# ABSTRACT

## BARRIERS TO ACCESSING GENDER AFFIRMING MENTAL HEALTH CARE IN CALIFORNIA'S CENTRAL VALLEY FOR TRANSGENDER AND NON-BINARY INDIVIDUALS

The transgender and non-binary community of the Central Valley is a unique and diverse population that has specific therapeutic needs. This study aimed to discover to what extent those needs are being met. Specifically, the researcher sought to find what experiences this community has had in attempting to access gender affirming mental health care in the Central Valley and what barriers exist for this community in accessing care.

The theoretical framework that was utilized in this study was ecological systems theory. The researcher conducted qualitative research through individual interviews, with 43 diverse trans and non-binary individuals from cities all over the Central Valley. The researcher found four common themes after analyzing the transcribed interviews. These themes were: good experiences with mental health providers, negative experiences with mental health providers (with the sub themes of transphobia, gatekeeping, conversion therapy, and therapist not informed in providing gender affirming care) biopsychosocial experiences (with the sub themes of eating disorders/disordered eating, substance abuse, domestic/intimate partner violence, hospitalization for mental health reasons, and homelessness), and barriers to accessing care (with the sub themes of issues with locating a therapist who was informed in providing gender affirming care and insurance barriers). Recommendations for addressing these barriers as well as suggestions for future research are included in this study.



Jordan Fitzpatrick
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# BARRIERS TO ACCESSING GENDER AFFIRMING MENTAL HEALTH CARE IN CALIFORNIA'S CENTRAL VALLEY FOR TRANSGENDER AND NON-BINARY INDIVIDUALS

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LGBT Centers provide a vital service for the community, they are a safe haven and resource hub for many in the Central Valley who may not have anywhere else that they feel that safety. I am especially grateful to the Fresno EOC LGBTQ+ Center who not only helped me spread the word about this study but also provided a safe, comfortable, and friendly environment for me to work on this thesis for untold hours. This center is like a second home for me and all those in it are like a family.

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# CHAPTER 1: INTRODUCTION

The purpose of this study was to discover what kind of experiences transgender and non-binary individuals have when seeking mental health care in the Central Valley. According to the World Professional Association for Transgender Health (WPATH) standards, gender affirming mental health care is the best practice for treating the transgender and non-binary community (Coleman et al., 2022). This thesis endeavored to discover what gender affirming mental health care services are available to the transgender and non-binary community of the Central Valley as well as how satisfied transgender and non-binary individuals have been with their mental health care.

The number of professionals fully trained and willing to work with transgender and non-binary individuals is very small, especially in the Central Valley. The Central Valley, despite its diverse population, is severely lacking in culturally competent care for a number of populations. Being a rural area, there are limited medical and mental health providers in general, let alone professionals trained in treating diverse populations. Research has shown that the transgender and non-binary community are at high risk for experiencing depression, anxiety, eating disorders, addiction, and are often targets of discrimination, harassment, and violence (Begun et al., 2016; Hendricks & Testa, 2012; Hughto et al., 2021; Kittaneh et al., 2021; Kurdyla et al., 2021; Livingston et al., 2020; Mensinger et al., 2020; Schnarrset al., 2019; Stanton et al., 2021). Therefore, the need for competent and compassionate mental health care is vital for this community. The transgender and non-binary community of the Central Valley is a population that little research has been conducted. This study aimed to address this gap in research and to illuminate the needs and experiences of this community.

## Major Concepts of Consideration

The major concepts of consideration that can be found in this study include mental health care, discrimination, access to care, rural populations, diverse populations, trauma, eating disorders, substance abuse, crisis care, rural healthcare, homelessness, education, and gender affirming care.

## Definitions

Gender Affirming Care: For the purposes of this study, gender-affirming care was defined as a form of care which encompasses a range of social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender identity when it conflicts with the sex that they were assigned at birth.

Gender Identity: "Our deeply held, internal sense of self as masculine, feminine, a blend of both, neither, or something else. Identity also includes the name we use to convey our gender. Gender identity can correspond to, or differ from the sex we are assigned at birth. The language a person uses to communicate their gender identity can evolve and shift over time, especially as someone gains access to a broader gender vocabulary" (Gender Spectrum, 2023, The Language of Gender section)

Intersex: "The term intersex is an umbrella term that refers to people who have one or more of a range of variations in sex characteristics that fall outside of traditional conceptions of male or female bodies. For example, intersex people may have variations in their chromosomes, genitals, or internal organs like testes or ovaries. Some intersex characteristics are identified at birth, while other people may not discover they have intersex traits until puberty or later in life. People with intersex traits have always existed, but there is more awareness now about the diversity of human bodies" (InterAct, 2022, p.1).

Non-binary: "An umbrella term for gender identities that are not exclusively masculine or feminine" (Gender Spectrum, 2022, The Language of Gender section).

Trans: an abbreviated form of the word transgender, which will be used throughout this thesis.

Transgender: "Sometimes this term is used broadly as an umbrella term to describe anyone whose gender identity differs from their assigned sex. It can also be used more narrowly as a gender identity that reflects a binary gender identity that is "opposite" or "across from" the sex they were assigned at birth" (Gender Spectrum, 2022, The Language of Gender section).

Sexual Orientation: "Our sexual orientation and our gender are separate, though related, parts of our overall identity. Gender is personal (how we each see ourselves), while sexual orientation is interpersonal (who we are physically, emotionally and/or romantically attracted to)" (Gender Spectrum, 2023, The Language of Gender section).

## Study Population

The population for this study was the transgender and non-binary community of the Central Valley of California. Transgender and non-binary people exist among all races, ages, ethnicities, religious beliefs, socioeconomic statuses. In the Central Valley, some academic research has been conducted on the experiences of this community: a report on the barriers to accessing gender affirming health care for the trans and non-binary community (Fobear & Fitzpatrick, 2022); a thesis on the lived experiences of former transgender youth in the Central Valley (Duarte, 2020) which emphasized the need for helping professionals to be informed on treating the transgender community; and a thesis which highlights the need for social work programs to teach future social workers how to provide gender affirming care, particularly in the Central Valley (Aersolon, 2021). While the amount of research that exists on this topic is small, there is still a large, vibrant community in the Central Valley that has unique needs and deserves competent care.

## Theoretical Framework

The theoretical framework that was utilized in this study was ecological systems theory (Crawford, 2020). This theory is one of the most common in social work practice and research and is very effective for analyzing how a person's environment can affect their mental, physical, social, and emotional health (Crawford, 2020). The parts of this theory consist of the micro, meso, macro, exo, and chrono systems (Crawford, 2020). Having inadequate support in any of these levels in the system can lead to detrimental effects on transgender or non-binary individuals' mental health. By examining the experiences of transgender and non-binary individuals in the Central Valley, we can better understand where resources are lacking or need improvement to facilitate holistic wellbeing for the community.

## Method

The study used a qualitative interviewing method for gathering data. The researcher interviewed transgender and non-binary people who reside in the Central Valley on their experiences with seeking and accessing mental health care. The interviews were recorded, transcribed, and analyzed through coding in order to find common themes. All participants were given the option of using their first name or a pseudonym of their choice. The rationale for using a qualitative design was to hear the authentic stories of the community and have a better idea of the needs and experiences of the individuals and community.

The questions the researcher sought to answer were what mental health resources are available for the transgender community of the Central Valley, how accessible are these resources, how satisfied is the community with these resources, and how knowledgeable are providers on addressing the needs of this community.

## Significance of the Study

This study has particular importance to the field of social work as social workers believe in addressing the needs of diverse communities on multiple levels, in fighting for social justice, and in providing competent, culturally relevant care. It is, therefore, vital to understand how we can best meet the needs of this community and provide the most competent care possible. Social workers and other mental health providers do not receive much education on treating this population (Aersolon, 2021; Fredriksen-Goldsen et al., 2011; McAllister et al., 2009). In addition, there is very little research on the experiences of transgender and non-binary individuals when seeking and receiving mental health care. Further, there is no research that exists on the mental health care experiences of the population of transgender and non-binary individuals in the Central Valley. Therefore, this study has vital practice, policy, theory and research implications. This study addressed a major gap in research and highlights areas where improvements and changes can be advocated for in the Central Valley.

# CHAPTER 2: LITERATURE REVIEW

Mental Health Care should be accessible to all, including transgender and non-binary individuals. Transgender is an umbrella term that describes any individual whose gender identity does not match the sex that they were assigned at birth (National Center for Transgender Equality [NCTE], 2016). Similarly, the term non-binary is a term that describes those whose gender identity falls outside the binary categories of man or woman (NCTE, 2016). The U.S. has a large and diverse population of trans and non-binary individuals (Anderson et al., 2021; Herman et al, 2022). While there is currently no specific data on the trans and non-binary communities of the Central Valley of California, California has an estimated 150,000 trans and non-binary individuals (Herman et al, 2022, Anderson et al., 2021). When seeking behavioral health care, trans and non-binary individuals need gender affirming care. Gender-affirming mental health care addresses the “physical, mental, and social health needs" along with affirming gender identity (De Vries et al., 2020, p. 2). While there has been some research on gender affirming care and best practices (Chang et al., 2018; Coleman et al., 2022; Feinstein, 2020; Pachankis, 2018; Shulman et al., 2017; Sloan & Shipherd, 2021), there is very little published research specifically on access to and the quality of gender affirming mental health care for trans and non-binary individuals. Further, there exists no published research on the experiences of the trans and non-binary community of the Central Valley. This chapter will explore the empirical literature related to the topic of trans and non-binary individuals and will present the theoretical framework that guides this study.

## Theoretical Framework

Ecological systems theory is a theoretical framework which was developed by Bronfenbrenner to understand how all environmental systems in a person’s life, no matter how remote, affect the individual psychologically, developmentally, socially,

emotionally, and even physically (Crawford, 2020). Ecological systems theory is one of the most commonly used theories in social work practice and research (Crawford, 2020). Based on the adaptable and broad nature of this theory, this theory can be applied to any community or individual (Crawford, 2020). This theory can be used to understand how the environment of a trans or non-binary person in the Central Valley of California is affected on the micro, meso, macro, exo, and chrono systems levels in their lives.

**Microsystem**

The microsystem level includes the immediate and close contacts in a person's life, their family, friends and other individuals they interact with daily or frequently (Crawford, 2020). The microsystem includes the individual's temperament, personality and personal beliefs which the society and culture can shape that a person is in (Crawford, 2020).

For trans and non-binary individuals, the level of family support that they have may change when they come out. While it is not a guarantee for all trans and non-binary individuals in the transgender community, many do end up losing support from family, friends, and other close individuals in their life because those previously close individuals do not support the trans and non-binary individual living as their authentic gender identity (Katz-Wise et al., 2022). The level of support that a trans and non-binary person experiences, especially from family, is considered a protective factor for the wellbeing of a trans and non-binary individual as this can have a profound effect on the mental health of the trans and non-binary individual. In fact, lack of support from family puts the trans and non-binary individual at a higher risk for depression, anxiety, suicidal ideation, suicide and other mental health concerns (Katz-Wise et al., 2022; The Trevor Project, 2022).

**Mesosystem**

The mesosystem is the interactions between microsystems in a person's life (Crawford, 2020). An example would be the interaction between work and school life for an individual. If a trans and non-binary person is experiencing discrimination from a mental health provider or cannot find one who is able to provide gender affirming care, this could lead to a worsening of mental health symptoms and then cause the individual to struggle with school or at work. The way in which a trans and non-binary person is treated or perceived by others in public, at school, at work, and in other environments that they go to on a regular basis can have a profound impact on their sense of belonging and mental health (Katz-Wise et al., 2022).

Protective factors, such as having a supportive group of friends, a community center for the LGBTQIA+ community, or a community organization that offers support for the local trans and non-binary community, can be a huge safety net for the trans and non-binary individual, especially if they do not have any other spaces or forms of support in their lives (Katz-Wise et al., 2022). For instance, if a trans and non-binary person is experiencing discrimination at work or a trans and non-binary youth is being bullied at school, having a supportive group of people to talk with or a safe space to go to can help increase resilience for the trans and non-binary individual in the face of adversity (Katz-Wise et al., 2022; Puckett et al., 2019; The Trevor Project, 2022).

**Exosystem**

The exosystem is also an interaction of systems, but there are factors that the individual may not be directly involved in; however, it still impacts their well-being (Crawford, 2020, Katz-Wise et al., 2022). For the trans and non-binary individual in the Central Valley, an example of what this could look like would be a nonprofit organization that advocates for more resources or services for the transgender community; even if this trans and non-binary individual is not involved in the

organization, they benefit from any success that the organization may have in advocating for direct services or resources for the community. The policies in place in society can add benefits and barriers to a person having a good quality of life. For instance, Hill et al., (2018) found that having one's name and gender marker updated can lead not only to more self-confidence and less gender dysphoria for a trans or non-binary individual but also aid a trans or non-binary person in gaining a better quality of life through easier access to medical and mental health care, higher socioeconomic status, higher rates of employment, and housing. However, it takes a very long time and lots of financial resources for a transgender person to have all forms of identification changed to the correct name and gender as there is a separate procedure and cost for each and every form of identification that a person may have (Transgender Law Center, 2022). It should also be noted that because of the length of time it takes to update these documents as well as financial (cost to change documents due to various processing and legal fees) and legal (for instance, some states do not allow a person to change their gender marker on their birth certificate) barriers, few trans and non-binary individuals have all of their IDs updated (Grant et al., 2011; James et al., 2016). This puts trans and non-binary individuals at a greater risk of being targets of discrimination in housing or hiring for jobs, denied service or entry at facilities, and to be victims of violence (Grant et al., 2011; James et al., 2016).

Having access to gender affirming medical care can also have a positive impact on the mental health of trans and non-binary people (Hughto et al., 2020). Having access to such medical care has been found to decrease depression and anxiety (Hughto et al., 2020). Additionally, if a trans and non-binary person does not trust or feel safe with their primary care doctor, they are less likely to seek medical help or will delay seeking help. So, living in an area without access to gender affirming medical care can put both the

medical and mental health of trans and non-binary people at risk (Loo et al., 2021; Seelman et al., 2017).

**Macrosystem**

The macrosystem broadly refers to the culture and society that a person lives within (Crawford, 2020, Katz-Wise et al., 2022). While the state of California is largely liberal politically, the Central Valley has a mostly conservative government and society. The Central Valley also has fewer resources for the transgender community compared to places like San Francisco and Los Angeles.

Researchers have found that the sociopolitical environment that trans and non-binary individuals live in makes a difference in their mental health. Trans and non-binary individuals living in conservative environments tend to have fewer resources and also experience more anxiety, depression, and other mental health concerns (Bockting et al., 2020; Drabble et al., 2019).

