Transforming Supports:

Trauma-Related Mental Health Care with Trans and Gender-Diverse Young People

by

Mattie Walker

B.C.Y.C, University of Victoria, 2013
M.A., University of Victoria, 2018

A Dissertation Submitted in Partial Fulfillment of the
Requirements of the Degree of

DOCTOR OF PHILOSPHY

in the Social Dimensions of Health

University of Victoria

We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

Transforming Supports:

Trauma-Related Mental Health Care with Trans and Gender-Diverse Young People

by

Mattie Walker

B.C.Y.C, University of Victoria, 2013
M.A., University of Victoria, 2018

Supervisory Committee

Dr. Nathan Lachowsky, Co-Supervisor
School of Public Health and Social Policy
University of Victoria

Dr. Aaron Devor, Co-Supervisor
Department of Sociology
University of Victoria

Dr. Sarah Hunt / Tłaliłila'ogwa, Committee Member
School of Environmental Studies
University of Victoria

Abstract

Previous research in Canada and internationally has consistently found that trans and gender-diverse (TGD) people face barriers to accessing the mental health care that they need. This dissertation presents findings from the qualitative, community-based project *Transforming Support,* which engaged with 34 TGD young people to understand TGD young people's experiences with trauma-related mental health care and identify recommendations and priorities for improving this care for these communities. Utilizing two qualitative methods for data collection, in-person community consultation workshops with 15 participants, and online, semi-structured interviews with 19 participants, this project focused on TGD young people's experiences with: navigating barriers to accessing mental health care; experiences of safety with mental health care providers; and community goals and priorities for future research on improving mental health care for TGD communities.

This dissertation is presented as three articles formatted for publication in peer-reviewed journals for academic and practitioner audiences. The first paper presents findings related to navigating barriers to care. Participants shared their experiences with seeking and accessing trauma-related mental health supports and spoke to the barriers they experienced in their navigation of mental health care services in their communities. This work provides insight into the ways that TGD young people are navigating barriers to care which can inform recommendations for improving access to trauma-related mental health care for these communities.

The second paper provides insight into how TGD people are experiencing and navigating safety within these contexts and points to future areas of inquiry regarding enhancing available training and building towards TGD-competency or -literacy training that encourages self-reflexive practice.

The third paper focuses on research priorities articulated by TGD young people. Findings suggest that future researchers be strategic in building projects that shift the focus from research on TGD people to research that focuses on mental health practitioners, practice approaches, and frameworks that acknowledge the multifaceted lived experiences of TGD people. This article calls for future research to pushback against deficit-focused narratives and an over-focus on harm experienced by TGD people.

Table of Contents

Acknowledgements

To all of the participants who took part in this project, this work would not be possible without your generosity. Thank you for sharing your experiences, your time, and your stories. Thank you for your trust.

To the community advisors, thank you for your willingness to share your time and expertise to support this project. Your thoughtful participation and guidance helped shaped this project into what is.

To my supervisory committee, thank you for your mentorship, support, and your belief in my work. I am enormously grateful to have the privilege to work with such inspirational scholars. Thank you for your time and your guidance.

To my community partners, thank you for your generosity, your time, and your energy.

To my partner, thank you for the steadfast encouragement and support, for always saying I could do it.

Dedication

To trans and gender-diverse young people everywhere, this is for you.

You are seen and supported.

Chapter 1: Introduction

What does it mean to have safe and accessible mental health care? Despite prominent trans scholarship discussing experiences of trauma and violence for decades (Lev, 2004; Namaste, 2000; Westbrook, 2021), much of the currently available literature does not adequately provide recommendations for mental health practitioners supporting trans and gender-diverse[1] (TGD) survivors of trauma (Panchal, et al., 2022; Shipherd, et al., 2019). While there is a rash of devastating statistics that so often open papers focused on TGD needs and experiences, this framing paints a heavy and disheartening portrait of TGD lives. Trans and gender-diverse people represent diverse and resilient communities that despite decades of activism and advocacy, continue to face inequities and social barriers leading to increased incidences of mental health needs requiring care and services (Navarro et al., 2021; Scheim, et al., 2021; Veale et al., 2017). Research regarding the mental health of TGD individuals has consistently highlighted significant barriers to appropriate, safe, and effective services (Ferlatte et al., 2019; Mizock & Lewis, 2016). Despite ample evidence that TGD communities experience health inequities leading to increased mental health needs (e.g., Scheim et al., 2021; Veale, et al., 2017), TGD people continue to experience discrimination, lack of relevant practitioner training, and systemic biases within mental health settings (Ellis, 2020; Mizock & Lundquist, 2016; Navarro et al., 2022).

This dissertation presents work conducted as a community-based research project, *Transforming Supports,* that aimed to explore and understand TGD young people's experience of safety in trauma-related mental health care and how TGD people are accessing, navigating, and

---

[1] For the purpose of this project the terminology of *trans and gender-diverse* was chosen by myself with consultation and input from my academic and community advisory committees. While imperfect this offers an umbrella term where I hoped people who do not identify as cisgender may see themselves. This can include people with many different identities such as (but not limited to): transgender, nonbinary, Two-Spirit, genderfluid, genderqueer, or agender. Language is always changing. I wanted to use terminology that was easily recognizable in project materials, and while maybe not exact, that people who are not cisgender would feel they fit with.

experiencing mental health services. In the four years that this project has gone from idea to actuation, and a full decade from the "transgender tipping point" (Steinmetz, 2014), there has been a further rise in anti-trans attitudes internationally (e.g., Cole, 2025; Redfield, et al., 2023). Despite much progress, Canada is starting to see a backlash leading to policy changes that threaten TGD people's safety and autonomy, such as recent changes in some provinces regarding schools requiring parental consent prior to using a youth's chosen name and pronouns (e.g., Johnson, 2024). Within these contexts, more than ever, TGD young people need safe and accessible mental health care.

Background

Across much of the current academic literature, the two primary recommendations for mental health practice with transgender and gender-diverse (TGD) people are *a need for further research* and *a need for education and training for mental health care practitioners.* There is a consistent call for more research regarding TGD people's mental health and well-being, the impacts of trauma on these populations, as well as further research and development of mental health and clinical frameworks for supporting these populations. Richmond et al. (2012) note that much of the literature at the time of their publication did not provide "adequate recommendations for intervention with transgender survivors of trauma" (p. 50) and over a decade later, this continues to be a gap articulated by authors (e.g., Ellis, 2020; Lange, 2020; Shipherd et al., 2019). There is, however, a growing body of literature advocating for *affirming* practices and incorporating *trauma-informed* perspectives in mental health care more broadly for TGD individuals (e.g., Austin et al., 2017; Brammer & Ginicola, 2017; dickey et al., 2020; DiFulvio, 2015; Ellis, 2020; Keating & Muller, 2020; Lange, 2020). Austin et al. (2017) state that, an "affirming and trauma-informed perspective recognizes that traumatic events and experiences, including non-life-threatening forms of transphobic prejudice, may threaten transgender and gender nonconforming clients' sense of safety, power, and control over their lives" (p. 1). dickey et al. (2020) argue that there is an urgent need to ensure that mental health care practitioners are not doing harm to trans and nonbinary clients, suggesting that affirmative and trauma-informed approaches are essential to decreasing this risk of harm. Service providers must be aware of the systemic and interpersonal factors that can lead to continuous re-traumatization for some clients (Keating & Muller, 2020). Affirmative practice approaches may be a key element of mitigating these risks of re-traumatization (Applegarth & Nuttall, 2016; DiFulvio, 2015; Keating & Muller, 2020; Lange, 2020).

A trauma-informed approach is a framework for engaging with clients, structuring a program, or delivering a service that recognizes the prevalence of trauma, and the potential impacts trauma may have on an individual and others. This approach recognizes that by using a few core principles, services can become safer, more accessible, and more effective for clients. Despite becoming an increasingly popular framework in mental health practice, there is a lack of consistency in how this approach is defined and applied in practice. Lange (2020) notes that while many evidence-based trauma-focused approaches are designed for addressing a single traumatic experience, less is known about the suitability of these modalities for treating complex trauma presentations and trauma stemming from minority stress experiences. As Livingston et al. (2020) suggest, trauma-focused therapies were not designed to target identity-related adaptations to trauma exposure and, with no studies including sexual or gender minorities in their randomized control trials, there is limited ability to draw conclusions about the relevance of current trauma treatments for specific populations such as TGD people. The authors emphasize the important need for research and development in this area, stating, it "is critical to providing culturally appropriate patient-centred PTSD [post-traumatic stress disorder] treatment for LGBTQ [lesbian, gay, bisexual, trans, or queer] patients" (p. 62). Shipherd et al. (2019) underscore the need for researchers and clinicians to focus on best practices for TGD people in order to better understand trauma recovery amongst these populations. Wirtz et al. (2020) call for research and programming to address gender-based violence against transgender people, suggesting that interventions developed in partnership with trans communities and those that offer comprehensive approaches to addressing violence may be the most helpful. Many counsellors have little knowledge or awareness about gender diversity and this lack of education can contribute to bias, discrimination and mistreatment of TGD clients within mental healthcare settings (Hendricks & Testa, 2012; Matsuno, 2019). This can lead TGD individuals who are seeking support for experiences of violence and discrimination to actually then experience discrimination from service providers themselves, which leaves many TGD people feeling unseen and unserved by the current systems of mental health care.

