC individuals' experiences obtaining referral letters for gender affirming medical treatment facilitated a deeper understanding of how TGNC individuals' experiences with therapy and transition are impacted by the referral letter requirement. Although referral letters have historically been required as a condition of accessing gender affirming medical treatment, the impacts of this requirement on TGNC people have not previously been empirically examined. Examining the experiences of TGNC clients related to obtaining referral letters from their therapists is consistent with several core values of the counseling psychology profession. These include valuing diversity, supporting healthy development including identity development, amplifying the experiences and perspectives of marginalized populations, considering clients from a

holistic framework, and accounting for individual strengths and personal autonomy. This study provides an important addition to the TGNC psychology literature.

The findings of this study highlight the benefits that TGNC individuals receive from the process of obtaining referral letters, including connecting with a supportive therapist, benefitting from having a referral letter, and moving transition forward. This study's findings also highlight the negative experiences TGNC therapy clients endure because of the referral letter requirement, including weakened therapeutic relationships, reduced benefits from therapy, oppressive experiences, and barriers to transition. Analysis of participants' experiences revealed that affirming therapist behaviors can help mitigate the oppressive aspects of the referral letter requirement and help TGNC individuals have an overall positive therapy experience. These findings can be applied to therapy work with TGNC clients, therapist training, and policy for TGNC healthcare. This study addresses an important gap in the TGNC psychotherapy literature, but further research is needed in this area. Examination of therapists' experiences providing referral letters, comparing experiences of therapist-client dyads, examining experiences of TGNC individuals who access gender affirming care through informed consent clinics, and quantitatively examining the relationship between obtaining letters and clients' therapeutic alliances and therapy outcomes would lead to deeper understanding of the referral letter process phenomenon.

Interview Protocol

Introduction

Thank you for taking time to talk with me about your experiences with therapy as a member of the transgender and gender nonconforming community. The purpose of this study is to better understand the experiences of transgender and gender nonconforming people in therapy, especially when it comes to the issue of getting referral letters from therapists for gender-related medical treatment such as hormone therapy and gender-affirming surgeries. Today I will be asking a lot of questions about your experiences in therapy and how needing a referral letter from your therapist impacted therapy for you.

There is little research about the experiences of transgender people in therapy, particularly on the topic of getting referral letters from therapists. The information you provide today will be among the first attempts to systematically understand how needing referral letters impacts transgender and gender nonconforming people's therapy experiences. I plan to publish the information you and other participants provide (after removing your identifying information) in order to help other researchers and therapists better understand and work with transgender and gender nonconforming therapy clients.

Demographic/Background Questions

First I have a series of "short answer" questions to ask you about your identities.

- In order to protect your confidentiality, I won't be using your real name when I publish this study. Would you like to pick the fake name I use to refer to you in my paper?
- What label do you use to describe your sexual orientation?
- What state do you live in?
- Do you live in a rural or urban environment?
- How far did you go in school?
- How long have you been meeting with your current/most recent therapist?
- How many referral letters have you obtained from your therapist(s) for gender-affirming medical treatments?
- When did you begin self-identifying as _____ (use their term they used above)
- With what people and in what contexts are you out about being _____(gender)?
- When did you begin your transition process?
- What gender-affirming procedures or treatments have you gotten a letter for? What gender-affirming procedures/treatments are you hoping to get a letter for in the future?
- What is your current/most recent therapist's approximate age and gender?

Study Questions

The following questions are about your therapy experiences and experiences with getting referral letters. Please answer these questions honestly and with as much detail as possible, because everything you share will likely be new and useful information. Also, if any of these questions are confusing, let me know and I'll clarify or ask another way.

- When thinking about your most recent/current therapy experience, what motivated you to go to therapy?
    - (If letter) Did you go to therapy for any other reason, as well?