As of writing this, the American Civil Liberties Union (ACLU) is currently monitoring 469 anti LGBT bills that have been introduced, are progressing, or have been passed in just the year 2023 alone (ACLU, 2023). The ACLU has classified these bills into categories: accurate IDs (limiting or restricting the ability of people to change their identification documents), civil rights (allowing businesses, employers, medical facilities and other agencies to discriminate against LGBT people), free speech and expression (allowing for the banning of books and other media that is about LGBT people, banning drag performances, and dictating how LGBT people can express themselves), healthcare (restricting or banning access to gender affirming care), schools and education (censoring or banning of education about LGBT people in schools and refusing to allow trans people to participate in sports and other activities or use gendered facilities such as locker rooms and bathrooms), and other (bills which target LGBT people and restrict rights but fall

outside of the other categories listed). The constant threats to the liberty and existence of LGBT individuals, especially the further limitation of access to gender affirming care, has a very high potential to have a negative impact on the mental health of trans and non-binary individuals.

The Central Valley of California is a very diverse area with people of all ethnicities, genders, ages, and religions. The Central Valley has a large Hispanic/Latino population and has one of the largest communities of Hmong individuals in the U.S. The Central Valley is originally Mono and Yokut native land and is one of the largest agricultural areas in the U.S. Trans and non-binary people are of many racial, religious, and ethnic, and socioeconomic backgrounds and this is just as true in the Central Valley. It is important to view the experiences of trans and non-binary people through an intersectional lens. Many trans and non-binary people experience not just transphobia but also racism, ageism, ableism, homophobia, classism, etc.

**Chronosystem**

The chronosystem refers to the time period in which a person is living. The chronosystem also refers to the age and aging process of the individual (Crawford, 2020). This is especially relevant when thinking about the experiences of trans and non-binary individuals as there have been significant improvements in the number of rights and level of acceptance of trans and non-binary people as a whole over the decades. A trans or non-binary person who came of age in the 1950s, when it was illegal to dress in the clothing of the opposite gender and there were no rights for trans and non-binary individuals, would have a very different experience compared to a trans and non-binary person who is a millennial living in the U.S. during a time where significantly more rights and resources exist (Katz-Wise et al., 2022).

What this theoretical framework of ecological systems theory highlights for us is the ways in which many factors shape a person in the environment (Crawford, 2020). Additionally, it emphasizes the need for communities to have resources for trans and non-binary individuals in order to provide good mental health care and an equitable society (Katz-Wise et al., 2022). The main problem explored in this research is the ways in which mental health care is or is not accessible, available and satisfactory to the trans and non-binary community of the Central Valley. Mental health care in this research focused on not just therapy but mental health crisis services, eating disorder treatment, and substance use disorder treatment.

The literature on mental health care for the trans and non-binary community will be analyzed in this next section. The mental health care of the trans and non-binary community must be affirming and take into account the unique needs of these individuals who experience stress as a minority. It is important for practitioners to be aware of best practices in order not to cause further harm to the trans and non-binary individual and to provide holistic care that is not include gatekeeping or pathologizing.

## Gender Affirming Therapy

Gender affirming mental health care is beneficial for trans and non-binary clients to fully be their authentic selves and overcome obstacles. Clinicians must be able to practice gender affirming care competently and have cultural responsivity when treating the trans and non-binary clients. The clinician's ability to establish rapport and trust with the trans and non-binary client is linked to more successful therapy outcomes and decreased psychological distress for trans and non-binary clients (Budge et al., 2021; Sloan & Shipherd, 2021).

One common experience of trans and non-binary individuals is gender dysphoria, which is discomfort or distress caused by the physical features they were born with not

matching their gender identity (Jessen et al., 2021). This gender dysphoria is also connected to increased depression and anxiety among trans and non-binary individuals (Sood et al., 2021). However, it is important to note that gender dysphoria is not something that all trans and non-binary individuals experience (Davy, 2015) Additionally, not every transition is the same and not all trans and non-binary individuals desire or pursue surgical transition and/or hormone replacement therapy (HRT). There is not one right or uniform transition experience. Transnormativity (assuming that there is one right or normal way to be transgender or non-binary) has historically played a significant role in pathologizing transgender and non-binary individuals, forcing transgender and non-binary individuals to conform to rigid, stereotypical, binary concepts of gender in order to gain access to care (Riggs et al., 2019). This does not take into account non-western concepts of gender and gender identities and presentations that fall outside of this arbitrary binary (Riggs et al., 2019).

Much harm has been done to the trans and non-binary community through pathologizing by mental health practitioners (Castro-Peraza et al., 2019; Davy, 2015; Hope et al., 2016). One common practice that has caused harm to the trans community is called gatekeeping. Gatekeeping refers to,

> clinicians' strict application of eligibility criteria to determine a trans patient's "fitness" to engage in medical transition, resulting in significant barriers to gender-affirming care. Gatekeeping often uses "mental readiness" as a prerequisite to medical transition, which contributes to patient distress and systemic discrimination. (Verbeek et al., 2022, p. 1)

This is in contrast to the WPATH Standards of Care, which state that clinicians must, "shift from a gatekeeping model towards an informed consent model, which improves access to care" (Verbeck, et al, 2022, p.1).

Another harm that has been enacted on trans and non-binary individuals is conversion therapy. Conversion therapy, also known as gender identity change efforts (GICE) or sexual orientation change efforts (SOCE), refers to a harmful practice that has the goal of making a transgender or non-binary person be cisgender or to turn a homosexual, lesbian, or bisexual person into a heterosexual person (APA, 2021). There is no reason for a person to go through this therapy, as there is nothing wrong with being LGBTQ+. Indeed, the American Psychological Association (APA; 2021) has stated, "the incongruence between sex and gender in and of itself is not a mental disorder" (p. 1). This is a very damaging practice that has not been shown to have any therapeutic benefit to any person (APA, 2021). Literature and discourse about this type of treatment "conceptualize gender diversity as a sin, a mental illness, and harmful, perpetuating cisgenderism and transmisogyny" (APA, 2021, p. 1). The harm of this practice is real and many people who have experienced it have "emotional distress, loss of relationships, and low self-worth" (APA, 2021, p. 2) and were "more than twice as likely to report having attempted suicide and having multiple suicide attempts" (APA, 2021, p. 2).

Trans and non-binary individuals experience higher rates of anxiety and depression when compared to cisgender and heterosexual individuals (Livingston et al., 2020). Additionally, many trans and non-binary individuals score high on the Adverse Childhood Experiences (ACE) scale (Schnarrs et al., 2019) and there are higher rates of post-traumatic stress disorder (PTSD) among trans and non-binary people (Hendricks & Testa, 2012).

Many trans and non-binary individuals stay "closeted" or conceal their identity in certain situations to protect themselves and attempt to stay safe. This is because many trans and non-binary individuals experience discrimination and harassment and this high rate of self-concealment and discrimination has been shown to increase depression and anxiety among trans and non-binary individuals (Livingston et al., 2020).

While both transgender and non-binary individuals experience similar stressors, such as a minority population, it has been found that non-binary individuals experience higher rates of co-occurring mental health and substance use disorders (Stanton et al., 2021). This is partly due to a high frequency of clinicians, physicians, and other individuals in their life refusing to validate or accept their identities. Non-binary individuals often have their identities dismissed as fake, a mental illness, or a phase (Stanton et al., 2021). This has caused some non-binary people to feel discouraged, that they are not "trans enough," and to feel that they do not even have a place in trans and non-binary spaces (Stanton et al., 2021). Having a social support network, a sense of belonging, and a connection with community is associated with better mental health outcomes (Budge et al., 2013; Stanton et al., 2021).

Mental health care goes beyond just care from a therapist. Services for eating disorders, crisis care, domestic violence, and substance abuse must also have gender affirming practitioners and treatment models. It is also important to look at the nuances of the needs and experiences of mental health care for transgender people of all races, ages, abilities, and socioeconomic statuses. Just as cisgender people do not have uniform life experiences, the same is true for trans and non-binary people who are a very diverse community. Kimberle Crenshaw (1989) introduced the concept of intersectionality and it is important to take into consideration the intersections of people's lives when providing mental health care, as none of us live in silos.

## Eating Disorder Treatment

Compared to cisgender individuals, trans and non-binary individuals experience higher rates of eating disorders (Mensinger et al., 2020). Eating disorders are often developed in trans and non-binary individuals to try to have some control over and to attempt to alter their body which does not align with their gender identity (Calzo et al.,

2017; Gordon et al., 2016). The risk of developing disordered eating is higher for trans and non-binary individuals who have experienced discrimination, harassment, and trauma (Mensinger et al., 2020).

## Substance Use Disorder Treatment

Compared to cisgender adults, trans and non-binary adults experience higher rates of substance use (Hughto et al., 2021; Kittaneh et al., 2021; Stanton et al., 2021). However, trans and non-binary individuals are less likely to utilize or seek treatment for SUD (Stanton, et al, 2021). This could be due to a lack of welcoming SUD treatment facilities (Stanton, et al, 2021). Rates of substance use increased for trans and non-binary people who have experienced discrimination and or harassment (Coulter et al., 2018; Katz-Wise et al., 2021; Newcomb et al., 2020). Many trans and non-binary individuals use substances as a form of coping; however, if a trans and non-binary individual has a strong social support network, this can serve as a protective factor in some cases and decrease the risk of SUD (Katz-Wise et al., 2021). There is a need for researchers and clinicians to develop and study the effectiveness of SUD treatment methods for trans and non-binary individuals (Kidd et al., 2022).

## Trans and Non-binary People of Color

Because of their intersectional experiences, trans and non-binary people of color often experience racism and transphobia when seeking gender affirming care (Howard et al., 2019; Sevelius, 2013). Because of the double-edged sword of racism and transphobia, trans and non-binary people of color have the highest rates of suicidality and victimization of violent crime (Angelino et al., 2020; Sevelius, 2013). In addition, trans and non-binary people of color are also at a higher risk of substance abuse, HIV/AIDS, and eating disorders (Sevelius, 2013). Trans and non-binary people of color also face higher rates of unemployment, lower socioeconomic status, and discrimination from

healthcare and mental health providers (Stanton et al., 2021). Sometimes, a trans and non-binary person of color may feel that they have to essentially "choose" one identity over the other and not disclose their gender identity if they find a practitioner who is accepting of people of color but not necessarily competent or willing to treat trans and non-binary individuals (Howard et al., 2019).

It should be noted that there is very little research on the specific experiences of trans and non-binary people of color and their experiences with accessing health care. Most studies have a majority of white trans and non-binary respondents and this is yet another gap in research.

## Intersex Individuals

Just as gender is not binary and exists on a spectrum, so does sex. The idea that there are just two sexes is scientifically false. Intersex individuals are those who are born with ambiguous genitalia, differences in sex chromosomes, or hormonal differences (InterAct, 2022). Approximately 1.7% of the population is intersex; this is comparable to the number of people born with red hair (InterAct, 2022). While not all intersex individuals identify as trans and non-binary, there are some who do and while their experiences are not necessarily the same as trans and non-binary individuals, they experience similar stressors that trans and non-binary people face (InterAct, 2022).

Frustratingly, there is very little research on the mental health experiences of intersex individuals. In 2020, the largest study on the mental health of intersex individuals was published, finding that intersex individuals experience higher rates of depression, anxiety, and PTSD than endosex (individuals who are not intersex) individuals (Rosenwohl-Mack et al, 2020). There has been a long history of intersex individuals being operated on at infancy or young age to force them to be a certain sex (Rosenwohl-Mack et al., 2020). This has been done without the consent of the individual

and usually does not actually align with the gender identity that the individual identifies with (Rosenwohl-Mack et al., 2020). This history of medical mistreatment has caused intersex individuals to have less trust in medical and mental health professionals (Mediå et al., 2022; Rosenwohl-Mack et al., 2020). In addition, many intersex individuals have been taught from a young age by caregivers and society that they need to keep their intersex identity a secret out of shame and fear, and this could contribute to hesitancy to discuss their experiences with a clinician (Mediå et al., 2022; Temko, 2020).

## Elderly Trans and Non-binary Individuals

Very little research has been conducted on the experiences of elderly trans and non-binary individuals. The research that does exist has shown that trans and non-binary Medicare beneficiaries (those who are elderly and/or have a disability) have higher rates of suicidality (Progovac et al., 2020). Other researchers have found that, like many lesbian and gay elders, trans and non-binary elders may feel pressured to go back into the closet, that is, hide their identity to avoid mistreatment from caregivers and nursing facilities (Boggs et al., 2017; Sage National Resource Center on LGBT Aging, 2021). Elder LGBTQ couples experience higher rates of discrimination at senior housing by staff (Boggs et al., 2017; Sage National Resource Center on LGBT Aging, 2021). Compared to the cisgender and heterosexual population, LGBTQ elders are more likely to receive care from their spouses, partners, and friends due to a lack of family connection and support (Boggs et al., 2017; Sage National Resource Center on LGBT Aging, 2021). LGBTQ individuals are less likely to have children to care for them in their old age (Boggs et al., 2017; Sage National Resource Center on LGBT Aging, 2021). These friends and partners who care for elderly LGBTQ individuals are more often than not of a similar age. This puts the LGBTQ elder at an increased risk of aging alone as

their friends and loved ones pass away (Boggs et al., 2017; Sage National Resource Center on LGBT Aging, 2021).

The obstacles facing trans and non-binary individuals when seeking gender affirming mental health care are transphobic practitioners, lack of resources, insurance limitations, and practitioners who are not informed in providing gender affirming mental health care (Loo et al., 2021; Puckett et al, 2018). When mental health care providers are not competent in addressing all aspects of a person's identity such as race, gender, spirituality, socioeconomic status, etc., then this is an example of intersectional failure (Crenshaw, 1989). While there has been some research on what gender affirming care best practices are, there has been very little research done on the experiences of trans and non-binary individuals who are attempting to access gender affirming care and their level of satisfaction with the care that they receive. Further, there has been no existing, published research on the experiences of trans and non-binary people in the Central Valley. This study will bridge the gaps in research on this topic.

The purpose of this study was to bring awareness of the lack of gender affirming mental health care resources in the Central Valley and to understand the experiences of the trans and non-binary individuals of the Central Valley as well as amplify the voices of these individuals. The researcher sought to answer the question what kind of gender affirming care is available to trans and non-binary individuals in the Central Valley and what is their level of satisfaction with this care? The researcher hypothesized that there would be very few options, low satisfaction with available resources, and high instances of transphobia in the Central Valley.

# CHAPTER 3: METHODOLOGY

This study utilized a qualitative interview research method. The rationale for this method was to gain an understanding of the unique experiences and perspectives of transgender and non-binary individuals when accessing or attempting to access mental health care in the Central Valley. The questions that the research was attempting to answer were:

1. What are the barriers to accessing mental health care in the Central Valley for trans and non-binary individuals?
2. How satisfied were trans and non-binary individuals with the mental health care that they received in the Central Valley?