When communities and identities are not seen or recognized by the systems that provide services, there remains a stark and glaring gap in what is available. This moves a step further when communities are not seen because of intentional erasure by the systems themselves. "Erasure is the most significant social relation in which transsexuals and transgendered people are situated" (Namaste, 2000, p. 265). As Spade (2015) argues, systematic erasure and pervasive marginalization through policy make life "administratively impossible" (p. 12). Furthermore, this connects to naming and supporting trauma experiences for TGD people: if the experiences, symptoms, and needs of these communities are unseen or unrecognized, the issue becomes erased. Appropriate and specific trauma supports for TGD people are not available because the issues and the people experiencing it have been and continue to be systematically erased by the systems that purportedly provide care and support.

Within Canadian contexts, the ongoing impacts of colonization continue to perpetuate this kind of systemic erasure and marginalization of gender nonconforming identities, particularly for Indigenous peoples. Hunt (2018) argues that the erasure of Two-Spirit[2] and TGD people was accomplished through the combined "ideological, socio-legal, and spatialized enforcement of colonial gender norms" (p. 25), particularly through the institutionalization of Indigenous children through the residential school system. "Categorization has been central to colonialism in Canada" (Hunt, 2018, p. 28), and when that categorization is forcefully gendered along a binary, people that fall outside of the available categories are erased. This continues to be significant in trauma-related health research, as TGD experiences, particularly TGD and Two-Spirit people, "fail to be accounted for in gendered analyses of health" (Hunt, 2018, p. 28). This serves as an exemplary of the powerful ways systems can and do erase trans and gender-diverse people. Further, in literature focused on TGD mental health needs, discussion about Indigenous TGD people and Two-Spirit TGD people are almost entirely missing. Instead, these discussions are siloed into Indigenous-specific literature, emphasizing the need for intersectional approaches to TGD mental health that can account for the multifaceted experiences TGD people represent and the differing interactions TGD people may have with structures and systems responsible for mental health care and research based on their positionality.

One of the most salient ways this erasure presents itself in the field of trauma work is the lack of research and the paucity of any trauma approaches specifically made for TGD experiences and a lack of intersectionality (Clark, 2016; Collins, 2015; Crenshaw, 1989; 1991) in

---

[2] For definitions and discussion of 2-Spirit or Two-Spirit see: Lezard et al. (2021).

the analysis of current gaps and barriers to service for TGD people. This erasure not only leaves a gap in available services and adequate approaches to treating trauma, it can and does directly lead to further experiences of trauma for TGD people (Barr, 2018). As Clark (2016) offers, trauma theory and practice "simultaneously erase the naming of structural acts of violence, while creating and exacerbating the psychological symptoms" (p. 6). This creates a cycle of violence and trauma that current approaches to supporting individuals with trauma not only do not always address but can also actively perpetuate.

Intersecting experiences place TGD people at unique gaps within structures and systems of care which create barriers to needed care that are not often discussed in the existing literature (LeBlanc, 2022; Ross et al., 2021). For example, in British Columbia, Canada, where this study took place, much of publicly accessible mental health care is managed through health authorities which are provincially and regionally managed; however, Indigenous First Nations people may access health and mental health care through the First Nations Health Authority, which has differing jurisdiction, pathways to care and eligibility criteria than other regional health authorities. These health authority services also have differing relationships to funding programs for individuals to access private-paid services and differing partnerships and collaborations with community organizations and trans health initiatives such as Trans Care BC (www.transcarebc.ca). Further, provincially and regionally mandated health programs have various eligibility requirements for services, based on age, specific need, or geographic location, and many programs do not offer longer-term (e.g. more than 3-5 sessions), individual, no-cost therapy for individuals over 19. This leads many individuals seeking individual therapy for concerns such as trauma to seek support through community agencies or private-paid therapy.

A critical intersection to name in the work of this project is the intersection of age and TGD identity experience. Young people are uniquely positioned within systems of care as their ability to consent and have autonomy in decision-making varies greatly across services and contexts based on age. In order to understand and address gaps to services, it is crucial to understand the context within which individuals and communities are seeking care and the ways in which the systems of care may not be seeing them or serving them effectively due to a misrecognition or systemic erasure of intersecting identities and experiences.

Within these contexts, despite calls for improvements in mental health care provision, there remains a critical lack of research that actively incorporates TGD voices and prioritizes community-driven goals for improving mental health services (LeBlanc et al., 2022; Ross et al., 2021). When, for over 10 years, the primary recommendation arising from academic research for practice for supporting TGD people with trauma has been a need for research and improving education and training for practitioners there is a clear need for work that improves mental health services for TGD communities (Alessi & Martin, 2017; Brammer & Ginicola, 2017; DiFulvio, 2015; Ellis, 2020). However, even with ongoing calls for additional research (e.g., Ellis, 2020; Mizock & Lewis, 2008; Wirtz, et al., 2020), there remains a paucity of literature and research addressing these concerns and a clear gap in knowledge and research regarding trauma support for TGD communities. To address these gaps, this dissertation presents research that offers insight not only on the need for services and barriers faced by TGD people seeking trauma-related mental health care, but also on what feels helpful and supportive from mental health practitioners. Further, this work presents research priorities articulated by TGD participants to build on the recommendations and research gaps articulated in the literature to date and offer direction for future research in this area from a specifically community-based and intersectional perspective.

The Project: *Transforming Supports*

This project idea came out of my work as a clinical counsellor. After working in community organizations focused on anti-violence and gender-based violence for many years I moved into a private practice as a counsellor. As a queer and nonbinary practitioner working in community organizations and nonprofit settings in an urban context in Victoria, Canada, I had witnessed countless instances of typical practice that were not affirming to 2S/LGBTQ (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, and Queer) people and had several experiences of seeing other practitioners engage in hostile, discriminatory, and harmful discussion and direct practice with TGD young people. When I started working in my private counselling practice, these experiences were echoed by the clients I was seeing who shared many stories about their negative, harmful, and even traumatizing experiences with mental health care services and providers. Unfortunately, these stories were not surprising to me; however, it was discouraging to hear 1) how often TGD people were having negative and harmful experiences when seeking help for their mental health and 2) how hard it was to find useful and accurate information to direct other practitioners to that offer recommendations for improving services based on TGD people's perspectives.

I was also noticing a pattern of challenges shared by the TGD young people I worked with. The youth were encountering multiple barriers to the care they needed and were often left compromising their care needs to get any level of support, often at the expense of not feeling seen and understood in their gender and identity experiences. Much of my practice work is with young people, particularly individuals around ages 15-30. This age range is when young people are navigating many intersecting experiences in their lives and face unique barriers to care (MacLeod & Brownlie, 2014). Young people in this age range can consent to their own services without parental/caregiver involvement; however, they still are often much younger than the practitioners they encounter which creates unique power dynamics when seeking mental health care. They also may be seeking services on their own for the first time and may be new to knowing how and where to find services that can help them. These young people face age limitations on services with many youth-focused services having varying upper age cut-offs for services ranging from 18, 19, or 25. Many young people need to navigate transitioning between youth-focused and adult services during this time or locate services that can offer a continuity of care for their needs. These young people are also traversing major life milestones such as transitioning from high school to the workforce or postsecondary education and training programs, newly living independently, and for many TGD young people they may be seeking gender-affirming care and may be at the early stages of their gender-affirming medical care journeys (Arnett, 2000). This age demographic accessing mental health services faces unique barriers and have unique perspectives and experiences with gender that vary from adults over 30 and from children and younger teenagers (Arnett, 2000; MacLeod & Brownlie, 2014).