- About how many sessions did you have with this therapist?
- What was it like to see this therapist?
    - What is/was your relationship with your therapist like?
- How did needing a referral letter for gender-affirming medical treatment affect your decision to go to therapy?
    - How important was obtaining referral letters for gender-related healthcare in your decision to go to therapy, compared to other reasons you started therapy?
    - Did you talk about anything in therapy besides issues related to your transition?
    - How did you find your therapist?
    - What kinds of things were you looking for in a therapist? (Did you have a mental check list?)
- In what ways did needing a referral letter affect your experience with your therapist?
    - What was it like to ask your therapist(s) for a referral letter? Can you walk me through what you remember about your thoughts and feelings before, during, and after that conversation?
        - At what point in therapy did you ask for a referral letter, and how did you decide it was the right time to ask?
        - What expectations or conditions, if any, did you have to meet to get a referral letter from your therapist?
        - Has there ever been a time when you asked for a letter but did not get it? If so, what happened?
    - How open were you with your therapist? Were there things you felt you couldn't share?
        - How did you talk with your therapist about your identity (use their label)? Did needing a letter affect how you talked about being (your identity) with your therapist?
- Thinking about work with the therapist who wrote your letter, how helpful was your therapy experience, overall?
- How did needing a referral letter affect your experience in therapy overall?
    - What were the positive (and negative) things about your experience in therapy as a person who identifies as (use their identity labels)? (Probe for examples)
- How did needing a referral letter affect your transition process?
- Did your referral letter include a diagnosis of gender dysphoria or gender identity disorder?
    - If so, how did you feel about that diagnosis?
        - What if any conversations did you and your therapist have about that diagnosis?
- What are your thoughts and feelings about the requirement that you get referral letters from a therapist before receiving gender-affirming medical treatment?
    - What are the positive aspects of this requirement (in society at large)?
    - What are the negative aspects of this requirement (in society at large)?
    - In what (other) ways did the experience of getting letters affect you personally (in a good way or a bad way)?
    - In your own words, tell me why the referral letter is important to you, why you need it.
- What advice do you have for therapists who work with transgender and gender nonconforming clients?

Appendix B

Consent to Participate in a Research Study

EXPERIENCES OBTAINING GENDER-AFFIRMING REFERRAL LETTERS IN THERAPY

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about transgender and gender nonconforming (TGNC) individuals' experiences obtaining referral letters for gender affirming medical services. You are being invited to take part in this research study because you are a transgender or gender nonconforming person over the age of 18 who has at some point obtained a referral letter for gender affirming medical treatment, such as hormones or gender affirming surgery, from a mental health professional who you are currently seeing in therapy or have completed therapy with in the past year. If you volunteer to take part in this study, you will be one of about 20 people to participate.

WHO IS DOING THE STUDY?

The person in charge of this study is Holly Brown, MS, EdS, a doctoral candidate in the University of Kentucky Department of Counseling Psychology. She is being guided in this research by Dr. Jeff Reese and Dr. Sharon Rostosky of the Department of Counseling Psychology. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

By doing this study, we hope to learn how transgender and gender nonconforming people experience the process of obtaining referral letters for gender affirming medical services from therapists. We hope this study will help us better understand how needing a referral letter impacts transgender and gender nonconforming individuals' relationship with their therapists and how it impacts transgender and gender nonconforming individuals' overall therapy experiences.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You should not participate in this study if you are uncomfortable with interviews about your life and experiences, or if you expect that talking about your therapy experiences may cause you distress or otherwise harm you in any way.

You are not eligible for this study if you are under the age of 18, if you have never obtained a referral letter for gender affirming medical treatment, if you have not seen a therapist within the past year, or if the only therapists you have seen in the past year have never written a referral letter for you.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

This is an interview study and will be done over the phone. Please find a quiet place where you feel comfortable talking openly during your scheduled interview time. Answering the open-ended interview questions should take approximately 60 minutes. The total amount of time you will be asked to volunteer for this study is 90 minutes.

WHAT WILL YOU BE ASKED TO DO?