Participants were adult trans and non-binary individuals living in the Central Valley. The major concepts being explored in this research were access to mental health care, level of satisfaction with care, experiences in different mental health settings such as individualized and group therapy, eating disorder clinics, emergency hospitalization, substance use disorder recovery sites, and other mental health care settings. Receiving individual counseling services is quite different from receiving care in other mental health settings and the researcher addressed these different dynamics by asking the participants specific questions about these experiences. In addition, the researcher sought to discover how these experiences and levels of satisfaction may have varied for trans and non-binary people of color, the type of insurance individuals had, and the socioeconomic status of trans and non-binary individuals. It was also important to determine if transphobia, racism, or any other types of discrimination or harassment occurred in these settings as well as how informed clinicians were in providing gender affirming care in mental health settings.

The data for this study were collected using a qualitative research method. The researcher interviewed trans and non-binary individuals in 30-60 minute sessions conducted over phone or zoom. The researcher conducted semi-structured interviews with participants, asking questions (See Appendix A) about their experiences with seeking and utilizing mental health care services in the Central Valley. All participants were asked the same questions but had the option to decline to answer any questions they did not feel comfortable answering. Participants were recruited through outreach at LGBT Resource Centers in the Central Valley, the local transgender nonprofit Trans-E-Motion, as well as other LGBT organizations throughout the Central Valley, and through social media. Participants were also recruited through snowball sampling. Any adult transgender or non-binary person living in the Central Valley was eligible to participate in the study.

Before starting this research, the researcher completed a Collaborative Institutional Training Initiative (CITI) certification training. The researcher submitted an institutional review board form and gained ethical approval from the University of California, Fresno, before interviewing participants. In addition, the researcher was under the supervision of Dr. Marcus Crawford of California State University, Fresno's Department of Social Work Education. Participants in the study were provided with a consent form (See Appendix B) to review before being interviewed. Due to the virtual nature of the interviews, participants were allowed to ask any questions or express any concerns about the study before being interviewed. The researcher asked for verbal consent before and after starting the recording of the interviews. In order to protect the identity and confidentiality of the participants, the researcher did not use the participants' last names or last initials. The researcher gave the participants the option to have the researcher use their first names or a pseudonym of their choice.

The audio of the interviews was recorded and then transcribed by the researcher. The researcher then conducted a thematic analysis of the transcripts in order to find common themes and experiences of the participants. The researcher assessed rigor for this study by gathering a large, diverse sample of trans and non-binary individuals and asking the same interview questions of each as well as carefully analyzing the transcripts of the interviews. The thesis chair of the researcher also provided feedback and analyzed the themes of the transcripts as well in order to achieve triangulation. In addition to the researcher's supervisor, two other readers also analyzed and reviewed this research to ensure best practices in research. The researcher gained a large sampling of participants in order to achieve saturation with common experiences of participants. The researcher endeavored to have a sampling of participants who were diverse culturally, racially, socioeconomically, etc.

The researcher managed risk by letting the participants know that their participation was entirely voluntary and informed them of any risks and benefits to participate in the study. Some examples of risks included potential emotional and mental distress from sharing personal and difficult experiences. Potential benefits of participating in this study included the potential to benefit the transgender and non-binary communities of the Central Valley by helping to bring awareness of unmet needs and barriers to accessing behavioral health care. This may lead to improvements in access and quality of services to the transgender and non-binary communities of the Central Valley.

The researcher further managed risks by giving the participants the option of using their first name or a pseudonym of their choice. The Researcher assured the participants that their stories would be anonymous and the researcher would only break confidentiality if someone shared something that the researcher, who is a mandated reporter, would have had to report by law. The participants were not deceived by the researcher and gave informed consent. The researcher ended each interview with a check

in, asking participants how they were feeling after sharing their stories and providing them with emotional support, as needed. Additionally, the researcher provided the participants with resources when relevant. The data collected from these interviews were stored safely by the researcher in a private google drive folder that only the researcher and thesis chair had access to.

The researcher's qualifications to conduct this research included the completion of several research courses at California State University, Fresno, including Experimental Methods (PSYCH 144), Feminist Research Methods (WS 153), Social Work Research Methods (SWRK 262), and Program Evaluation and Social Work Research (SWRK 262). Additionally, the researcher has experience working as a research assistant for Dr. Katherine Fobear of California State University, Fresno's Women, Gender, and Sexuality Studies department. The research projects that the researcher has assisted Dr. Fobear include the reports titled, "Nowhere to go: Housing Assessment for LGBTQ+ People Living in Fresno County" and ""We don't get to go just anywhere" Community Health Assessment of Barriers to Gender-Affirming Healthcare in Fresno, California." The second report is currently being reviewed for publication. The researcher is also a non-binary individual who has been actively involved in advocacy and activism with the local trans and non-binary community of the Central Valley for over 10 years.

In summary, the researcher has made every effort to conduct ethical, efficient, accurate research and made every effort to ensure the anonymity and safety of the research participants.

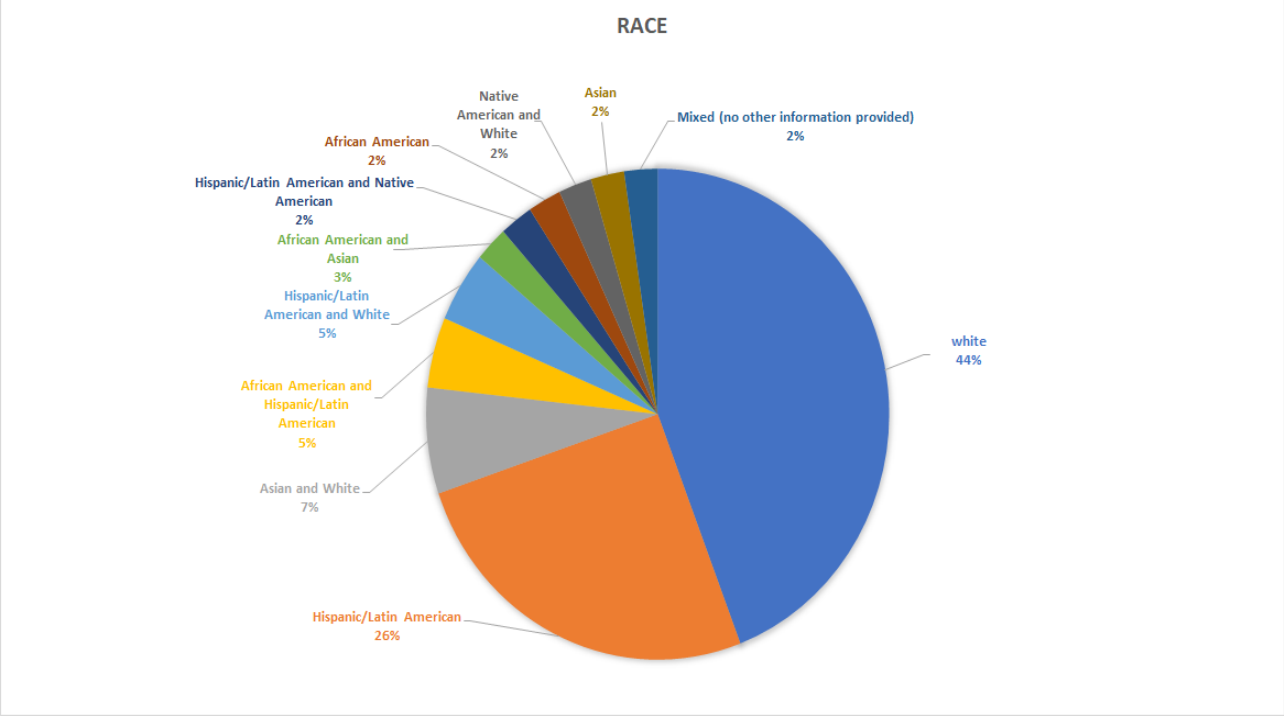
CHAPTER 4: RESULTS

## Demographics of Participants

The researcher conducted interviews with 43 transgender and non-binary adults living in the Central Valley, ranging in age from 18 to 53. The mean age was 32 (*SD*=9) with a median and modal age of 29. The race of participants (see Figure 1) varied with most participants identifying as white (*N*=19, 44%) or Hispanic/Latin American (*N*=11, 25.6%). Many of the participants identified with more than one race or ethnicity, with the most common being Hispanic/Latin American and White (*n*=2, 4.7%) and Hispanic/Latin American and African American (n=2, 4.7%). See Figure 1 for more details.

**Figure 1**

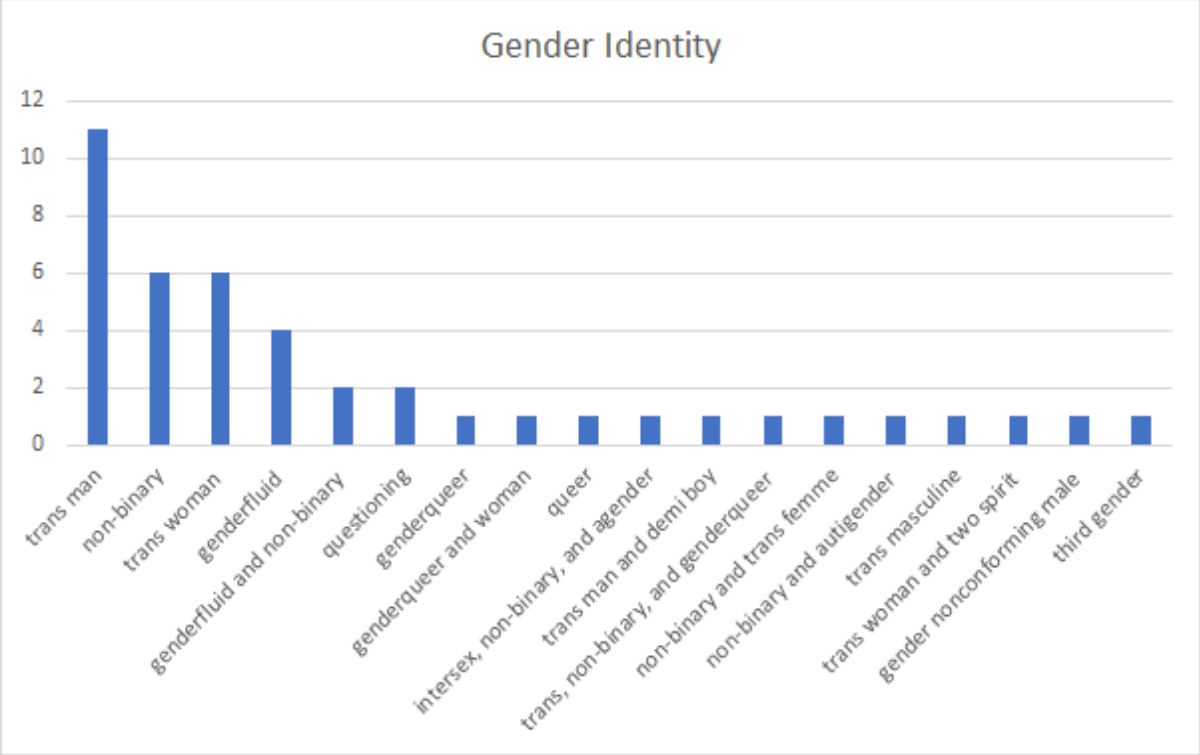
*Race of Participants*



The gender identities of the participants were very diverse (see Figure 2). It is important to note that gender identity is a unique part of every person and many of the participants used more than one label to describe their gender identities. The gender identities of the participants consisted of trans men (*N*=11), non-binary (*N*=6), trans women (*N*=6), genderfluid (*N*=4), genderfluid and non-binary (*N*=2), and questioning (*N*=2). The following each had one selection: genderqueer; genderqueer and woman queer; intersex, non-binary, and agender; trans man and demi boy; trans, non-binary, and genderqueer; non-binary and trans femme; non-binary and autigender; trans masculine; trans woman and two spirit; gender nonconforming male; and third gender.

**Figure 2**

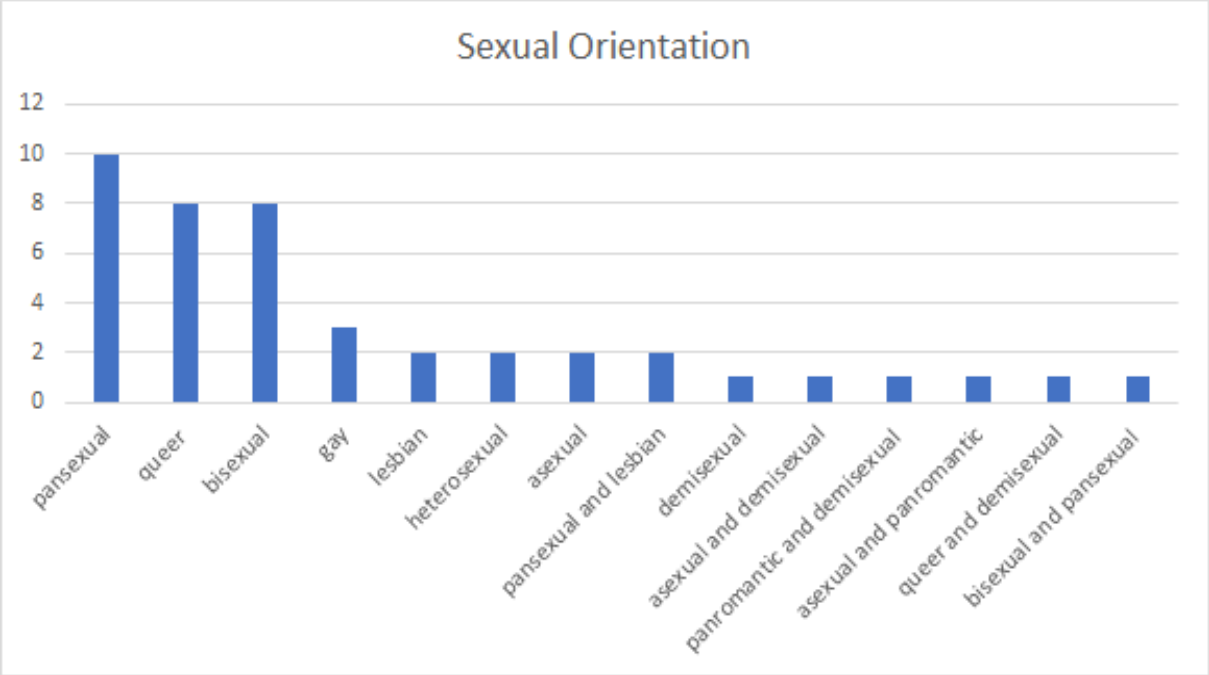
*Gender Identity*



The sexual orientations of the participants were also quite diverse (see Figure 3). Once again, many participants used more than one label to describe their sexual orientation. The sexual orientations of participants consisted of pansexual (*N*=10), queer (*N*=8), bisexual (*N*=8), gay (*N*=3), lesbian (*N*=2), heterosexual (*N*=2), asexual (*N*=2), pansexual and lesbian (*N*=2), demisexual (*N*=1), asexual and demisexual (*N*=1), panromantic and demisexual (*N*=1), asexual and panromantic (*N*=1), queer and demisexual (*N*=1), and bisexual and pansexual (*N*=1).