The young people I was working with also shared that many approaches to therapy that they had tried did not feel helpful, often sharing that therapeutic approaches that centred the idea of ‘safety’ felt hard to understand as they did not often feel safe in their bodies or in their current life contexts. In one particularly poignant conversation, a client was sharing the lengths they went to avoid perceiving their own body due to gender dysphoria, the client stated, “my body is not a safe place to be right now.” This statement sparked my reflection on the idea of safety in trauma work with TGD people, particularly given that many current approaches to working with trauma focus on the body as the site of healing. Within current approaches to trauma therapy, there are two central themes posited as necessary for supporting healing: bearing witness to a survivor's story (Briere & Scott, 2015; Herman, 1997) and re-establishing a sense of safety within the body for the individual who has experienced trauma (Herman, 1997; van der Kolk, 2014). Both of these central tenets to trauma practice require specific attention when considering the unique experiences of TGD populations. As Barr (2018) notes, determining what is defined as traumatic has been a contentious aspect of the field of trauma research and theory. This has often led to the invalidations of survivors and dismissal of experiences that are considered outside the bounds of what is defined as traumatic (Barr, 2018). Further, what safety is and how embodied safety is felt for TGD people who have experienced trauma is an important consideration when the current approaches to trauma support emphasize safety within one's body as a starting point for healing.

For my doctoral work, I decided to bring these questions and challenges I was hearing from my practice work into my research and develop a community-based project that could begin to address these questions and challenges. This dissertation presents some of the findings from this project, focused on three main topics: navigating barriers to care; experiencing safety with mental health practitioners; and community priorities for research on mental health.

This project started with four research questions:

1. How do TGD people describe their experience of safety when accessing trauma services and supports?
2. What does safety in trauma service provision mean for TGD people who have experienced trauma?
3. What hinders or prevents access to trauma-related support services for TGD people?

4. How can trauma services and supports be improved to better serve the needs of TGD communities?

Following the engagement with the community advisory and initial community consultations with participants, a fifth research question was identified:

5. What are TGD community members priorities for research related to improving mental health care?

The *Transforming Supports* project was started from this practice experience and from there I established and worked with a community advisory group of four trans and nonbinary individuals with different experiences of mental health services, some as service users and some as both service users and practitioners themselves. Community advisors were recruited through word-of-mouth through my professional connections and sharing digital posters through community organizations and practitioner and mental health services listservs. In a statement written for the project website (see: www.transformingsupports.com/team), the advisors share that their experiences and contributions represent perspectives of "trans, nonbinary, BIPOC, working-class, disabled, and neurodivergent" people as well as, "middle-class, white and settler" communities. The represented a range of ages including youth under 25 and adults over 25.

Advisors met together with me online for a total of six meetings (2 hours each) over the course of 1 year of the project from September 2022 – September 2023 and assisted with additional document review and written input in between meetings. Following the first year of their engagement, some of the advisors continued to be available for document review and input as I analyzed the data and prepared the research outputs. Each advisor was compensated at a rate of $50 an hour for their time during the online meetings. At the start of their work with the project, we created a shared group agreement for how to run meetings and how the advisors wanted to share their perspectives and input on the project. The advisors chose to remain anonymous throughout their engagement with the project and they developed a statement for the project website to share a bit about themselves and their role in the project (see: https://www.transformingsupports.com/team). As noted in their statement, through our work together we identified that some key perspectives were missing from the advisory committee, most notably, there were no members representing Indigenous and/or Two-Spirit perspectives. Despite targeted efforts in the recruitment process, we were unable to find someone who could represent these perspectives on the committee who was available to take this role on at the time the project started. Because of this, I made the decision, with the input of the advisory committee, to partner with an Indigenous community organization to ensure that the project could intentionally invite engagement and collaboration with TGD Indigenous young people so that their perspectives were included in this project.

The name of the project was created by the community advisors to emphasize the trans perspectives leading the project and the voices of the participants during this project. During meetings with the advisory committee, I brought my plans for participant engagement for input and direction from the committee. I planned to use two methods of data collection, one through in-person community consultation workshops, and one through semi-structured online qualitative interviews (further details about data collection methods are included in subsequent chapters). The advisors helped to shape the questions asked to participants in both data collection methods, including order of the questions, wording of the questions, and focus on specific topics. We also discussed planning to have mental health support available for all participants in the project if needed for debriefing following their engagement with the project. Centring the participant experience in the project, I recruited a network of trans and gender-diverse mental health professionals that we available to participants to have one individual debriefing session (paid for with project funding) with the practitioner of their choice if needed following their involvement in the project.

To make this project possible, I've worked with community partners at the Community-Based Research Centre (www.cbrc.net) and an Indigenous Youth organization in Vancouver, the 2Spirit Collective at the Urban Native Youth Association (https://unya.bc.ca) to develop community research events and connect with TGD young people to hear their perspectives and goals for research on mental health care for their communities. I aimed to understand how TGD people experience safety in mental health and trauma support contexts in order to improve services that provide trauma support to these communities. By engaging with TGD community members as community consultants as well as research participants, my project focuses on understanding the lived experiences of TGD young people who have accessed, or wanted to access, trauma-related mental health supports and other community resources. The project is a starting place for more work that can improve mental health care for TGD young people.

Situating Myself and the Project

I come to this research work as a queer and nonbinary person with lived experience of mental health services and systems and professional experience working in the anti-violence sector for over 15 years. I have worked in a variety of mental health and social services contexts, including sexual assault response; domestic violence; child and youth trauma counselling; child and youth advocacy and victim services; and private clinical counselling practice specializing in trauma. At the core of my research work is a commitment to understanding and listening to the lived experience of gender-diverse people regarding our needs and access for mental health support.

My counselling practice and my research work for this project is based in Victoria, British Columbia (BC), Canada, on the unceded territories of the lək̓ʷəŋən (Lekwungen)[3] and W̱SÁNEĆ peoples. I have spent the majority of my life here and continue to live and work on these territories. I am a non-Indigenous scholar of Irish and Scottish ancestry. The territories in which I live and work and where this research work was completed are intentionally named here to bring attention to the ways in which Indigenous knowledges, experience, and presence continue to be erased in much of the academic literature written by non-Indigenous scholars and to make present the tension of doing research work in colonial systems. I take this practice up as part of my relational responsibility as a non-Indigenous scholar working with Indigenous community partners and project participants. It is intentional that the nations and places which are named are the ones related to the lands around the cities of Victoria and Vancouver. This is where I was physically present during the research process and participant engagement. Throughout the project, I worked with community advisors, community partners and participants throughout southwestern part of the province of BC, throughout the unceded territories of Coast and Interior Salish First Nations. The project work was based in Victoria on the unceded territories of the lək̓ʷəŋən (Lekwungen) and W̱SÁNEĆ peoples and the in-person workshops were held in Vancouver on the unceded territories of the Sḵwx̱wú7mesh (Squamish), səl̓ilw̓ətaʔɬ (Tsleil Waututh) and xʷməθkʷəy̓əm (Musqueam) peoples.

---

[3] The Indigenous territories and nations are named here as part of the practice of land acknowledgement which acknowledges the Indigenous Peoples, the land, and place as a way of recognizing the intersections of both the historical and present-day Indigenous peoples' presence, land rights, ways of knowing, and the ongoing impacts of colonialism. Land acknowledgements are connected to Indigenous cultural practices and to calls for Truth and Reconciliation in Canada.

Method and Approach

The legacy of pathologizing and stigmatizing trans identities within the medical and mental health fields has led to a significant wariness among TGD people towards both researchers and mental health professionals (Gill-Peterson, 2018; Ross et al., 2021). Moreover, the continued presence of gatekeeping in mental health contexts, alongside instances of harm and negative experiences, underscores the need for ethical research practices that prioritize community engagement and participation (Acker, 2017; Blodgett et al., 2017; Brown et al., 2018; James et al., 2016; Navarro et al., 2022). Within contexts where systems of care have often failed to meet the needs of marginalized communities, such as TGD people, community-based research (CBR) can offer a pathway to understanding and addressing community priorities for change (Israel et al., 1998). Through active involvement in research processes, community-based research seeks to align research activities with the needs and goals of the community of focus (Katz-Wise, et al., 2019; Travers et al., 2013). By engaging directly with TGD people, CBR can not only align approaches to community goals and needs, rather than imposing externally determined goals that may not address community priorities but can also offer mental health practitioners and policy-makers actionable insights into systemic changes needed for equitable and appropriate mental health care for TGD communities. As Boilevin et al. (2019) offer, research can be oriented for the community through nuanced and reflective engagement in ethical practices with community members throughout the process. I have chosen this approach for several reasons. Grounded in community-based participatory research principles of reciprocity and collaboration (Boilevin, et al., 2019; Israel et al., 1998; Katz-Wise et al., 2019), this project was built to be in service to TGD communities, to generate knowledge that is useful for pushing for change in response to these concerns. Further, the work was designed to offer something back to each person involved and have their engagement in the project feel helpful and useful not only as part of the larger goals of the project, but on an individual level as well, such as having opportunities to share their stories and feel part of collective change efforts.