You will complete a phone interview that will be audio recorded. During the phone interview you will be asked to answer questions about your identities (gender, race, sexual orientation, etc.). Then, you will be asked open-ended questions about your transition experiences, therapy experiences, and experiences asking for referral letters from your therapist. You will be asked to answer questions honestly and with as much detail as possible.

Optional follow-up: After your interview, you will have the option of reviewing your interview transcript for accuracy as well as an option to give feedback on the themes the research team pulls from the interviews overall and how well those themes fit your experiences. Both of these activities are completely optional and choosing to do them or not will have no effect on your participation in this study or the payment you receive.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To the best of our knowledge, the things you will be doing for this study have no more risk of harm than you would experience in everyday life.

However, talking about experiences in therapy can sometimes bring up memories of difficult times in your life. You may find some questions we ask you to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings. We also want to make sure that you have access to a gender affirming crisis line in case you ever need it. If you are experiencing a crisis and need to talk to someone, consider calling Trans Lifeline at 877-565-8860.

In addition to the risks listed above, you may experience a previously unknown risk or side effect.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study. However, some people have experienced a sense of satisfaction or personal fulfilment when sharing their perspective and experiences as a member of a group that experiences societal oppression. Additionally, your willingness to take part may, in the future, help society as a whole better understand this research topic.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can choose to skip any questions or stop at any time during the study and still keep the benefits and rights you had before volunteering.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no anticipated costs related to participating in this study. You will need to be able to access a working phone line.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will receive $50 for taking part in this study. If you decide to participate in the study and during the interview decide you do not want to finish or answer all the questions, you will still receive the $50 payment as compensation for the time you did commit to the study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep confidential all research records that identify you to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private. We may use quotes from your interview to give examples of our findings, and we will label your quotes with a fake name in order to protect your privacy.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. The audio recorders your interview recording is stored on will be kept in a locked box in a locked cabinet. The audio recording will be transferred to a password protected computer, then transcribed and stored in a password protected file.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your

information to other people. For example, the law may require us to tell authorities if you report information about a child, elder, dependent adult, or domestic partner being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you, or if they find that your being in the study is more risk than benefit to you.

WHAT ELSE DO YOU NEED TO KNOW?

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind before you begin your interview. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Holly Brown at 859-878-7613 or holly.michelle.brown@gmail.com. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8am and 5pm EST, Mon-Fri. at 859-257-9428 or toll free at 1-866-400-9428. This copy of the informed consent information is for you to keep for your records.

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VITA

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Research Team Member
August 2013-September 2018
Reese Research Lab
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Research Assistant
October 2012-June 2018
Bridging Research Efforts and Advocacy Toward Healthy Environments (BREATHE) Team
College of Nursing, University of Kentucky
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Research Team Member
August 2013-August 2017
Sexual Health Promotion (SHP) Lab
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CLINICAL EXPERIENCE

Psychology Intern
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Supervisor of First Year Students
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Counseling Psychology Program; University of Kentucky
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September 2017-April 2018
Transform Health; University of Kentucky Family Medicine Clinic
Supervisor: William Elder, Ph.D.

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University of Kentucky Counseling Center
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Student Testing Administrator
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School Psychology Private Practice
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Student Therapist and Group Co-Leader
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PEER REVIEWED PUBLICATIONS

Hahn, E. J., Rayens, M. K., Wiggins, A. T., Gan, W., **Brown, H. M.**, & Mullett, T. W. (2018). Lung cancer incidence and the strength of municipal smoke-free ordinances. *Cancer, 124*, 374-380. doi: 10.1002/cncr.31142

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Reese, R. J., Duncan, B. L., Kodet, J., **Brown, H. M.**, Meiller, C., Farook, M. W., ... & Bohanske, R. T. (2017). Patient feedback as a quality improvement strategy in an acute care, inpatient unit: An investigation of outcome and readmission rates. *Psychological Services*. doi: 10.1037/ser0000163

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SCHOLASTIC AND PROFESSIONAL HONORS

UK Graduate and Professional Student LGBTQ* Research Grant
April 2017

Kentucky Opportunity Fellowship
April 2015-May 2016