**Figure 3**

*Sexual Orientation*

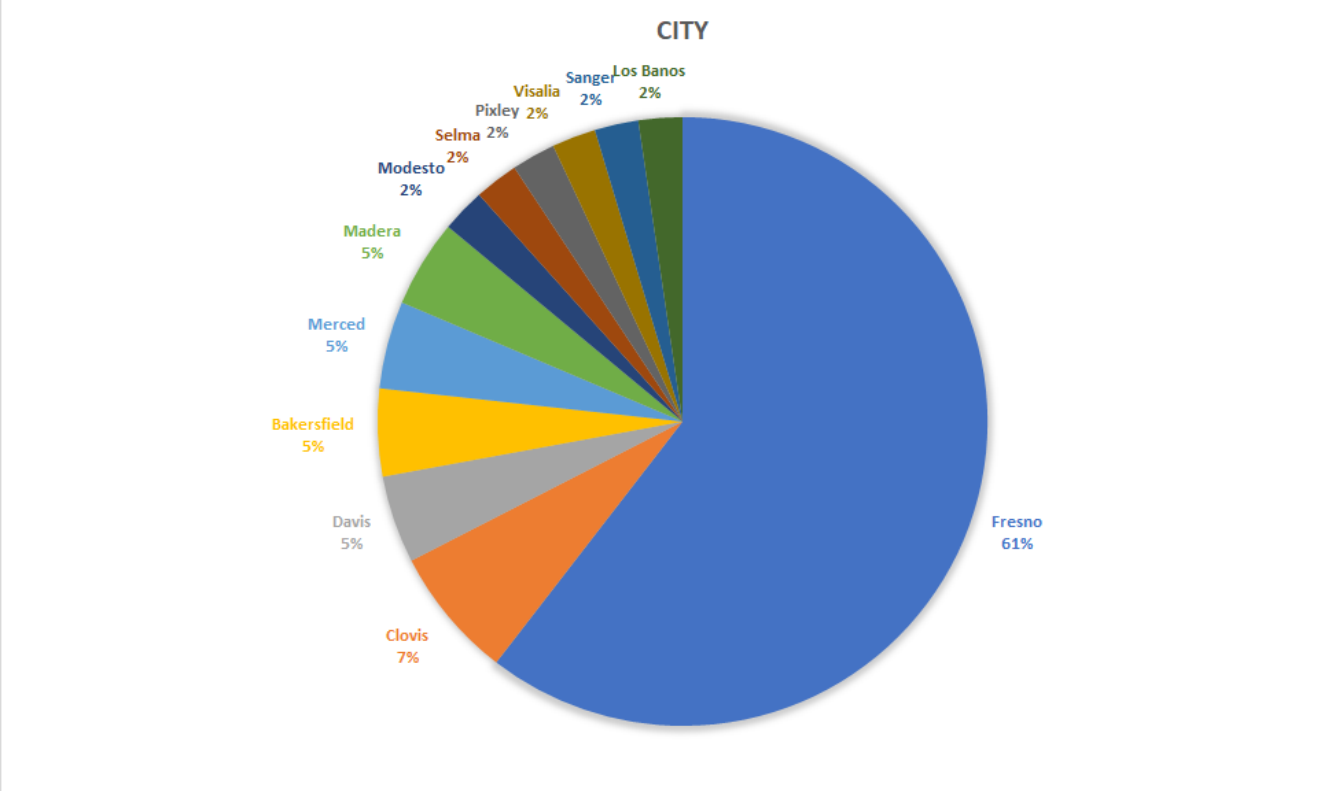



The participants came from cities all over the Central Valley (see figure 4); however, most came from Fresno (*N*=26, 60%) or Fresno County (Clovis, *n*=3, 7%; Selma, *n*=1, 2.3%; Sanger, *n*=1, 2.3%). Davis, Bakersfield, Madera, and Merced each had

two participants (4.7%). Modesto, Pixley, Visalia, and Los Banos each had one participant (2.3%).

**Figure 4**

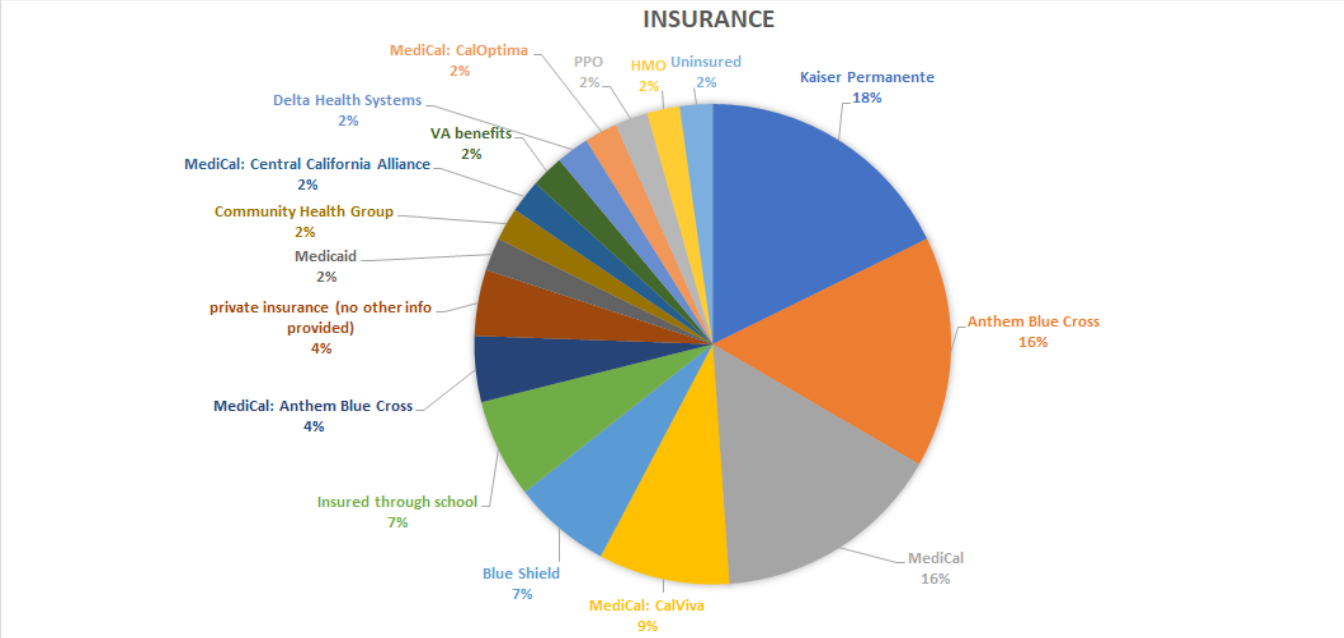
*City*




Insurance is a vital piece of the puzzle when looking at access to mental health services for the transgender and non-binary population of the Central Valley. For this reason, participants were asked about their insurance coverage (see Figure 5). Some participants had more than one type of insurance. Insurance coverage was common including a mix of private and public insurances, and including various periods that participants endured without insurance over their adult lives.

**Figure 5**

*Insurance*




## Experiences of Participants

The researcher analyzed the common experiences to find how many had seen a therapist who was not informed in providing gender affirming mental health care (See Figure 6). A total of 58% (*N*=25) had a therapist who was not informed in providing gender affirming care, whereas 41% (*N*=18) had a therapist who was informed in providing gender affirming care.

Participants were asked if they felt that their insurance had ever created barriers in their ability to access gender affirming mental health care (see Figure 7). Almost three out of four participants (*N*=31, 72%) said that they believed their insurance had caused barriers. More than half the participants had to seek care outside of the Central Valley to find gender affirming mental health services (*n*=23, 53.5%) (see Figure 8).

**Figure 6**

*Therapist Informed in Providing Gender Affirming Mental Health Care?*

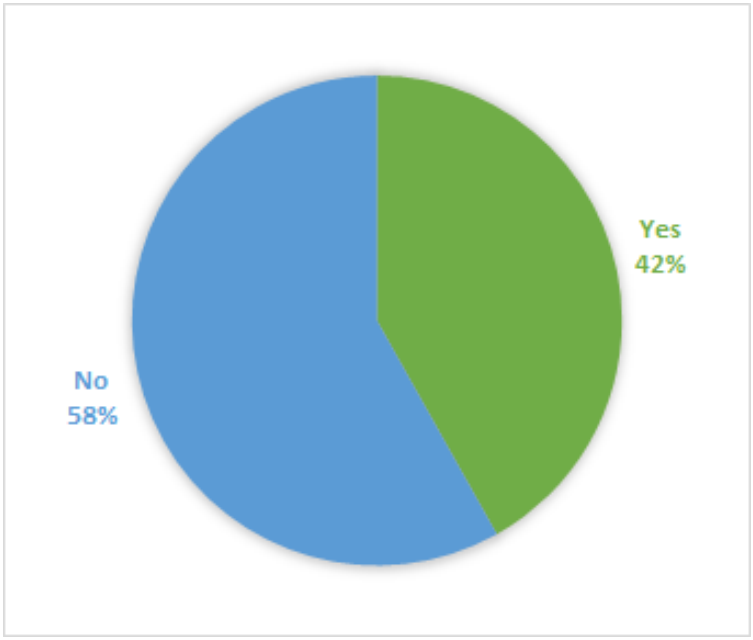



**Figure 7**

*Barriers with Insurance*

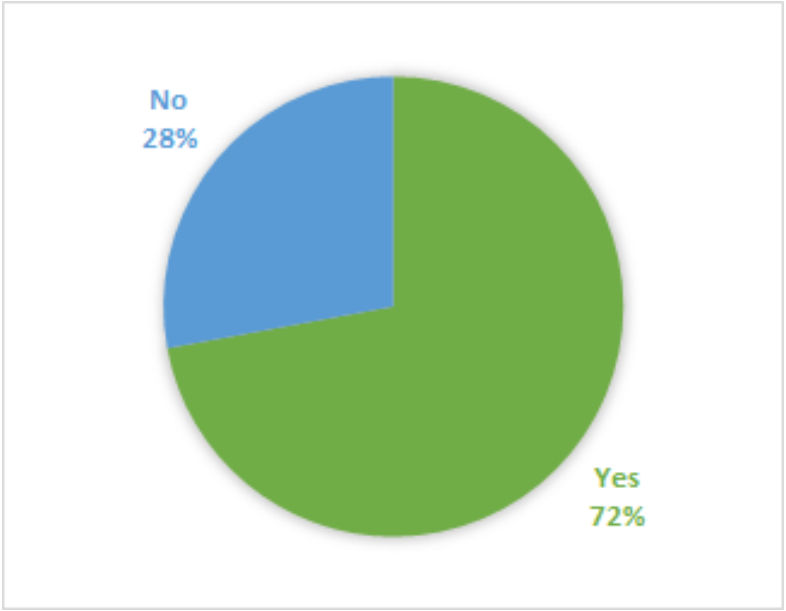
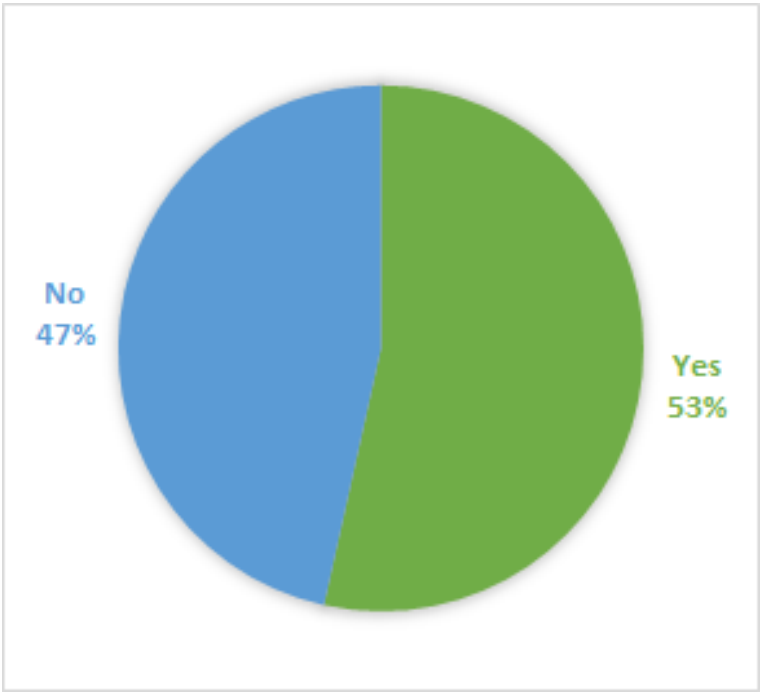


**Figure 8**

*Sought Mental Health Care Outside of the Central Valley*




Of the 43 participants, 44.2% (*N*= 19) disclosed that they had experienced substance abuse (see Figure 9). Of the participants who had experienced substance abuse issues (see Figure 10), 52.6% (*N*=10) never received any substance abuse treatment. Of the participants who did receive treatment, 21% (*N*=4) were satisfied with the substance abuse treatment that they received, while 26.3% (*N*=5) were not satisfied with the substance abuse treatment that they received.

A shockingly large number of participants experienced having an eating disorder (*n*=27, 62.5%, see Figure 11). For those who experienced an eating disorder, a majority did not receive any sort of treatment for these eating disorders (*n*=22, 81.5%, see Figure 12). Of the participants who did receive care, 14.8% (*N*=4) were satisfied with the care that they received while 3.7% (*N*=1) were not satisfied with the care that they received.