My approach to this work was informed by three theoretical perspectives: *Lived Experience as Knowledge; Intersectionality;* and *Trauma-Informed Research Principles*. For this project, I centred the lived and living experience of TGD people and consider lived experience as legitimate forms of knowing (Ahmed, 2006; Aultman, 2018; Million, 2008). This approach emphasizes that individual and community experience can provide real insight and elucidate understandings of complex topics from the perspective of the individuals effected by the topic of concern (Aultman, 2018; Million, 2008; Salamon, 2014). As Namaste (2000) and Thom (2024) remind researchers and practitioners, the theorizing about gendered experience must be grounded in the lives of actual TGD people in the world.

As Thom (2019) states, "safety is . . . an inherently classed, raced, and gendered experience" (p. 22). The context and diverse experiences and identities of TGD community needed to be centred as an essential perspective from which to think about safety and mental health care experiences. Building on lived experience as knowledge, intersectionality provides an analytical framework (Cho et al., 2013; Clark, 2016; Collins, 2015; Crenshaw, 1989; 1991) from which to pay specific attention to the multidimensionality of TGD communities and to specific ways in which systems of power operate to impact the experiences of the participants. Applying intersectionality as a framework brings attention to the structural and systemic barriers that TGD people experience and how this informs their experiences of mental health care. It was important to ensure that the participants engaging in the project could represent a diversity of experiences and identities reflective of the multi-faceted subjecthoods present in TGD communities.

Finally, this project was informed by *trauma-informed research principles.* Through several decades of research on trauma, researchers and service providers have raised their awareness about the needs of victimized individuals leading to the “trauma-informed practice movement” (Campbell, et al., 2019, p. 4767). This movement asks service providers supporting individuals impacted by trauma to *realize* the impact of trauma, *recognize* the signs and symptoms of trauma, *respond* by integrating an understanding of trauma into their approaches, and *resist* instances of possible re-traumatization for individuals (SAMSHA, 2014; Elliot et al., 2005). Informed by trauma research, the trauma-informed practice movement has been taken up in some mental health service, health care, criminal justice systems, and other social services. Within the field of sexual violence research, Campbell et al. (2019) present an application of trauma-informed principles in the research context. Adapting Elliot et al.’s (2005) article outlining trauma-informed practice principles, Campbell et al. (2019) provided recommendations to researchers for how to take-up the ideas of trauma-informed practice to foster a research approach with participants that takes the impacts of trauma into account. I utilized this framework for this research as the community members engaging in the project had experience with trauma-related mental health services and, of course, also experience with trauma. While participants were not asked to discuss their traumatic experiences that led them to seek trauma-related mental health care, each participant did have their own history of trauma. As Legerski et al. (2010) found, the evidence does not suggest that participating in trauma research itself can be retraumatizing; however, in order to support a safer and trauma-informed approach to research activities, I adapted recommendations from Campbell et al. (2019) to apply to the current project (see Appendix A).

Outline for the Dissertation

The primary aim of this project was to provide data and recommendations that can have practical applications to improve trauma-related mental health care for TGD people. With this aim in mind, this dissertation presents three articles written for publication in peer-reviewed journals for academic and practitioner audiences. These articles present findings related to three of the areas of focus of the project: navigating barriers to accessing trauma-related mental health care; experiences of safety with mental health care providers; and community goals and priorities for future research on improving trauma-related mental health care for TGD communities. The papers are presented in this order to reflect the experiences shared by the participants of the process of finding care, experiencing care, and hoping for change. Each paper is presented as a stand-alone piece that articulates the methods and participants associated with the findings shared within each piece. Each paper is situated within the larger body of the project work and this dissertation aiming to not only understand TGD young people's experience with trauma-related mental health care but to also identify recommendations and priorities for improving this care for these communities.

Article 1: "It's Not a Very Clear Path Forward": Responding to Barriers to Finding Trauma-Related Mental Health Support for Trans and Gender-Diverse Young People

This article will be submitted to the *Canadian Journal of Community Mental Health* and aimed for an audience of public health and mental health research and practitioners. This chapter presents findings from the qualitative interviews conducted with 19 TGD participants from March to August of 2023. Following previous research in Canada and internationally (Ellis, 2020; Ferlatte et al., 2019; James et al., 2016; Lange, 2020; Trans Pulse, 2020) the article examines the significant barriers that TGD young people encounter when trying to find and access trauma-related mental health services and the strategies participants engaged in to navigate these barriers. Barriers identified include availability of information; time; cost; anti-trans bias; and the prevalence of identity-focused services.

This article provides unique insight by focusing on TGD young people within Canada and articulating barriers specific to finding trauma-related mental health care. Further, it additionally offers insight into the ways in which TGD young people navigate the barriers they encounter which can in turn provide direction to addressing these barriers and improving access to needed mental health services. Drawing on the data collected through the semi-structured interviews with participants, this paper identifies the systemic issues faced by TGD people such as lack of information, high costs and lack of affordable options, long wait times, and encountering anti-trans bias in service provision. Participants navigate these barriers through building their own mental health literacy; drawing on community knowledge; and relying on individual and community persistence and self-advocacy.

Locating this article as the first piece in the dissertation offers insight into the challenges faced by TGD young people when they start their journey to locating mental health services. As with previous research identifying barriers to care (e.g., Anzani et al., 2019; Blodgett et al.; Ferlatte et al., 2019), in addition to common barriers such as high cost, long wait-times, lack of services, and restrictive eligibility requirements, a prevalent issue for TGD young people seeking trauma-related mental health services was experiencing anti-trans bias from the practitioners they encountered. By participants articulating how they manage these barriers while finding care, this paper offers insight into the strategies young TGD people adopt to navigate these obstacles and underscores the need for more inclusive and accessible mental health support.

Article 2: Trust, Recognition, and Safety in Trauma-Related Mental Health Services with Trans and Gender-Diverse Young People

This article will be submitted to *Psychotherapy Research.* This chapter presents an article aimed for an audience of practitioners, specifically psychologists, counsellors, and therapists, as well as practice-focused mental health researchers. Presenting findings from the qualitative interviews conducted with 19 TGD participants from March to August of 2023, this paper examines TGD young people's experiences of safety with practitioners in trauma-related mental health care settings. Demonstrating the importance of feeling seen, understood, and recognized, this piece offers insight into the ways in which practitioners can approach the therapeutic relationship with TGD clients that prioritize safety, recognition, and respect for TGD individuals and communities.

The therapeutic relationship between a counsellor/therapist and a client has been found to be one of the most important factors predicting positive outcomes in psychotherapy (Norcross & Lambert, 2019). However, for TGD people, interactions with mental health care providers are often sites of challenging experiences, and mental health care more broadly is a historically complex context (Blodgett et al., 2017; Brown, et al., 2018; Gill-Peterson, 2018; Navarro, et al., 2022). While there is growing awareness of the need for affirmative approaches to mental health care with TGD people (e.g., Ellis, et al., 2020; Mizock & Lundquist, 2016; Richmond et al., 2017; Singh & dickey, 2016; 2017), there is a lack of research that examines the specific experiences of TGD young people in psychotherapy (Hall & Delaney, 2021).

Participants were asked to describe their understanding of safety and definitions of what safety is meant to be both generally and specifically within the context of mental health care. Definitions of safety focused on the experience of *being able to be myself, being understood and* *seen, an absence of vigilance,* and *safety as an action.* The key themes emphasize the importance of TGD participants feeling able to express themselves and be seen and understood by practitioners. A common experience shared by participants was a sense of vigilance in their lives, so much so that when this vigilance was not needed, it was a noticeable and a key indicator of feeling safe. Further, safety was described as an active process and not a passive feeling by participants. Several participants emphasized the importance of practitioners demonstrating safety through repairing miscommunication and moments of disconnect.

Participants were also asked to describe their experiences with trauma-related mental health care focusing on what experiences felt helpful, what helped them feel safe, what experiences felt unhelpful and unsafe, and what impacted their feelings of safety and the helpfulness of the services. From this, key themes were *trust and risk* and *signals of safety*. Finding a practitioner that could demonstrate understanding and recognition for participants often felt like a risk and participants often took measures to mitigate this risk by engaging in what they described as looking for “signals of safety.” By reflecting on how TGD young people navigate risk and trust within the therapeutic relationship, practitioners can incorporate approaches to their practice that better signal safety to clients and foster understanding and recognition within the therapeutic work.

This second paper offers areas for reflection and consideration for practitioners as well as queries the utility of basic trans competency models for practitioners. While research has shown that training that focuses on TGD experiences and identities for practitioners is effective for shifting practitioner attitudes towards TGD clients (e.g., Boot-Haury, 2023), there continues to be gaps in a felt sense of safety with practitioners for TGD people. This paper provides insight into how TGD people are experiencing and navigating safety within these contexts and points to future areas of inquiry regarding enhancing available training and building towards TGD-competency or -literacy training that encourage self-reflexive practice.

Article 3: Mental Health Research Priorities for Trans and Gender-Diverse Young People: Findings from Community Consultations on Improving Mental Health Care for Trans and Gender-Diverse Communities

The third and final paper presented as part of this dissertation is an article intended for an audience of public health, health and mental health researchers, and health and mental health practitioners to be submitted to the *International Journal of Transgender Health*. This chapter presents findings from the community consultation portion of the *Transforming Supports* project which consisted of two in-person workshops held in March 2023 and consultation questions related to research priorities asked of interview participants during their qualitative interviews held March to August of 2023. Sharing findings from 34 participants, this paper focuses on the research priorities articulated by participants related to improving mental health care for their communities. Participants were asked: “What would you like to see researched in the future related to mental health care and trauma supports for trans and gender-diverse people?” and: “How do you think these topics should be researched? What types of research would you like to be involved in or could see as helpful for future research on this topic area for trans and gender-diverse people?” Research priorities were group into topic themes and included: *Practitioner Education and Training; Indigenous Perspectives on Anti-Racism, Cultural Safety, and Reconciliation; Addressing Racism and Cultural Differences; Impact of Geography; Co-occurring Needs; Understanding Trauma; Disability, Autism, and Neurodivergence; Pathways to Care;* and *Approaches to Therapy.* Participants also emphasized the importance of research being led by TGD community members and conducting research that shifted the focus from research on TGD people to research led by TGD people on services and service providers. The findings from this paper parallel previous community recommendations (LeBlanc et al., 2022; Veale et al., 2022) that have urged researchers to move away from research that replicates harmful narratives. There was a strong call for research to move away from deficit and harm foci for TGD people and instead focus on mental health care workers and medical professionals, such as doctors, nurses, counsellors, and psychologists to understand their knowledge about TGD people, where their knowledge gaps were, what biases they have, and what they need to know to be able to provide more helpful and accessible care. These findings can provide direction for future research on mental health care for TGD people and offers insight into the specific priorities of young TGD people. Building on these recommendations, future research can continue to centre community voices and aim in new directions for addressing the gaps needed in mental health care for TGD communities that moves away from a focus on TGD people themselves and shifts the attention to the systems and services TGD people are navigating care.

Significance and Contribution

There is a distinct need for changes to trauma-related mental health care for TGD populations (Lange, 2020; Shipherd et al., 2019; Wirtz et al., 2020). Research that can provide specific suggestions for practice improvements will help support training and education for future practitioners. Without reliable, culturally competent care, mental health and health care settings can become sites for traumatization for transgender individuals (Mizock & Lewis, 2008). There is a crucial and well-documented need for better education and training for mental health practitioners working with TGD people. dickey et al. (2020) call practitioners to move from an affirming to a liberating approach to mental health. A key place to start is research that can address the glaring gaps in the literature in order to offer direction for appropriate, respectful, and supportive trauma care for TGD young people and communities. This is of particular importance when addressing the intersection of TGD experience and age. Research that acknowledges and upholds TGD young people's agency in response to systems of care that often deny youth their agency and autonomy over their own care is vitally needed.

This project started from my work with TGD young people and the challenges I was hearing from my clients regarding finding helpful and safe trauma care. While the initial question was sparked from a client's comment about safety and the body, as the project developed and grew over the course of the community participation and engagement, what became clear is that the site of change for improving mental health care is not within the individual but within the larger the social structures that continue to place TGD people at intersections of systems that do not see and serve them. The findings of this project demonstrate the ongoing challenges with feeling safe in a society that seeks to vilify and erase trans experiences. This project seeks to address a well-identified gap in service provision and make needed changes to a mental health system that is not serving the needs of TGD people. By understanding what safety is and how it is experienced in mental health care settings for TGD young people, it may be possible to begin to make change within the mental health care systems so that care can be helpful, safe, and useful for TGD young people.

Chapter 2: "It's Not a Very Clear Path Forward": Responding to Barriers to Finding Trauma-Related Mental Health Support for Trans and Gender-Diverse Young People

Authors: Mattie Walker, Aaron Devor, and Nathan Lachowsky

Formatted for submission to the *Canadian Journal of Community Mental Health*

Abstract

Previous research in Canada and internationally has consistently found that trans and gender-diverse people face barriers to accessing the mental health care that they need. This paper presents findings from qualitative interviews conducted with TGD young people from March 2023 - August 2023 as part of a community-based research project. Participants shared their experiences with seeking and accessing trauma-related mental health supports and spoke to the barriers they experienced in their navigation of mental health care services in their communities. The strategies utilized by TGD young people to navigate these barriers can inform recommendations for improving access to trauma-related mental health care for these communities.

Keywords: Trans; transgender; gender-diverse; young people; trauma; mental health care; access to care; barriers to care; intersectionality

Introduction

Previous research in Canada and internationally has consistently found that trans and gender-diverse people face barriers to accessing the mental health care that they need (Ellis 2020; Ferlatte et al., 2019; James et al., 2016; Lange 2020; Trans Pulse, 2020). Utilizing an intersectional lens (Clark, 2016; Crenshaw, 1989; 1991), this article provides novel insight into the specific, structural barriers faced by young trans and gender-diverse (TGD) people when starting the process of finding mental health care in British Columbia, Canada. This paper presents findings from qualitative individual interviews conducted with TGD participants aged 19-33 between March to August 2023 as part of a community-based research project. Participants shared their experiences with seeking and accessing trauma-related mental health supports and spoke to the barriers they experienced in their navigation of mental health care services in their communities. The strategies utilized by TGD young people to navigate these barriers can inform recommendations for improving access to trauma-related mental health care for these communities.

Background

Minority stress theory has been used to understand how stressors resulting from experiences related to membership in a minority group, such as overarching societal attitudes, prejudice, and discrimination, can negatively impact mental health (Meyer, 1995; Hendricks & Testa, 2012). Applying this theory with TGD communities (Hendricks & Testa, 2012; Shipherd et al., 2019) demonstrates how, within systems and societies that are heteronormative and cis-normative, TGD individuals can experience conditions that are chronically stressful and even traumatizing (Ellis, 2020; Shipherd et al., 2011; 2019; Tishelman & Neumann-Mascis, 2018). These experiences are associated with a higher need for mental health support related to trauma and violence recovery (Veale, et al., 2017). However, there continue to be problems with general and reliable access to healthcare for TGD people (Mizock & Lewis, 2008; Ellis, 2020; Lange, 2020).

With disparities in mental health experiences between gender minority youth and their heterosexual and cisgender counterparts (Navarro et al., 2021; Scheim et al., 2021; Trans PULSE Canada Team, 2020; Veale et al., 2015; 2017), TGD young people may be more likely to access mental health services than their cisgender peers (Simeonov et al., 2015; Wells et al., 2024). This paper identifies specific barriers faced by participants when seeking trauma-related mental health care and highlights some of the ways in which current systems of care result in gaps in access to needed mental health care. This builds on previous research related to mental health care access in Canada (e.g., Ferlatte et al., 2019; Moroz et al., 2020) to offer recommendations for how trauma-related mental health services can improve access to needed supports for TGD communities.

Methodology and Methods

Community-Based Research

Following community-based research principles, this project was led with TGD community members and structured to be in service to the communities impacted by the research topic and outcomes (Bauer et al., 2013; Boilevin, et al., 2019; Israel, et al., 1998; 2005; Katz-Wise et al., 2019). The project activities were informed by a community advisory committee and community consultations with trans, Two-Spirit[4], and gender-diverse young people. The advisory committee was comprised of four trans and nonbinary individuals who represented a range of experiences including: youth <25 and adults >25, white, BIPOC, working-class, disabled, and neurodivergent. The advisors had experience being clients in mental health care services and three of the members were also a service provider themselves. The community consultations were held with the support of an Indigenous youth Two-Spirit collective where TGD young people shared their perspectives and questions for research on this topic area, which informed the focus of the qualitative interviews, priorities for sharing project findings, and directions for future work. All community advisors, community consultation participants, and interview participants were compensated for their time and work with the project. All the

---

[4] For definitions and discussion of 2Spirit or Two-Spirit see: Lezard et al (2021)

community advisors and participants were given the option to receive updates about research project and be invited to knowledge sharing events and have access to publications and knowledge sharing resources resulting from the project. The project work was based in Victoria on the unceded territories of the lək̓ʷəŋən (Lekwungen) and W̱SÁNEĆ peoples and the community consultations were held in Vancouver on the unceded territories of the Sḵwx̱wú7mesh (Squamish), səl̓ilw̓ətaʔɬ (Tsleil Waututh) and xʷməθkʷəy̓əm (Musqueam) peoples.