**Figure 9**

*Substance Abuse*

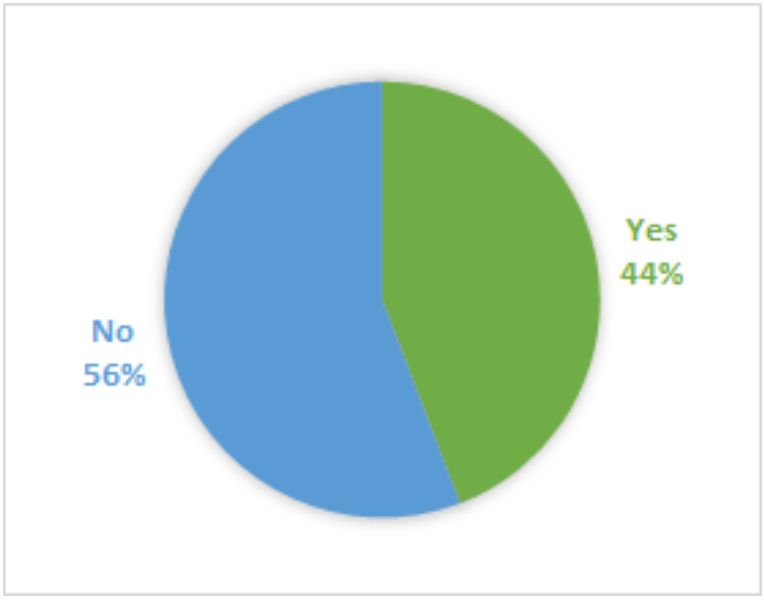



**Figure 10**

*Satisfaction with Substance Abuse Treatment*

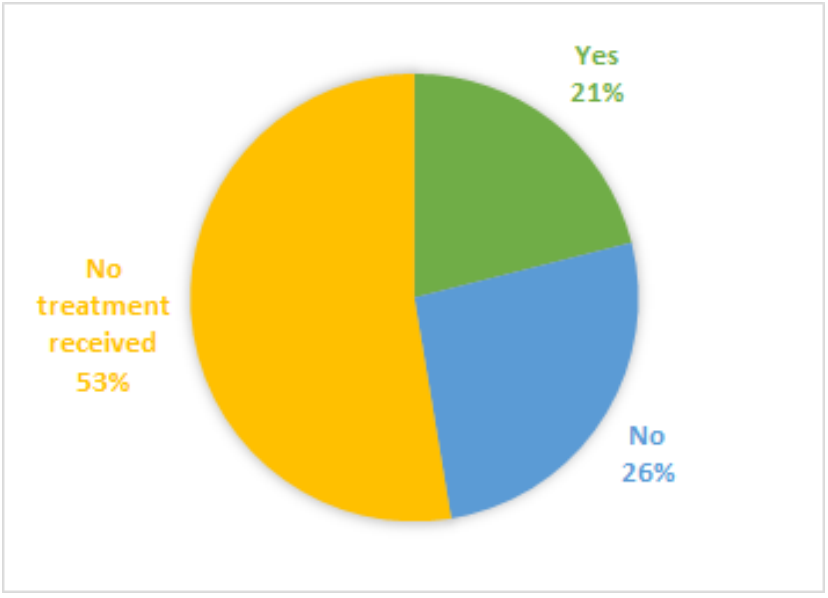


**Figure 11**

*Eating Disorders*

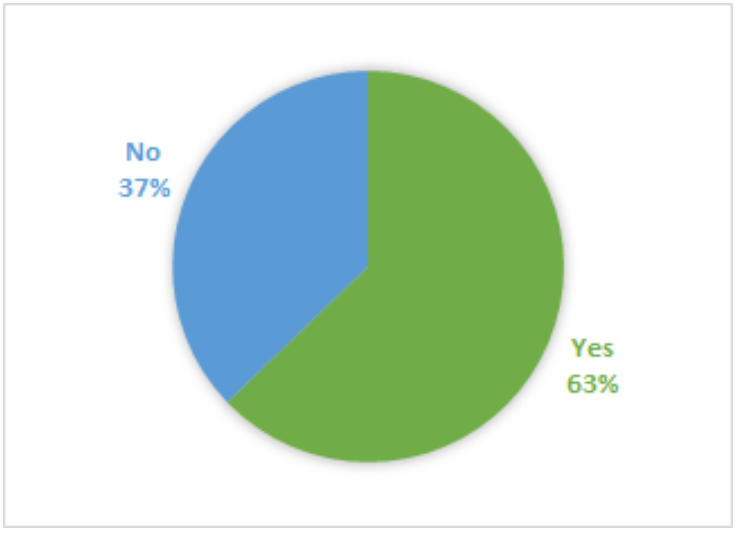
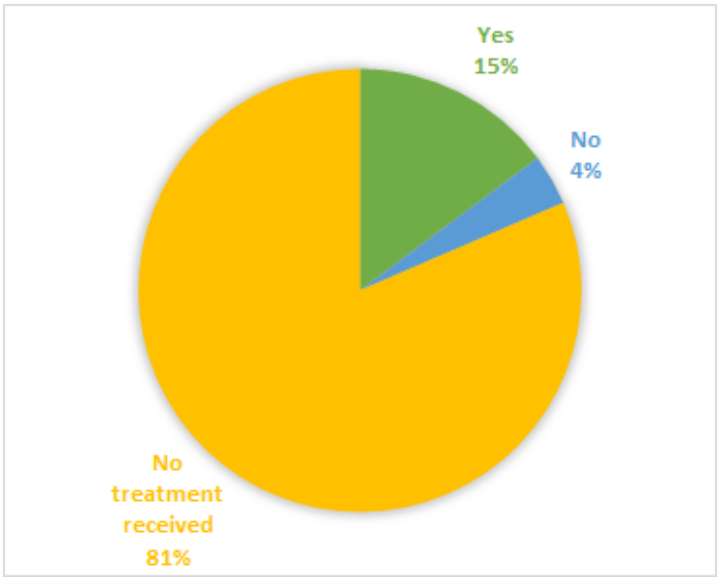



**Figure 12**

*Satisfaction with Eating Disorder Treatment*



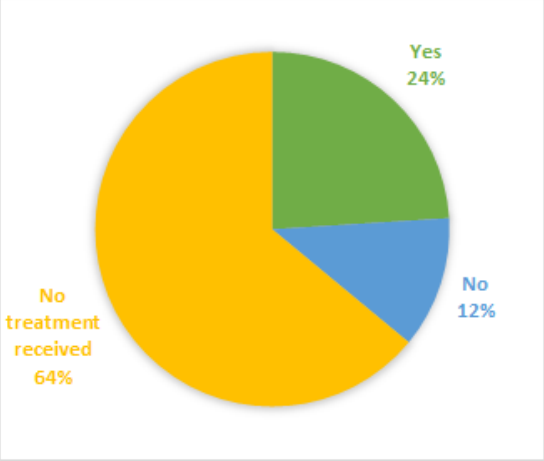
Unfortunately, domestic or intimate partner violence was also common, with 60.5% (*N*=26) of participants experiencing it (see Figure 13). Most participants 64% (*N*=16) did not receive any support or treatment for these experiences (see Figure 14). Of the participants who did receive help, 24% (*N*=6) were satisfied with that help and 12% (*N*=3) were not satisfied with the care they received.

**Figure 13**

*Domestic/Intimate Partner Violence*


**Figure 14**

*Satisfaction with Care for Domestic/Intimate Partner Violence*



Participants were asked if they had ever been hospitalized for any type of mental health reason, such as a 51/50 or a voluntary stay in a hospital (see Figure 15). Sixteen (37.2%) of respondents had experienced hospitalization while 27 (62.8%) had not. Of the participants who had been hospitalized (see Figure 16), 82% (*N*=14) were not satisfied with the care that they received. Just 11.8% (*N*=2) were satisfied with the care that they received, and 5.9% (*N*=1) had a mixed view of their experience with hospitalization.

**Figure 15**

*Hospitalization for Mental Health Reason*

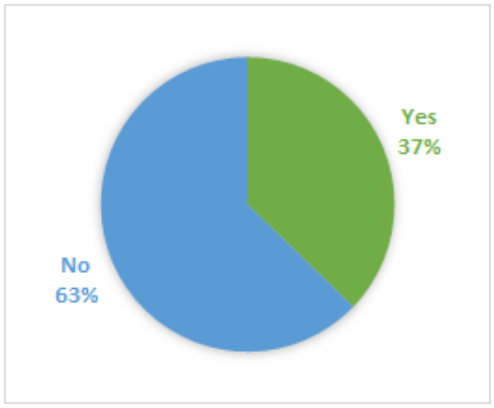
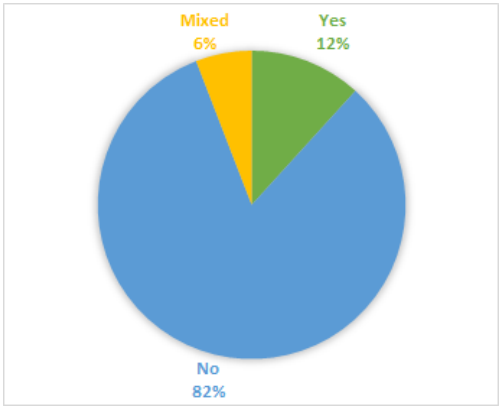



**Figure 16**

*Satisfaction with Treatment in Hospital*



## Thematic Analysis

After interviewing the 43 participants of this research, the transcripts of the interviews were analyzed for themes of the shared experiences of the participants. The following four themes emerged after extensive thematic analysis:

1. Good experiences with therapists
2. Bad experiences with therapists
3. Biopsychosocial experiences
4. Barriers to accessing care

### Theme 1: Good Experiences with Therapists

The participants in this study who shared about having good experiences with therapists all had very similar things to say about what made that therapeutic experience effective and satisfactory. Above all, having a therapist who was competent in providing gender affirming mental health care was the most important factor in the therapy experience being good. Only 41% (*N*=19) participants had been treated by a therapist who was competent in providing gender affirming care.

The fact that the therapist that they saw was informed in providing gender affirming care, meaning the participants did not have to educate their therapist about their gender identity as well as culture, was a huge benefit as the participants did not have to do the labor of teaching their therapist. Having knowledge of the needs of transgender and non-binary people, being knowledgeable of community resources; having connections to the local transgender community, its organizations and events was also of benefit to the participants. Carli (trans woman) said this of her therapist:

> She knew a lot about transgender people. Like, at the time, a lot of my education about what being trans was, came from my sessions with her. So, she like, knew about the transition process. She knew about hormones. She knew that just

> because someone's trans, it doesn't mean that they have to undergo any kind of medical transition. There's varying degrees of social, medical transition. She knew that being trans is a very individualized experience and that there's no right way to be trans, there's no wrong way to be trans, any way you want to be trans is the right way. She was always really affirming. She knew a lot about community resources. She knew where to go if you need help for a particular thing in Fresno. Whether that's like finding community, finding medical care, she knew of other like trans affirming surgeons and stuff who were accessible within California, depending on like your insurance and whatnot. She was like a plethora of knowledge about trans people. She also like, told me how she like, she was close to a lot of trans people in her personal life, and she was like really active in like the local community where she was from previously. So, it just seemed like she not only knew a lot about trans people, but she really cared a lot about trans people.

Many participants also shared that having a therapist who was also a member of the LGBT+ community was a relief and beneficial, making it easier to open up and gain rapport with the therapist. Deege (intersex, non-binary, and agender) shared this about their therapist:

> I'm currently with [a therapist who] is a queer, non-binary person. That has helped a lot, in surprising ways, like, I don't have to explain my sexuality, I don't have to like, cover the gender of my exes and cover my why I feel so um, black sheep in my family, because I'm the only queer person in my family.

Gilberto (genderfluid, drag queen) shared how having a therapist who is knowledgeable of the organizations and events in the community as well as being a member of the LGBT+ community and of the same ethnic background was helpful for them to feel comfortable with the therapist:

> I was really lucky at the time, because I got a counselor who was queer, she was lesbian…. she was familiar with the Imperial Dove Court [local drag organization]….It was such a relief to have someone who I could identify with, you know, we shared a similar background. She was also, you know, Mexican, Native American. So, there were definitely a lot of things about like, you know, my family, my culture, and the things I was doing, you know, socially my extracurricular stuff, like all the drag shows and the Court. So, it was really comfortable.

While being a part of the same racial community and being a member of the LGBT community is a benefit for working with a client, it is not a requirement to be an effective therapist, Alex (trans man, Hispanic) said

> Having, like therapists that you know are open-minded if they're not from that culture, or at least act like knowledgeable about the culture enough to where they're sensitive as well. Not just like, oh, yeah, I know these things. It's like, yeah, I know some stuff, but I'm also not going to act like I know. So, like knowing their limitations was really helpful.

Many of the participants mentioned that an important aspect of what made them feel safe and comfortable talking with their therapist was the fact that the therapist was not judgmental, was validating of the individuals' experiences, and did not pathologize them. As Eli (questioning gender identity) said, "I didn't feel like they judged me. It felt more like an opening and welcoming environment, and it felt like my concerns were heard, and that they were deemed valid." D (queer) said of their therapist:

> It doesn't feel as if this person is pathologizing me or that this person is analyzing every little word that comes out of my mouth and trying to, you know, psychoanalyze me. It just felt like someone who was interested in developing me

> and helping me reframe because they are not someone in my immediate life, they are someone on the outside who's able to bring in that outside perspective.

Going to an office or clinic that is openly accepting and affirming of the transgender and non-binary community was found to be vital for the participants who had a good experience with their therapist. This means that even the front desk staff, other employees as well as the therapist were all accepting and informed on how to interact with transgender and non-binary people. Micah (trans masculine) stated

> Just knowing that the office in general was queer-friendly helped me to, you know, even be able to like, approach them because I was putting it off for so long because I didn't know if I was going to be able to find someone in you know, the Central Valley that's, you know, not like, a private insurance situation, that would be queer-friendly. So, just like, knowing that that was kind of like the basis of their um, their office made me feel comfortable enough to open up to them, to begin with, but specifically with my um, with my therapist.

Overall, the factors that made a good therapeutic experience for the participants was seeing a therapist who was informed in providing gender affirming mental health care and worked in a setting where all staff were also informed in how to interact with trans and non-binary individuals. It was also crucial that the providers were able to practice cultural humility and had some knowledge of addressing the intersectionality of an individual. Having knowledge of the relevant resources in the community for the trans and non-binary community as well as organizations and events was beneficial.

### Theme 2: Bad Experiences with Therapists

When discussing interactions that participants had experienced with therapists, several common negative experiences were shared. These experiences form the following subthemes under the negative experiences:

1. Transphobia
2. Gatekeeping
3. Conversion therapy
4. Not informed in providing gender affirming care

### *Transphobia*

Unfortunately, many of the participants in this study saw therapists who were transphobic. Cassie (non-binary) said of their therapist:

> I was actually consistently told that my identity was invalid, that it didn't exist, and that I was a woman and what the female role was expected to be. Um, and I was only allowed to- for most of my childhood, I was only allowed to go to Christian therapists and I never met anybody that either supported the LGBTQ community, was okay with the queer community, or had queer people in their circle.