Intersectionality

TGD communities are not homogenous; diverse aspects of identity can and will impact experiences of mental health care. Intersectionality as an analytical framework (Cho et al., 2013; Clark, 2016; Collins, 2015; Crenshaw, 1989; 1991) was employed throughout the project design as well as in analysis of the data in order to pay specific attention to the multidimensionality of TGD communities and to specific ways in which systems of power operate to impact the experiences of the participants. Using intersectionality as a framework elucidates some of the structural barriers that TGD people experience. It does this by facilitating an examination of the ways in which systems of care present intersecting experiences of power and privilege, which limit choice, control, and autonomy in seeking care.

Interview Participant Recruitment

Participants were invited to participate in the project through digital and physical posters shared with the support of community partners: Community-Based Research Centre (https://www.cbrc.net) and an Indigenous youth organization, Urban Native Youth Association (https://unya.bc.ca). Recruitment materials were shared on social media and listservs through various community organizations, mutual aid groups, and university 2S/LGBTQ+ Pride organizations throughout southwestern British Columbia. Physical posters were shared in community locations in Victoria and Vancouver at local coffee shops, queer/2S/LGBTQ+ open stage events, community centres, and on university campuses. Eligibility criteria included: being aged 19-30 and having experience accessing, attending, or wanting to access or attend, trauma-related mental health supports in British Columbia. Participants had to identify as trans or gender-diverse. To sign-up for the project, participants completed a brief online survey asking them to describe demographic information and their experiences with trauma-related mental health care. The first author contacted all participants who signed up for the project to inform them if they fit the eligibility criteria and confirm consent to participate. Thirty-two surveys were completed, and a total of 19 participants were eligible and consented to participate. If participants were eligible and consented to participation, the information from the eligibility screening was used as their demographic information. All study protocols were approved by the Human Research Ethics Board at the University of Victoria (22-0210) and all participants provided verbal informed consent prior to participating.

Data Collection and Analysis

Data were collected through semi-structured individual interviews. Interviews occurred between March to August 2023. Based on participant preference, interviews were conducted online by the first author over Zoom video or phone and ranged from 1 hour to 2 hours. Interviews were recorded using Zoom and transcribed verbatim professionally. Interview participants were given the option to review their transcript and had the option of adding additional clarity or changing or correcting any information that they shared. Two participants chose the option to review their transcripts and provided additional details in their answers and edited some of their previously given answers. The first author coded the final transcriptions using *NVivo* software (Lumivero, 2024) and conducted reflexive thematic analysis (Braun & Clarke, 2006; 2014). The first author analyzed the data using an inductive approach to generate initial codes. Following this, the first author identified patterns in the initial codes and identified key themes, paying specific attention to the systemic and structural context overlaying the participants' experiences, utilizing intersectionality as an analytical framework (Cho et al., 2013; Clark, 2016; Collins, 2015; Crenshaw, 1989; 1991). After reviewing the themes, the first author named and defined the themes to present the findings, identifying exemplar participant quotes and key words to be quoted in the presentation of the findings. Participants were given the choice of using a pseudonym, their own name, or an anonymized participant number; they also chose which identifying information they wanted to connect with any direct quotations used throughout this article. All identity information connected to a participant's direct quote uses their own wording.

Trauma-Informed Approach

Recruitment and data collection methods incorporated a trauma-informed approach, adapted from Campbell et al. (2019) and Elliot et al. (2005) to allow participants to have more choice and control in their engagement. Participants were not asked directly about their traumatic experiences that led them to seek trauma-related mental health support, nor were they required to disclose details about their symptoms and trauma-related mental health needs. Interview questions focused on processes and experiences accessing services, types of services, and experience with seeking services. Participants were also given the option to attend a single debriefing session for support, if needed, with their choice of a trans or gender-diverse mental health worker from a list of professionals hired with the project.

Findings

Participants

Most participants (n=11/19) were aged 19-25 and 8 participants were over 25 at the time of the interviews. Participants used a variety of terminology to describe their genders: trans (n=6), trans woman (n=1), trans man/guy (n=2), trans masculine (n=1), Two-Spirit (n=1), transsexual (n=1), nonbinary (n=12), agender (n=1), gender fluid (n=2), and androgyne (n=1). Participants represented a range of cultural, racial, and ethnic identities and heritages, that they described using the terms (presented in alphabetical order): Indigenous (n=3), Jewish (n=2), Métis (n=1), mixed race (n=3), person of colour (n=2), Peruvian (n=1), settler (n=1), Sudanese (n=1), Taiwanese (n=1), Vietnamese (n=1), and white (n=1), 3 participants did not share any information about their cultural, racial, or ethnic identity. Participants shared a range of lived experiences that they indicated shaped their perspectives on mental health care and their experiences with mental health providers and services, including experiences related to ability/disability; neurodivergence; immigration; income and socioeconomic status; education level; transition experience; physical health; and body size.

Participants were from a range of locations throughout southwestern British Columbia, residing in locations on Vancouver Island, the lower mainland, and the southern gulf islands, within the traditional unceded territories of Coast and Interior Salish First Nations. Participants lived in large urban centres (n=11), smaller cities (n=3) and small towns (n=5). Participants noted how their location impacted their ability to access resources, what resources were available, and the presence and connection to 2S/LGBTQ+ community within their area. Almost all participants noted a lack of options and diversity of services and practitioners from which to choose when they were seeking services; however, the participants living in places outside of

Victoria and Vancouver, especially emphasized how limited resources impacted their access to help when they needed it, and several participants noted plans to move to larger urban centres to be able to connect with 2S/LGBTQ+ communities.

Types of Services Sought

Participants spoke to a range of experiences with mental health services and noted that while some were trauma-specific many that were not specifically trauma-focused were chosen or needed due to trauma-related mental health needs. Services accessed were grouped into five categories: *health authority programs and services*; *school-based supports*; *community organizations or services*; *private paid services*; and *peer support*. *Health Authority programs and services* included hospitals or community programming. These programs were free to access; however, many participants noted long wait-times to access services outside of emergency care and the need for a referral from a physician to access many needed services. *School-based supports* included counsellors participants accessed through their secondary or postsecondary school; typically, these services did not require that participants pay for services or were low-cost. *Community organizations and services* included mental health support related to specific concerns such as sexual assault or violence or suicide. Services in this category varied in terms of cost to access from no to low-cost, sliding scale or paid services and were not associated with a health authority. *Private paid services* included individual and group support through counsellors, registered social workers, psychiatrists, and psychologists as well as online programs and mental health apps. *Peer supports* included community organized support groups that were not connected to a specific organization or program. All participants spoke to experiences with formal or professional services. While participants did share experiences related to peer supports, these experiences were in addition to experiences with professional or formal services. Barriers included in the following section relate to participant experiences with services provided by professionals and/or organizations.

Barriers To Finding Mental Health Support

Not a Clear Path Forward

For many participants, the limited availability of information about services and how to connect to services posed a major barrier to finding mental health care that they needed. One participant articulated this as "not a very clear path forward when you have a mental health problem" (Participant 4, transgender male, age < 25). Many participants shared that they struggled to know where to find information about available services, how to know how services were delivered or where they were provided, and often struggled to understand what specific services would meet their needs. They were often unsure where to start and many participants would start their pathway to care at the hospital emergency services as a means to connecting to a professional who may be able to assess and direct them where to go.

Participants shared that a challenge with starting with hospital emergency services was that they felt they needed to be in a crisis to be allowed to connect with this service. This often meant that they would wait until they felt their mental health symptoms were severe enough to attend emergency services, meaning that their first contact with mental health care providers was often during a mental health crisis or related to suicidality. A common sentiment throughout all the participants' stories was a desire to be able to find services that were available before a crisis happened, but being unsure how to find services that would take their needs seriously if they were not in crisis. Many participants shared that even after connecting with emergency services there was no clear pathway forward for support, often leaving participants continually searching for support without an understanding of how to find what they needed.

Many participants shared that it was difficult to know where to start when searching for community organizations that offered low-cost or funded services, or even for private practitioners. This was further complicated for participants when they were seeking practitioners or services that were trans-friendly or 2S/LGBTQ-knowledgeable. For example, one participant (Two-Spirit, nonbinary, age < 25) noted, "the information isn't there… even if you Google trans-friendly counsellor and stuff, LGBT friendly counselors, it just doesn't show up . . . it's hard to find that information when you're someone seeking resources and don't know where to start."

Participants also identified how medical systems did not overlap with community-based services. First contact with emergency mental health care often directed participants to services within the medical system or within health authorities. This was often without recommendation to connect with private or community-based services while waiting for funded services. With long waitlists and limited availability of practitioners within the medical system and an uncertainty how to connect to community services, participants often were left unsure of how to find the support they needed, and where to find the correct information to help them locate services.

The Burden of Time

Due to the lack of available information, participants shared that they had to spend a lot of time researching what services do/offer, what could be helpful for their needs, and what services may be trans-friendly and/or suitable for working with trauma. Time spent seeking services also included attending trial appointments to try out services as well as waiting on waitlists for months before being able to see a practitioner. As one participant shared (Participant 6, anonymous), "it's just kind of discouraging . . . I don't want to keep going, and to make the time for it as well, it’s like I need to work, I need to do all these other things, I don’t want to just make myself a full-time job off of just looking for services.”

An additional barrier was failed referrals that added to the frustration of the time it takes to find appropriate services. Participants shared experiences of waiting months for a referral only to find out that their previous practitioner had not completed the referral process, and they would have to continue to wait, or wait for a new appointment to initiate the referral again. One participant even shared that a medical practitioner chose not to even make a referral for a mental health care program because the waitlist was too long to be helpful for the individual; however, there was no alternative offered. Participants noted that this was further complicated by trying to locate practitioners who were both knowledgeable regarding their trauma needs and their gender identity and expression, or other lived experiences and identities (such as: cultural and racial identities; Indigenous-specific experiences of trauma; or their socio-economic class), rarely finding services or practitioners that felt competent supporting them in their full experience.

Cost and Choice

Cost was the most frequently mentioned barrier by all participants. Participant 13 (transmasculine, age > 25) shared, “I’m gonna say it repeatedly, but poverty, you can't access much help if you don’t have the funds to do it.” When looking for no-cost or low-cost options choices were limited to services that had long-waitlists where there was no choice of practitioner. Waitlist time experiences varied for participants, ranging from several months to more than a year, which inhibited participants from being able to get the care they needed when they needed it. Many participants shared that in order to access low-cost services sooner or to have their symptoms seen as serious enough to be prioritized, it seemed like they were required to be in crisis or amplify their symptoms to appear more severe. For example, Participant 4 (transgender man, age < 25) shared “the only time I really got services was when I was in crisis and after I had made an attempt, and so I really don’t want people to have to be in crisis and have a severe mental health problem before they’re able to access services.”

Cost was also a major factor in participants’ ability to choose a service provider who felt like a good fit for them. In order to have a choice in practitioners or to find a practitioner who could meet all their needs, participants were often required to seek support through private paid services. Speaking to their experience trying to find a counsellor with shared racial and cultural experiences, Participant 9 (Taiwanese, nonbinary, age >25) shared,

> I couldn’t afford to go to practitioners that looked like me. They were generally private practices or paid and I couldn’t afford it, so I had to go the public route which was, I can't choose my practitioners, I can't be picky about my practitioners. I just have to see whoever I get, and there wasn’t a fit, so I always ended up leaving.

This lack of choice often left participants feeling like the services they could afford were not helpful or not what they needed, particularly in order to reflect their intersecting identities.

The cost of services also exacerbated other barriers mentioned by participants including availability of information, referral processes, and the time participants spent searching for services. Information and pathways to getting care vary considerably between no-cost services provided through Health Authority programs and community nonprofit organizations. For example, most Health Authority programs require a referral from a medical doctor or nurse practitioner to access services, while community organizations can vary from self-referral or professional referral required. When seeking mental health support through private practitioners or paid services through organizations, most services are self-referral but are dependent on the practitioners’ own policies. There are also a variety of search tools and platforms for finding information about available services that do not always provide consistent information about referral processes, intake requirements, and service expectation or the expertise of the service providers.

Fear, Risk Assessment, and Anti-Trans Bias

The fear of, and the actual experience of, anti-trans bias was a major barrier to finding and receiving appropriate care for participants. Participants balanced the need to be seen in their gender experience with trying to find practitioners who would help them with their mental health needs, often finding that services understand these two needs as mutually exclusive. Participants would then try to find services while testing out the safety of presenting their gender experience and negotiate how much information about their gender they would share with practitioners during their first contact. This required complex decision-making and risk assessment for participants as they navigated different mental health supports and systems. The first contact with a service or care provider was often described as the “scariest” or hardest part for participants as they weighed the risk of sharing their gender with the impact of not being served or seen in the service. One participant emphasized this point by sharing, “the potential for experiencing homophobia or transphobia while trying to ask for help is one of the scariest things for me” (Participant 15, Two-Spirit, nonbinary, age < 25). The more practitioners and services individuals contacted, the more experiences they reported with disrespectful or harmful behaviour from practitioners, further exacerbating the stress of finding appropriate mental health care. A frequent experience was opting to not mention their gender identity or gender experience in order to find services that either could work with trauma or could be culturally relevant (see next theme for more detail). However, this left participants feeling unseen by the practitioners and services they accessed and often would lead participants to discontinue support.

Further, participants shared how experiences of anti-trans bias often compounded the mental health symptoms they were seeking support for in the first place. Participants shared stories where they felt traumatized or harmed from anti-trans bias during their contact with emergency mental health care, sharing that these felt like scary and difficult experiences compounding the mental health crisis they were experiencing. For example, one participant spoke about being involuntarily held in youth psychiatric care after a mental health crisis and not being allowed to wear their binder while in the hospital. The distress from this felt overwhelming and impacted the participant's further contact with mental health care following this event. Not only was the service not helpful, it exposed the participant to systemic anti-trans discrimination which was itself a source of harm and caused them to not seek future services.

Fragmented Services

Participants found it difficult to know which services might fit best with their needs as well as for which services they would be eligible when services or programs were designed or targeted based on a single identity, their age, or particular experience. Many felt that they were only able to find either trans and queer focused services or race, ethnicity, or cultural focused services, but rarely did participants have experiences where programs were designed to offer support or programming that acknowledged their multidimensional identities. Participants often had to make decisions about what part of their identities felt most connected to the issue for which they were seeking support and which parts of their experience they wanted to leave out in order to be able to find something that had the potential to be helpful, even if this meant leaving out important parts of their identities. Participants shared that they felt they had to do this because they perceived that their service providers were not knowledgeable in certain parts of their identities/experiences or that the services defaulted to centre a particular experience. As Participant 1 (trans, age < 25) shared, “a lot of the supports are aimed for white, cis women, and that doesn’t fit with your experience.” So, while the service may focus on the issue or type of support they need, the service often did not recognize experiences or identities outside of their perceived norms for their client-base. Participants expressed wanting services that were designed to see them in their full identity and support them with the needs they had.

Age eligibility for programming was also a barrier for participants. Many participants had experiences accessing both youth and adult services. The age cut-off for services varied across different programs, with different services having an upper age limit for youth services ranging from 18, 19, 24, and even 30. Many participants were often unclear for which services they were eligible as young adults and noted discouraging experiences with having to wait for a service or particular practitioner for several years due to long waitlists, but then being required to transition into new adult services once they aged out of the program.

Participants encountered ageist policies and attitudes both towards gender and regarding participants’ choices over their own care needs. Participant 14 (nonbinary, age < 25) shared,

> I think I was looked down upon a lot, just like very ageist policies, and I think that that tied into being misgendered because if these organizations are not respecting me as a youth, as a person, are they really gonna … I could feel it in my eyes, the way they looked at me they were like oh this person is just a mentally ill, oh this person is just a phase.

While at times, youth-focused services could be more aware of TGD identities, practitioners could also be very dismissive of youths’ identities by using age as a way to dismiss or discount their experiences. These examples highlight how the intersection of age and gender places participants in a gap of available, competent care. Services based solely on age without an appropriate understanding of gender create structural barriers to care for young TGD people.

Responding to Barriers

While participants identified many barriers to accessing support, they also shared their skills and strategies they had developed to respond to these barriers outlined through the themes: *Mental health literacy*; *community knowledge and support*; and *persistence and self-advocacy.*

Mental Health Literacy

In order to deal with the lack of information about how to find services and what services would fit their needs, participants became experts in mental health care provision, researching what services might be helpful, where to find them, and what to say to get the services that they needed. They also spent hours of their time researching mental health concerns and strategies they could implement on their own without the help of a practitioner. While this was helpful for many, it also was very labour-intensive and time-consuming. Participants shared that they wished that they did not have to do this, but also acknowledged that they had built skills and knowledge for themselves by having to take on these tasks. Participant 19 (disabled, trans-fem nonbinary queer, age < 25) shared: “I think part of being a trans person, for me at least, has been seeking out my own care a lot, and seeking out other people who can help me understand.”