Alex (trans man) spoke about how he had to hold boundaries with therapists who wanted to ask him inappropriate things about his identity. In addition, his therapist tried to suggest that the negative things that had happened to him were his fault because of his gender identity:

> I had to learn how to do a lot of boundary working with therapists, which is really weird. because there were always like comments about like my transness or queerness being like an issue, or like a barrier and using that as an excuse for like certain things when I was literally experiencing discrimination outside of therapy.

### *Gatekeeping*

Seven participants shared specifically about experiencing gatekeeping interactions with mental health clinicians. Because many transgender and non-binary individuals must acquire a letter from a mental health clinician to gain access to medical care, such as

surgeries, “we’re at their mercy” as Oscar (trans man) said. He further stated, “that can be difficult when they gatekeep those things and hold power over us.” Oscar had a particularly horrible experience with a clinician he saw to get a letter for top surgery (a surgical procedure in which a chest becomes flattened or more “masculinized”). He described the therapist’s requirements:

> [The therapist] wanted me to uh, be on testosterone for a year before she would even consider getting me a letter. Which, you know, wasn't the standard of care anymore. I tried to explain to her that it was dangerous for me because I was, you know getting facial hair pretty quickly, and changes were happening, and I had a really large chest, and it was something that I wanted to do sooner than later.

In addition, this therapist was refusing to treat Oscar with dignity and respect his name and pronouns until he “passed” better. Oscar stated, “I would get misgendered, not until I was like, ‘passing enough’ was I like, respected.” This had a negative effect on his mental health as he said that after sessions with this therapist, “I would leave there crying and call my partner to get therapy from the therapy.”

At some point, Oscar said he offered to pay extra money to get the letter, and it worked. This, as Oscar said, “just kind of goes to show it wasn't about me or my mental health, it was just a gatekeeping technique.” After finally receiving this letter, Oscar shared that, “I ended it with her, and she even called me and was like, ‘you shouldn't be doing this, you're gonna need me after top surgery!’ And kinda like, threatened me a little bit.” Because of this experience, which Oscar described as, “really disheartening,” this “prevented me from like, being vulnerable again with a therapist.” Oscar said he did not feel that he could report what he experienced from this therapist because, as far as he knew, “she was the only one writing letters.”

Morgan (trans man) described going to a gatekeeping therapist for a year, “trying to convince this therapist who had never met another trans person that I was trans.”

Another experience with a gatekeeping therapist was shared by D (queer):

> [The therapist] made you see him for like 6 months before he gives you a letter, to make sure that you saw him afterwards, to make sure you didn't kill yourself. He brought that up multiple times. No trigger warning, he brought up like, a trans woman who like, killed herself after she transitioned medically. Just brought that up during our sessions as a way to make himself feel better, that it's okay that he's forcing people to wait this long before they get their letter. Because he literally said, he's like, "I'm not a gatekeeper."

Like Oscar and other participants in this study, D's gender presentation was also critiqued by the therapist, with questions about their clothing: "He asked me if that top made me dysphoric about my chest. Which then made me dysphoric. It was incredibly triggering, and it was really frustrating."

Rachael (trans woman) spoke about how her therapist wanted to make sure she was a "true transsexual" before being able to get a letter for her medical transition:

> There was a lot of testing that they wanted to do to determine if you were a what they- what had eventually become the term… a true transsexual, and a lot of that testing was out of my own pocket. And so, we're talking hundreds of dollars, that on top of her regular hourly rate because you're seeing, you know, a psychiatrist or a psychologist, and they're charging their normal hourly rates and insurance doesn't- isn't covering that.

When asked what kind of tests were conducted on her, Rachael described personality tests like Meyers-Briggs. She elaborated:

> But there were two or three others that I recall having to take that were like, 100, 200… 300 question long tests that ask very you know, specific details about my sexual history…. just vague things and I'm not sure what they were testing for precisely. I know that I was very frustrated.

Samuel (trans man) was told by his therapist that he had to meet certain weight requirements before his therapist would write him a letter. This is something outside of the therapist's scope of practice; it is the physician's duty to determine such things. As Samuel said of his experience with his therapist:

> I thought she [therapist] would be with me in writing a letter for gender affirming care for the top surgery, but the problem that I'm running into with her is the fact that that I need to lose a great deal of weight before she will even write a letter for me you know, for the top surgery. And then, she charges too, which I didn't really like that well.

Indeed, this is a common gatekeeping technique that other participants shared about: the fact that some therapists charge an extra fee for these letters. Carlos (trans man) recalled not wanting to pay someone to tell him he could have the surgery.

### *Conversion Therapy*

Four of the participants who were interviewed for this research shared about experiences with conversion therapies. Melissa (trans woman) said, "their goal was to get me to stop dressing, stop being myself rather than aid me [in] understanding my own path." And Sophia (trans woman) spoke of how the therapist who she saw took advantage of her fear of living as her authentic self:

> One of the reasons that I went to him [therapist] in particular, was because I had stated in the therapy, I want to be a woman but I would rather not want to be a woman. And he went with that as the treatment plan.

Morgan (trans man) spoke about being forced to go through this treatment when he was just 10 years old and didn't realize at the time that it was conversion therapy, it was only after processing flashbacks of the experience as an adult that he realized what he had gone through. He recalled one memory:

> I'm assigned female at birth, and I was forced to wear feminine clothing to school and I finally realized it was conversion therapy because I put together that the days that I had to wear feminine clothing, that my mom had picked out, were the days that I was forced to go to therapy.

He described the therapy as a "fundamentally harmful" practice from the 1980s with "electro-convulsive therapy [and…] terrible medications that were, you know, intended to sedate …[and] change [me]." He further recalled:

> I remembered the feeling of unsafety with that and that carried through with me my whole lifetime, and it took me until I was in my mid-40s finally, to actually seek help from a therapist. It was an extraordinarily damaging experience for me personally, but also in terms of being able to trust anyone in the therapeutic profession.

For Cassie (genderfluid, non-binary) conversion therapy occurred in their teen years and the therapists that they saw during this time were "closely tied to my church community, and so sometimes, what I reported would be shared with my pastor." One aspect of this therapy entailed Cassie reading books and writing in a journal which they "would review those once a week with a member of the church or pastor and the therapist." Cassie described an example of this:

> Say I had one bad thought which would be, you know, I find that woman really attractive. I would have to write a more appropriate response. So, I actually am attracted to her partner. I'm just jealous that she's got something I don't have, which is why I must be attracted to her. And they called it reprogramming. So, I had to relearn what I was attracted to.

Cassie shared about the negative beliefs that were instilled in them by the therapists, such as "I was born evil and that that was something I had to atone for, and I had to earn my goodness back." This had the effect of making Cassie believe that, "being celibate was

the only answer and that I would never get to have a partner." In addition, this therapy had detrimental effects on their mental health as they described:

> I got really depressed. And I really felt like there was nothing I could do to fix myself, and so I must be destined for evil. So, the only way I could see out of it was suicide.

In fact, Cassie shared that they had multiple suicide attempts "that only stopped happening when I finally came out of the closet in 2020." Like Morgan, this had a negative impact on their ability to trust mental health professionals in the future, stating that, "I think my foundation for trusting people has been severely shaken."

### *Therapist Not Informed in Providing Gender Affirming Care*

Approximately 58% (*N*=25) of participants saw a therapist who was not informed in providing gender affirming care. One example of this was shared by Mercy (trans woman), who spoke about how the fact that her therapist did not know how to write a letter for her to receive gender reassignment surgery (GRS) and this meant that she had to seek assistance from another provider for this letter:

> I needed a therapist note and my therapist at Madera County was not going to supply that. It's not that they weren't willing to, it's that the letter that you need, you know, the WPATH standards, they need to be written to, my therapist at the time was even willing to sign a letter for me, but he thought all he really had to do was just like sign the name at the bottom of a letter. He didn't know he had to like assemble a letter explaining my history and this and that. So, I had to start seeking outside of, and it didn't have to be outside of the county.

Mandy (non-binary) talked about their frustration with their therapist who wanted Mandy to educate them. Mandy described that therapist would focus on gender identity, which was not the purpose of the session, wanting Mandy "to like, educate them on

[gender identity] again when I was not seeing them about that at all. Um, then brought up their religion during our session."

Kaede (non-binary) shared how seeing a therapist who was not competent in providing gender affirming care affected them when the therapist would not use correct pronouns: "I just feel like I was brushed aside…like I was [not] being seen. I felt like my gender was an afterthought to them. It just didn't feel very good."

For people like Sam (non-binary), consistently having experiences with therapists who are not informed in providing gender affirming mental health care, can lead to a loss of hope and feelings as if they cannot talk about anything pertaining to their gender identity with their therapist. As Sam said, "I've stopped, I've given up on talking about my trans experiences and my problems as a trans person to my therapist."

There are many factors that contribute to negative interactions with mental health providers but the most prevalent that were discussed by the participants of this research were transphobia, conversion therapy, gatekeeping, and seeing therapists who were not informed in providing gender affirming mental health care. These experiences caused participants to have less trust and hope in mental health providers and some didn't even want to attempt to trust another therapist again.

### Theme 3: Biopsychosocial Mental Health Concerns

Biopsychosocial mental health concerns entail a variety of types of experiences that affect a person on a physical, psychological, and social level. The participants in this study experienced a variety of biopsychosocial mental health concerns and they have been separated into the following five sub themes of experiences:

1. Eating disorders/disordered eating
2. Substance abuse
3. Domestic/intimate partner violence

4. Hospitalization for mental health reasons
5. Homelessness

***Eating Disorders/Disordered Eating***

One of the most shocking results of this research was discovering just how many participants had experienced an eating disorder or disordered eating. As discussed above, 62.8% (*N*=27) of participants disclosed that they had experienced an eating disorder or disordered eating. Most 81.5% (*N*= 22) did not receive any sort of treatment for these disorders. One participant, Bear (trans man) shared:

> My family put me on diets when I was about 10 years old because I was a little chubby. In high school, I developed bulimia. I started binging and purging and I was also exercising. Especially in my junior and senior year of high school, I started exercising excessively, I would say. Over 2 hours every day in the gym. So, I lost a lot of weight but then after being a little bit on the chubby side and people see that, I got a lot of remarks about how good I looked and that I should keep it up and they had no idea that I was bulimic. At least, I didn't think they knew. So, you know, I kept doing that for a while and it wasn't till my mid 20's that I really started to seek help.

`When Bear tried to go to the one eating disorder clinic in Fresno at the time, he was not able to receive help because that clinic did not accept his insurance, which was MediCal. As he explains, "they said, 'sorry, we don't cover this type of care.' And, there was no way at that time that I could afford that out of pocket." Bear also talked about fatphobia playing a role in access to services:

> When you're fat, a lot of eating disorder clinics - at least what I've seen – or heard talked about are usually focused around folks who are anorexic, who are starving themselves and are too thin. I've rarely seen a space curated for folks who are

> trying to have a better relationship with their food, to not be afraid of their food, for fat people. Because I know, I'm not the only fat person who is starving themselves right now. I've known a lot of people that have made themselves really sick because they're trying to lose weight and they just can't lose weight for whatever reason.

Cher (genderqueer) shared about how they also experienced fatphobia when trying to seek care for their disordered eating:

> When I did seek help from the nutritionist at Fresno State it was pretty much like "Here's ways to lose weight," and didn't really like, listen to me when I was saying I'm not eating, and I had disclosed that I was a fat person. I'm not eating. I don't find eating comforting, I'm having eating discomfort, and just not using the restroom like, this is not how I used to be. She pretty much, says, "Oh, well, when you have diabetes, your stomach hurts and stuff like that," and I didn't even disclose I have diabetes. I didn't even disclose that I'm feeling like that. How do you know if I'm diabetic or not? I just said that I'm fat. And that nutritionist just went like, "Oh, you just need to lose weight. Here's a diabetic food care plan." and I was trying to explain to them that like, hey, I'm not eating. That's the issue. I don't find joy or comfort in food or anything like that. So, what can I do? And she pretty much just brushed me off.

Ezra (non-binary) had a similar experience to Cher, in which their concerns were dismissed by a medical provider. Ezra said that when he talked with his doctor, " they said that my weight like, was normal, or maybe even a little overweight. So, they were like, you know, we can't do much for you because you're not underweight." Alex (trans man, Hispanic) shared about how he felt that eating disorder clinics are targeted towards white people only and how eating disorders aren't talked about in the Hispanic community:

> I never saw it as an eating disorder. Like, in my head, the way that eating disorders work is like that's only capable for white people. Because white people are coddled in the mental health system the way like Black and Brown people will never be given those like services, or you know, accessibility, and like white people are allowed to say they have an eating disorder proudly, whereas, like Latinos, specifically, it's like eating disorders are not a thing. Like, you're just a fat ass, or you need to eat more, you know? So, all my life I didn't realize that I do have this disorder because that's not something that's like discussed in like Hispanic households, at least for myself, what I've experienced and witnessed. Whereas, like my white friends like, they're open about the fact that they have an eating disorder.

At the time of writing this, there is just one eating disorder recovery clinic in Fresno. Some participants also shared about going to support groups like Overeaters Anonymous (OA) but most were unsatisfied with the experience of going to these groups.

### *Substance Abuse*

As discussed earlier, about 44.2% (*N*= 19) of participants shared that they had experienced substance abuse. However, 52% (*N*=10) of participants did not receive any treatment. Many spoke of using substances as a way to cope. Alex (trans man) stated, "I was self-medicating because of all the mental health issues."

Most inpatient substance abuse treatment facilities are segregated into two binary gender categories and sometimes this means that staff at these facilities place patients in the section that is associated with the sex a person is assigned at birth. Tink (two-spirit, trans woman), shared about how she was allowed to stay in the women's side of an inpatient substance abuse recovery clinic; however, she was forced to use the men's

shower. The fact that she had been assigned male at birth meant that staff assumed she would be a threat to the other women at the facility: “I was put on the female side and I was told I would have to shower on the men’s side and I had to deal with the shower on the men’s side.”

However, several people, like Savun, (genderfluid), did have good experiences with substance abuse treatment programs, specifically, a Fresno program which has a program specifically for people who are living with HIV and are recovering from substance abuse:

> They are very supportive. And they supported me when I signed up for it and what's great about [the facility] is that they have …an HIV resource center, and they also supported their clients that are in recovery who's living with HIV.

Some participants even shared about how support groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) helped them to find community. Although, satisfaction with the experience of being in these groups was mixed.

### *Domestic/Intimate Partner Violence*

As stated earlier, 60.5% (*N*=26) of participants experienced domestic or intimate partner violence. However, most participants, 64% (*N*=16), did not receive any support or treatment for these experiences. Savun (genderfluid) shared the reason they did not seek help:

> I was too embarrassed to go to a shelter. um, and it's also the fact that there was this stigma for mental health. At that time, I thought- I thought it was shameful to receive help in that way because um, I was taught that it's weak-minded to seek help.

Bryn, a non-binary individual felt satisfied with the care that they got from a social worker and domestic violence support line: “I think it's one of those situations

where it's like, if you're not in it yourself, it's really hard to understand like why you're still in this situation. So. Yes, I did receive amazing help and support."

### *Hospitalization for Mental Health Reasons*

It was found that most of the participants did not experience being hospitalized for mental health reasons. However, for those that did, 82% (*N*=14), had negative experiences at these facilities. Cher (genderqueer, African American, Latin American) experienced mistreatment at multiple intersections of their identity, experiencing racism, fatphobia, and transphobia at the hospital:

> My heart was like, beating super-fast and it turned out that I was having a really bad anxiety attack. I thought I was having a heart attack, but it was a really bad anxiety attack that I was experiencing…. I am a fat person, so they're just like, "oh, you need to lose weight. That's why you're experiencing all these heart palpitations and why your blood pressure is super high, you just need to lose weight." And I'm like, there's something else wrong. I'm pre-diabetic, so, I know, like I monitor my blood sugar, and I was like, I monitor my blood sugar, like, there's something that's going on, and um they are like, "no, you just need to lose weight." They were pretty much brushing me off. And I was like, you know what, I want to see someone else that can help me out. So, it was really hard navigating and very traumatizing um, especially since I just wanted to go by they/them pronouns and they were just like, "Well, she needs to do this" and like, I was like, "I identify as non-binary right now. Can you please stop?" And they're like, "you're a girl, you are a woman." and it was very like debilitating and traumatizing…. So, that was one of the instances I was like, oh my goodness, I don't have faith in the health care system…. I had to constantly fight for my voice to be heard, and um, black individuals already have such a hard time with service

> providers invalidating and like not acknowledging that they're experiencing some type of pain.

Some participants even shared about brutality from hospital staff, Tink (two-spirit, trans woman) said that the staff was “so aggressive and most of them are just there so they can physically harm some of us.” Lynx (autigender), said of the staff at the hospital, “they straight up treated us like criminals.” Red (questioning gender identity) said of their experience in the hospital:

> There is something kind of jail-like feeling about it, even like, having to call my mom and be like, can you bring me things? like, there's only certain things that are allowed in here, and just like, I you know, like I don't have socks, can you bring me socks? they're charging me for socks like, you know? So, it was kind of- yeah, it was kind of weird in that sense. There was so many like, boundaries of like, where you could walk, or where you could go, or where you could be during certain times.

***Homelessness***

While there were no specific questions asked of participants on whether they had experienced homelessness, four of the participants disclosed experiences of homelessness. Zeno (third gender) spoke of how being homeless affected their mental health:

> It made everything really difficult when it came to like, um, kind of staying grounded. like, I really was getting unhinged because when you’re not really participating in society in any meaningful way, you start to kind of like, feel like you're separating off that, lifting away from it and it's just, you get further and further away if there's nothing to anchor you down.

Zeno also engaged in paid sex work as a form of survival, “I was surviving through um, just you know, selling myself.” They described therapy as being a beneficial thing in their life during this time, “therapy helped with staying- from like, completely just floating off.” For Alex (trans man), being homeless also came with additional barriers with insurance and transportation:

> I moved to Fresno when I was homeless, and I didn't have a therapist for a long time. So, because MediCal like cut out, and it was like a whole issue like there was always issues with MediCal and transportation. So, for a few years, I wouldn't have therapy - or like sparingly off and on, if I had transportation to go see a therapist out of Fresno back to Mendota, because that's where you know my MediCal was.

Alex expressed frustration with the difficulty of finding a therapist who met his needs and understood him:

> It was really hard, because, like being Hispanic and being like queer and trans it just - and also at the time being homeless. it was really hard to find folks who can understand, because it was like toxic positivity. But it's like how the fuck are you gonna be like super positive when you're homeless, and you know, you don't know when or if you’ll ever get off the street.

Tink (two-spirit, trans woman) shared about the dangers that trans people in the Central Valley who are experiencing homelessness face: “there’s a lot of them getting beat up” she said. Van, a trans man, disclosed that he was living out of his car for a period of time as a result of not having anywhere else to go.

Many participants experienced these biopsychosocial issues of substance abuse, intimate partner violence, eating disorders, hospitalization and homelessness. Few had access to or received the compassionate care that they needed for these concerns.

**Theme 4: Barriers**

From the interviews with the participants, two main barriers were spoken about that caused difficulties in accessing gender affirming care that are the sub themes discussed here:

1. Difficulties with finding a gender affirming therapist
2. Insurance barriers to accessing gender affirming mental health care.

***Difficulties with Finding a Gender Affirming Therapist***

The process of locating a gender affirming therapist has not been an easy or even successful journey for many of the participants. Some people found a therapist through recommendations from friends in the community, like Kaede (non-binary) who shared how they found their therapist: “I knew through my spouse, because they- I don't remember how they found out about it, probably um through somebody in the community.” Many others found their therapist through websites where therapists can advertise their services. The most common of these that was shared was Psychology Today’s website.

Unfortunately, many of the people who searched for therapists on these websites found that therapists could check a box indicating that they are competent in treating the trans and non-binary community; however, once the individuals went to get treatment from these providers, they found that this was not actually true. Frank (trans man) was one of these participants: “If you look at their [therapists] Psychology Today…. A lot of people have the tagline of like LGBTQ accepting but that doesn't mean that you're an expert, or that's what you're comfortable with.” Several participants also expressed a desire for a directory that would list all the gender affirming mental health services in the Central Valley. For example, Kiel, a genderfluid person said, “just wishing there was resources for deciding how and um who to seek care with…. a choose your own adventure kind of guide.”

Finding therapists that can provide gender affirming care who are also culturally responsive and informed in addressing other intersectional concerns has also been a struggle for the participants. Most participants spoke about a desire to see a therapist who understood that there is more to them than just their gender identity and could understand all intersections of their identities, such as how race, ability, age, and other relevant factors affect their lives and identity. For instance, Kevin, (genderfluid, Black) spoke about how he does not currently have a therapist because he would prefer to speak to a therapist who is a black man but there is a shortage of therapists who fit this demographic in the Central Valley:

> It's very, very difficult. I think the ones [therapists] that I even found that I'd be interested in were in like, Oakland. There's a very, very small population of therapists in Fresno, even smaller, if you'd like a black therapist, even smaller, if you'd like a black, male therapist.

The shortage of therapists in general in the Central Valley has limited the options for the trans and non-binary community. For example, Deege (intersex, agender) spoke about the shortage of therapists in Visalia and how that affected their quality of care and mental health:

> I finally like, went and found the one therapist in Visalia, the *one* therapist in Visalia who took MediCal and could see me within the next like 2 months, and then at that point, we would have sessions once a month for 30 minutes. They were not private, like, we all constantly had people knocking on the door to ask him questions. Uh, and he would let them come in. Like, he was not very like, "I'm in my session, please don't come to the door". He was like, "yeah, come on in" while I'm like, bawling…. I went through three sessions with that guy before I was like, this is making things worse, not better. I stopped seeing him.

Due to difficulties with finding a gender affirming therapist in the Central Valley, 53.5% (*N*=23) of participants had to seek care outside of the Central Valley, usually through telehealth methods like zoom. Unfortunately, for most people who saw a therapist outside of the Valley, it was not covered by insurance. Most participants who had to see a therapist outside of the Central Valley spoke about having to pay expensive out of pocket fees since this care was not covered by insurance.

### *Insurance Barriers*

While the participants of this study all had many kinds of insurance, most, 72% (*N*=31) stated that insurance had caused barriers for them to receive gender affirming care. One of the reasons for this was described by D (queer):

> So many people who are competent at all at talking to queer clients don't accept insurance and that's a huge problem. That's a huge part of the problem. We, statistically, the majority of the trans population is in poverty and on MediCal. So, then even if you even get up past MediCal and you do get health insurance, you still aren't going to be able to afford therapy! It's really frustrating.

Some individuals had therapists who moved practices or agencies and then changed what insurances they accepted, if any. This had a negative effect on Bear (trans man), who currently does not have a therapist for this reason:

> you have to choose “well, should I stay with my therapist with this insurance or change my insurance, lose my therapist, so I can get this gender affirming care?” It happens all the time. Or, like right now, I don’t have a therapist. My therapist I was with during COVID left the office that she was with and now she doesn’t take my insurance and she doubled her rates. And she said she could see me on a sliding scale but the point with insurance is that after some time, I don’t have to

pay as much out of pocket. Then I can save up for next year. So, I'm trying to find a therapist right now.

Frances (non-binary) shared that they are currently uninsured because they cannot afford insurance costs, after losing insurance through work but still earning too much to qualify for Medi-Cal. This has caused them to be unable to get access to gender affirming mental health care, "So I tried to basically get mental health help again but didn't have much success with that to this point."

Overall, there are not enough gender affirming mental health providers in the Central Valley, and there is not a clear way to find these resources for the community. There are few therapists who can be a compassionate and competent therapist in addressing the intersections of gender identity and race, sexual orientation, age, ability, body type, immigration status, economic status, etc. and there is a need for more mental health providers who are transgender or non-binary, especially trans and non-binary therapists of color. Many participants have had to find therapists outside of the Central Valley to meet their mental health needs and take on large fees. Insurance has caused barriers to accessing gender affirming mental health care by further limiting already slim options and causing more financial burdens for trans and non-binary individuals.

# CHAPTER 5: DISCUSSION

This research sought to answer the following research questions:

1. What are the barriers to accessing mental health care in the Central Valley for transgender and non-binary individuals?
2. How satisfied were transgender and non-binary individuals with the mental health care that they received in the Central Valley?

After interviewing the participants of this study and analyzing the transcripts for common themes, it appears there are few mental health professionals and facilities that are informed in providing gender affirming care. Many therapists have not met the needs of trans and non-binary clients and, in some cases, have even caused harm through transphobia, gatekeeping techniques, and conversion therapy.

The majority of participants had negative experiences with therapists who were not informed about providing gender affirming care. There is also not a clear, accessible, and accurate directory of gender affirming therapists in the Central Valley, and this makes it very difficult for individuals to access the care that they need and to know if the mental health provider they are going to see will be a good fit for them. Facilities that treat people with SUD, eating disorders, crisis care centers, domestic violence shelters, homeless shelters, and other mental health-related facilities do not clearly state whether they are competent or willing to help trans and non-binary individuals. Many trans and non-binary people did not receive help for substance abuse-related issues, domestic violence, eating disorders, homelessness, and other mental health-related concerns. For those who did use these services, the levels of satisfaction were mixed, and the majority of those who went to a hospital for mental health reasons had a negative experience. Participants shared experiences of conversion therapy and gatekeeping in the Central Valley. Although conversion therapy practices have been banned in the state of

California (SB 1172, 2012), they are still occurring and causing serious harm to the trans and non-binary community.

Further, the number of mental health providers who do provide gender affirming care in the Central Valley is very small. It is also difficult to find therapists competent in treating a person in a culturally competent way in all areas of themselves, in the areas of race, ethnicity, gender, sexual orientation, spirituality, etc. There is also a real shortage of therapists in the Central Valley who are trans or non-binary and of diverse ethnicities.

Insurance has been a huge barrier for most trans and non-binary individuals in the Central Valley, many have found that insurance does not always cover those therapists who provide gender affirming care. Because of the limited number of mental health providers who do provide gender affirming care, many people have sought therapists outside of the Central Valley and this is often quite expensive as their insurance usually does not cover this care.

## Theoretical Framework

Looking again at the ecological systems model, one can see how the barriers to accessing gender affirming care affect a person at the micro, meso, macro, exo, and chrono levels. On the micro level, having a support system of friends and family can make a difference in the mental health of a trans or non-binary person. The absence of this support, in combination with a lack of access to gender affirming mental healthcare can make resilience in the face of transphobia and cissexism much more difficult. This is even more vital when a person experiences SUD, eating disorders, trauma, intimate partner violence, homelessness, etc.

At the meso and exo levels, not having access to therapists and facilities that provide gender affirming mental health care in the Central Valley can prevent a person from getting the psychological and physical care that they need to live a happy, healthy,

and fulfilling life as their authentic self. Because of the lack of gender affirming services, relationships and interactions with family, loved ones, friends, and colleagues are impacted for the individuals. As Cassie's description shows, this interaction between relationship groups is conflicted when the care they receive is not affirming.

An example of how this issue has been found to affect the community at the exosystem level is how the insurance that trans and non-binary individuals of the Central Valley have can create barriers to accessing care. With high costs for mental health care and further limitation of who people may seek care from for their mental health, insurance has not provided the aid that individuals had hoped for. Also, many participants had MediCal, the insurance for those of lower socioeconomic status, and even fewer therapists accept this insurance. Many gender affirming therapists do not take insurance or only take limited insurance types and this further disadvantages those of lower socioeconomic status in the trans and non-binary community.

Looking at this issue from a macro lens, trans and non-binary people are more represented in the media (McLaren et al., 2021, Steinmetz, 2014), have more rights than the past and more people feel comfortable coming out and living as their authentic selves. However, the effects of transphobia, cissexism, and the rise of anti-trans violence (NCTE, 2022), combined with the over 400 anti-LGBT bills (ACLU, 2023) that have been proposed all across the country just in the year 2023 (ACLU, 2023) has all served to worsen the mental health in the transgender and non-binary community and has also further threatened the availability of gender affirming care (NCTE, 2022, Sahin, & Buyukgok, 2021).

It is imperative that policies that expand access to gender affirming care be advocated for, this is an important role and duty of social workers who are involved in both macro and micro practice. The Social Work Code of Ethics calls us social workers to live by the core values of social justice, recognize and respect the dignity and worth of

a person, understand the cultural importance of human relationships, have integrity, and practice within their scope of competence and to develop and to continue to enhance their expertise within this profession (National Association of Social Workers [NASW], 2021). By standing up for the most marginalized individuals in society, particularly trans and non-binary individuals, social workers are practicing the value of social justice. Treating individuals with dignity and respect, as our values call us to do so, includes trans and non-binary individuals. Social workers must connect with organizations and individuals to strengthen their understanding and relationship with the trans and non-binary community as part of the value of understanding the cultural importance of human relationships. Social workers must practice with integrity, that is, they must interact ethically with the trans and non-binary community. Finally, and crucially, social workers must gain competence in providing gender affirming mental health care and continually grow in understanding the ways in which gender identity intersects with race, socioeconomic status, spirituality, ability, age, body type, immigration status, and all other qualities of an individual and especially how the combinations of transphobia, homophobia, ageism, ableism, racism, fatphobia, classism, etc. in society affects the mental health of an individual.

At the chronosystem level, gender affirming care is something that trans and non-binary people of the past could only dream of; however, for the Central Valley, trans and non-binary people still do not have many options and there are many barriers to accessing the care that they need. This was seen clearly in Morgan's experience, who experienced shock treatment and sedation, among other harmful things, as part of conversion therapy in the 80s. Since this time, conversion therapy has been discredited and condemned by the APA (APA, 2021). And although harm in mental health settings has shifted further from physical harm, there has been more psychological harm and microaggressions, which are unfortunately easier to ignore. While gender affirming care is seen as the gold

standard of care for meeting the mental health needs of trans and non-binary individuals, ongoing reviews and improvements must continue in order to meet the needs of the diverse trans and non-binary community. It is also imperative that more mental health practitioners become educated in providing gender affirming care and to prevent further harm that has historically occurred at the hands of mental health providers.

## Empirical Foundation

The findings of this research are consistent with the findings of other research in that there are high rates of substance abuse, intimate partner violence, homelessness, anxiety, depression, and other mental health concerns for the trans and non-binary community (Begun et al., 2016; Hendricks & Testa, 2012; Hughto et al., 2021; Kittaneh et al., 2021; Kurdyla et al., 2021; Livingston et al., 2020; Mensinger et al., 2020; Schnarrs et al., 2019; Stanton et al., 2021). This research is also consistent with other research that has shown that there are major barriers and limited options for gender affirming care (Aersolon, 2021; Arroyo et al., 2019; Duarte, 2020; Fobear & Fitzpatrick, 2021, 2022; Loo et al., 2021; Seelman et al., 2017). This research demonstrates this is especially true in the Central Valley.

## Limitations

This study was conducted with rigor, having a large number of participants; a total of 43 participants were interviewed. The data of this research were inspected with triangulation, both the researcher and thesis chair of the researcher read the transcripts of the interviews to analyze for common themes. This research achieved saturation with most of the participants sharing common experiences and this made it easier to find common themes among the data gathered from participants. However, there were some limitations to this study. These limitations include the fact that although there were participants of many different racial and ethnic backgrounds, the largest racial group that

participated in this research were white trans and non-binary individuals, which is common in the extant literature. There were also a good variety of gender identities and sexual orientations represented in this study, however, it would have been nice to have equal representation among all gender identities and sexual orientations. This study also would have benefitted from more intersex and two-spirit individuals. Perhaps most notably, this study's participants were mostly from Fresno. While many other cities in the Central Valley were represented in this study, certainly not all were represented and again, this study would have benefitted from having higher numbers of participants from a variety of cities all over the Central Valley.

## Suggestions for Future Research

Future research on this topic is necessary. It is vital that further research is conducted on the barriers to accessing gender affirming care for trans and non-binary individuals in the Central Valley. It is recommended that research on eating disorders, substance abuse, homelessness, crisis care, and other mental health concerns among trans and non-binary individuals be conducted. It is also recommended that research be conducted on the amount of education that mental health providers receive in higher education programs on transgender and non-binary individuals and on gender affirming care. While there are a few studies on the amount of education that social workers receive on the topic of trans and non-binary individuals (Aersolon, 2021; Fredriksen-Goldsen et al., 2011; McAllister et al., 2009) more studies need to be done on the amount of education that students (particularly students at California State University, Fresno and other CSUs and UCs) in higher education programs (such as social work, psychology, marriage and family therapy, rehabilitation, counseling, etc.) receive on transgender and non-binary individuals and gender affirming care, as well as what barriers are faced by students in getting this training. It would be beneficial to conduct research on how mental

health concerns affect trans and non-binary individuals of color in particular as their experiences in mental health settings to get help for these concerns. As stated before, the Central Valley is a region where little research has been conducted on the experiences of trans and non-binary individuals so there are many opportunities and topics that should be addressed with research.

## Recommendations

There is clearly still a lot that needs to be done in the Central Valley in order to serve the mental health and wellbeing needs of the trans and non-binary community of the Central Valley. Many of the following recommendations for change were made by the participants of this study. These suggestions came from asking participants what they would like mental health care providers to know about treating the trans and non-binary community of the Central Valley and also what kinds of mental health care resources they wished there were in the Central Valley.

### Recommendation 1

There is a need for more mental health care providers in the Central Valley who are informed in providing gender affirming care. Further, these providers need to be understanding of the intersectionality of trans and non-binary clients.

By far, the most common thing that participants said that they wanted was more mental health care providers in the Central Valley who were competent in providing gender affirming mental health care. Many participants wanted providers to know that trans and non-binary individuals are all very unique and diverse and that there is more to them than their gender identity. It is vital that mental health care providers are educated in treating trans and non-binary individuals in a way where all intersections of their identity are treated with knowledge and compassion.

**Recommendation 2**

Higher education programs, especially those for future social workers, psychologists, counselors, and others going into the mental health field must provide education for students on how to provide gender affirming mental health care for trans and non-binary individuals.

More education at university programs and training opportunities for current providers on providing gender affirming care is needed in order to address the shortage of gender affirming care in the Central Valley, future and current providers must have access and opportunities to be educated on this care. Universities, especially those in the Central Valley, like California State University, Fresno, need to make education on providing gender affirming care a priority for students who are going into the mental health field. Connections between universities and WPATH may be beneficial in ensuring education on providing gender affirming care meets the highest standards. It should be noted that there are local organizations in the Central Valley such as Trans-E-Motion and the Fresno EOC LGBT+ Resource Center that are attempting to address this gap by providing training for current providers. More resources and support are needed for these organizations to continue to provide and expand training opportunities.

**Recommendation 3**

The Central Valley needs more trans and non-binary representation in mental health care providers, especially trans and non-binary providers of color.

There are not enough trans and non-binary mental health providers, especially trans and non-binary mental health care providers of color. These individuals can understand and empathize with trans and non-binary individuals at a deeper level than their cisgender counterparts. Participants expressed a desire for trans and non-binary therapists to talk to and those who had experienced this, felt they had an easier time opening up to the therapist and felt more comfortable. It is crucial that there is trans and

non-binary representation in the mental health field in order to ensure diversity and direct feedback from the community for the community on best practices.

**Recommendation 4**

All mental health facilities must have staff that is knowledgeable in treating trans and non-binary individuals.

This is especially important in facilities such as homeless shelters, centers for survivors of domestic violence, as well as eating disorder and substance abuse treatment centers. As seen in this and other research, due to minority stressors (Griffin et al., 2019). These are common areas where the trans and non-binary community need support. Facilities that are openly supportive with informed and compassionate staff help to draw in trans and non-binary clients and help them to feel safe to open up and get the support that they need in these environments.

**Recommendation 5**

Hospital staff must be trained to be compassionate and informed in treating trans and non-binary individuals who are experiencing a mental health crisis.

The majority of trans and non-binary participants of this study who experienced voluntary or involuntary hospitalization for mental health reasons did not have a positive experience at these hospitals. It is at these facilities where people may be experiencing some of the most challenging and vulnerable moments in their mental health journey and this makes it even more vital that staff is compassionate and competent in order to provide care that will support and uplift clients rather than cause further harm and trauma.

**Recommendation 6**

Recruitment for more trans and non-binary individuals to join this field as well as scholarships to make academia more accessible for trans and non–binary folks is recommended.

This recruitment and effort to make academia more accessible will help to increase trans and non-binary representation in the mental health field. Beyond recruitment, access to housing and affirming mental and physical health care is a necessity for students as it is incredibly difficult for one to successfully complete school without access to these basic needs. Mentorship and support is needed for trans and non-binary students entering into careers in the mental health field.

**Recommendation 7**

A directory of current mental health providers who are competent in providing gender affirming care is needed for the Central Valley.

Given that most participants of this study had a difficult time finding a gender affirming therapist, this resource is in high demand. This resource must be accessible, vetted for accuracy, and easy to find. A web and printed version would be beneficial. This resource should be available at LGBT resource centers and organizations. Central Valley nonprofit organizations PFLAG and Trans-E-Motion have created directories like this. Efforts to promote awareness of these resources and ongoing review of their accuracy would be beneficial.

**Recommendation 8**

There is a need for more support groups for the trans and non-binary community of the Central Valley, especially groups that are facilitated by a mental health provider.

Support groups for the trans and non-binary community are needed all over the Central Valley and preferably, these groups would be run by mental health providers who

are informed about providing gender affirming care. This would help trans and non-binary folks to make connections to others who are experiencing similar things. A variety of groups that address intersections of the community would be beneficial. For example, a group for disabled trans and non-binary individuals, a group for trans and non-binary people of color, a group for trans and non-binary elders, and a desire for a support group for individuals who are recovering from surgery was also expressed.

**Recommendation 9**

It is important to have more LGBT events in the Central Valley, especially events that address stigma about mental health in the trans and non-binary community.

There is still much shame and stigma associated with mental health in the trans community and events where people can uplift each other and learn about mental health would be of benefit to the community. An example of an event like this is the 2023 Transgender Day of Visibility Event hosted by Trans-E-Motion in Fresno California. The focus of this year's event will be on healthcare for the community and this includes mental health care.

**Recommendation 10**

There needs to be more accessible, inclusive events for the LGBT community of the Central Valley.

While historically, many LGBT events have occurred in bars, it is vital that more LGBT events are sober in order to have more events that are supportive of those who are recovering from substance abuse disorders as well as events that are youth-friendly. All events for the community should occur in venues that are accessible to individuals with disabilities. It would also be good to have more events where food is not the focal point (for example, a gathering at a restaurant) in order to be more comfortable for those living with eating disorders to attend. Having events that are accessible to everyone helps build

community connections for individuals and helps build community and individual resiliency.

**Recommendation 11**

There is a need for both residential and outpatient centers that are inclusive.

Outpatient and inpatient centers such as substance abuse recovery centers, domestic violence shelters, homeless shelters, eating disorder clinics, and other mental health related facilities just for LGBT, or even just trans and non-binary individuals. This is necessary so that there are safe and affirming places for trans and non-binary individuals to get support.

**Recommendation 12**

It is crucial to have gender affirming mental health providers who will provide affordable care and take all forms of insurance.

Given that the majority of participants saw insurance as a barrier rather than a benefit to them, it is important that more therapists are informed about providing gender affirming care, who can provide affordable care, and that accept all insurance would be a great relief for many who are burdened with outrageous fees or do not have a gender affirming therapist within their insurance network. It is hoped that one day a universal healthcare system in which everyone is under the same system and can access care for free would be ideal.

## Conclusion

In a region as richly diverse as the Central Valley, culturally competent, accessible, informed, and empathetic mental health care is necessary. Many individuals have had negative experiences with mental health providers who were not informed about providing gender affirming care. There are also not enough therapists in the Central

Valley to meet the mental health needs of the trans and non-binary community. For this reason, there must be more education on how to provide this care as well as understanding the many intersections of an individual's identity in order to best serve them. The need for mental health care in the community is even greater due to the effects of transphobia. The trans and non-binary community of the Central Valley deserve the right to live authentically and to thrive in the Central Valley.

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# APPENDICES

# APPENDIX A: INTERVIEW QUESTIONS

## Interview Questions:

- What is your name?
    - Would you like to use your first name or pseudonym of your choice for this research?
- What pronouns do you use?
- What is your age?
- How would you describe your gender identity?
- How would you describe your sexual orientation?
- What is your race or ethnicity?
- Are you insured right now?
    - If so, what kind of insurance do you have?
- What city are you currently living in?
- Could you share with me your experiences with finding care and support for your mental health? When did you first seek help?
- Have you ever sought treatment from a therapist in the Central Valley?
    - If so, what was that experience like?
    - Were you happy with the care you received from this therapist?
    - How did you become aware of this therapist?
- Have you ever been hospitalized in a facility for mental health care in the Central Valley?
    - If so, what was that experience like?
    - Were you happy with the care that you received at this facility?
- Have you ever sought help for an eating disorder in the Central Valley?
    - If so, what was that experience like?
    - Were you happy with the care that you received at this facility/from this provider?
    - How did you become aware of this facility/provider?
- Have you ever sought help with an addiction in the Central Valley?
    - If so, were you happy with the care you received at this facility/from this provider?
    - How did you become aware of this facility/provider?
- Have you ever sought help for experiences with domestic violence?
    - If so, were you happy with the care that you received from this facility/provider?
    - How did you become aware of this facility/provider?
- Have you ever had to seek care outside of the Central Valley for any type of mental health care?
- Has your insurance ever caused you to have limited options for mental health care?
- Are there any mental health care resources that you wish the Central Valley offered?
- What would you like mental health care providers to know about treating transgender and non-binary people?
- Is there anything else that you would like to share with me?

# APPENDIX B: CONSENT

# CONSENT TO PARTICIPATE IN RESEARCH

*Barriers to Accessing Mental Health Care for Transgender and Non-binary Individuals in California's Central Valley*

You are asked to participate in a research study conducted by Jordan Fitzpatrick who is under the supervision of Dr. Marcus Crawford from the Department of Social Work at California State University, Fresno, as part of a graduate thesis research project. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything that you do not understand, before deciding whether or not to participate.

## PURPOSE OF THE STUDY

The purpose of this study is to gain an understanding of the experiences of transgender and non-binary people in the Central Valley who have sought or received mental health care in the Central Valley. The researcher also hopes to find out how accessible and accepting mental health services in the Central Valley are for transgender and non-binary people.

## PROCEDURES

If you volunteer to participate in this study, you will be asked to participate in an interview conducted over zoom or by phone. The interviews will be recorded but recordings will not be shared with anyone. Transcripts of the interviews will be analyzed by the researcher for this thesis. The interviews are anticipated to last one half-hour to one hour long, in which the student researcher may invite you to talk about your past or current experiences of seeking or receiving mental health care in the Central Valley and discuss other related issues of concern to you.

## POTENTIAL BENEFITS

This study will not bring you specific benefits outside of an opportunity to share your views and opinions. Your participation, however, will be of considerable benefit for educational and research purposes, for it will give the student a critical opportunity to develop professional skills in research and also potential to illuminate the voices of local transgender and non-binary individuals and to inspire further research and action on this issue.

## POTENTIAL RISKS

This project is not intended to provoke any physical or emotional discomfort. However, you may choose to share sensitive and confidential information during the interview. All efforts will be made to ensure confidentiality.

## CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as

required by law. Confidentiality may be maintained by using a pseudonym instead of your name when transcribing the interview.

## PARTICIPATION AND WITHDRAWAL

You can choose whether or not to be in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind or loss of benefits to which you are otherwise entitled. You may also refuse to answer any questions you do not want to answer.

## IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about this research, please discuss with the researcher or with the researcher's supervisor:

Researcher: Jordan Fitzpatrick
Email: jfitzpatrick89@mail.fresnostate.edu
Research Chair: Dr. Marcus Crawford
Email: marcuscrawford@mail.fresnostate.edu

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I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date