Community Knowledge and Support

Connecting with community knowledge and support was a strategy employed by participants in order to find information about practitioners and services that might not otherwise be available. This was particularly relevant regarding locating services that would be welcoming of TGD people as well as services that other community members had found to have less bias, discrimination, racism, or ableism. This strategy helped participants save time and potentially reduce negative or harmful experiences with services. However, this could, at times, lead participants to not seek professional support at all.

Participants also connected with other TGD people citing that this felt more supportive and helpful than any professional services. Participant 19 (disabled, trans-fem nonbinary queer, age < 25) said, “a lot of my most positives when it comes to support in my transness, and my queerness, actually comes from members of my community and the people I met.” This connection and sense of belonging and support, helped participants feel seen and understood.

Persistence and Self-Advocacy

Many participants would try services repeatedly, determined to find one that felt helpful. This persistence took time and energy and often meant multiple experiences that felt harmful or dismissive. Participants would often first attend services with a clear goal in mind, questions for practitioners, and advocate for their needs. While this could lead to finding the services or practitioners they needed, it did not erase or reduce barriers related to cost of services, the time it takes to employ this strategy, or the potentially harmful situations participants would experience from practitioners. Further, this was not a strategy that felt available to all participants, leaving them with the difficult choice of having to tolerate bias and discrimination from practitioners or no longer attending a service that they required.

Discussion and Recommendations

All young TGD interview participants shared that their identities and lived experiences were complex and multifaceted. When trying to find trauma-related mental health supports, they brought the intersecting experiences in their lives with them to services and were often met with services and practitioners who could not recognize or work with these intersections of identity, experiences, and needs. When the systems of care do not recognize people in their complexity, services are experienced as, at best, unhelpful and, at worst, unsafe.

The intersections of age, gender, race, culture, ability/disability and poverty/class constituted the primary structural elements of the experiences shared by young TGD participants in their search for trauma-related mental health support. These converging intersections require intervention strategies that are responsive to these intersections (Crenshaw, 1991). However, what participants described were experiences with services that often left them in a gap of available, competent care for their needs. Participants found that when their experience did not neatly fit into the categories required by services or funding programs (e.g. age, sexual orientation, being racialized as non-white) they were left to compromise their needs or were left waiting for services that do not exist. The onus was then placed on the individual to navigate a system that was not built for them and does not see them or serve them. This takes enormous grit, resilience, and self-advocacy on the part of individuals seeking care.

When considering that these individuals were navigating the search for trauma-related mental health care, these barriers are further amplified when comparing the identified barriers with recommendations for trauma-informed care (e.g. SAMHSA, 2014; Sweeney et al., 2018). Trauma-informed principles (e.g. SAMHSA, 2014) emphasize the need for services to consider the impacts of trauma, facilitate collaboration with service users, focus on individual empowerment, choice, and control, and centre safety and trustworthiness with service providers. Each of the barriers identified by the participants in this study highlight the ways in which the current mental health care systems are not centring empowerment, choice, or control and are actively limiting the choice and control individuals have in their care. While these are barriers that have been identified in previous studies related to barriers to mental health care more broadly (e.g. Ferlatte et al., 2019), individuals managing the impacts of trauma are more likely to be acutely impacted by these barriers. This is further amplified when we consider the age of the TGD people sharing their stories in these interviews. When a young person is already dealing with the impacts of trauma that is leading them to seek mental health support in the first place, looking for new services that present multiple barriers can be overwhelming and daunting and on top of that having to vet practitioners for transphobia, racism, ableism, ageism, or other forms of bias and discrimination.

The stress of navigating these systems can be seen as an expected reaction to a system that does not see or acknowledge the needs with which the system purportedly is designed to assist (Hendricks & Testa, 2012; Meyer, 1995). Currently, individuals are relying on strategies that require time, energy, and resources that are demanding for those already living with mental health needs requiring care and support. The barriers participants identified and the strategies they employed to respond to these barriers can direct future research and improvements for mental health care provision. Future research can work with TGD young people to develop strategies for mental health care access that better recognize diverse experiences as well as addresses structural gaps in service provision. Recommendations can focus on solutions that seek to make systems of care more accessible for all potential care seekers by providing clearer pathways to accessing care.

With affordability being one of the most frequently mentioned barriers articulated by participants, a clear recommendation continues to be called for across the literature to address financial barriers (e.g., Ferlatte et al., 2019; Moroz et al., 2020). Cost is not a barrier that is unique to TGD communities. There is a well-documented need for mental health care services within Canada (Mental Health Commission of Canada, 2017; Moroz et al., 2020). In order to address barriers to mental health care, the cost for services and the wait times for no-cost services must be addressed. Increasing the availability of no-cost services and reducing the eligibility requirements of funded programs would support individuals to get the care they need at no-cost. Strategies to address affordability must take into consideration the experiences of communities who are particularly impacted by poverty.

Similar to calls to action in recent research (e.g. Canadian Mental Health Association, 2025), findings from this work suggest that current services must increase the availability, accessibility, and clarity of information about what they offer, who the practitioners are, and how individuals can connect to their services. Providing information on websites in clear, lay-language was named by participants as a way to reduce the amount of labour required by care seekers. Information and signage that can signal to individuals seeking care that services may be understanding of diverse experiences was seen as an important signal of safety for participants. In addition, practitioners sharing information about who they are, how they work, and relevant identity information such as race, culture, gender, sexuality, disability was felt as an important way that individuals could know more about their potential practitioners before attending services.

The findings from this project highlight the ways that TGD young people continue to build strategies to find the supports they need. The young people who participated in this project have built extensive knowledge about accessing mental health support in their communities. Building community roles that took on this mental health literacy work would honor the current community-driven strategies of knowledge sharing being utilized while reducing the labour required of individual care seekers. Many approaches to 2S/LGBTQ health-focused community work honour community knowledge by building health care interventions that utilize models for peer support, peer advocacy, and community knowledge sharing. Applying these models to mental health care access, such as through navigator roles (e.g. Canadian Mental Health Association, 2025), could offer strategies for responding to current barriers to care access. Building on community knowledge can support the development of strategies that take into consideration the current systemic gaps and the unique intersections of identity and experience that require responsive and diverse approaches to support.

Limitations and Future Research

As a qualitative project, the findings provide a snapshot into experiences shared amongst TGD young people within the context of southwestern BC, Canada. While these experiences may not be universal, findings align with other current research both in Canada and internationally regarding inequities in access to care and disparities in mental health for TGD populations (e.g. Canadian Mental Health Association, 2025; Ferlatte et al., 2019; Moroz et al., 2020; Trans Pulse, 2020).

The project sought to engage with a diversity of participants. Recruitment and data collection methods, including length of recruitment, locations where information was shared, time required for the project, and data collection through interviews, may have limited the participant pool. Recruitment and eligibility strategies also did not include engagement with incarcerated individuals or individuals located in rural and remote areas. Future research may consider specific engagement with these populations to understand better other context-specific barriers experienced and strategies used by TGD young people when accessing trauma-related mental health care. Further, future research can work with both practitioners and TGD young people to envision ways to increase clarity of information and develop new strategies to support pathways to care for TGD young people, such as piloting navigator roles.

Conclusion

Building on previous Canadian research regarding barriers to mental health supports (Ferlatte, et al., 2019; Trans Pulse, 2020), this project provides novel insight into some of the specific barriers faced by TGD young people and the strategies they utilized to navigate these barriers. Research continues to show the need for appropriate and accessible trauma-related mental health support for TGD communities. The findings from this study suggest that improvements to systems of care can build on the strategies TGD people are already relying on to find access to the care that they need. Future research can continue to explore ways that these gaps in access to care can be addressed through building on community knowledge and working with TGD communities and service providers to determine if these recommendations are effective in addressing the barriers to seeking care experienced by TGD young people.

Chapter 3: Trust, Recognition, and Safety in Mental Health Service Provision with Trans and Gender-Diverse Young People

Authors: Mattie Walker, Aaron Devor, and Nathan Lachowksy

Formatted for submission to *Psychotherapy Research*

Abstract

The therapeutic relationship between a counsellor/therapist and a client has been found to be one of the most important factors predicting positive outcomes in psychotherapy. However, for TGD people, interactions with mental health care providers are often sites of challenging and even harmful experiences. While there is growing awareness of the need for affirmative approaches to mental health care with TGD people, there is lack of research that examines the specific experiences of TGD young people in psychotherapy. This paper provides insight into how TGD young people are experiencing and navigating safety within these contexts and points to future areas of inquiry regarding enhancing available training and building towards TGD-competency or -literacy training that encourage self-reflexive practice. Presenting findings from 19 qualitative interviews conducted with TGD participants from March to August of 2023, this paper offers insight into the ways in which practitioners can approach the therapeutic relationship with TGD clients that prioritize safety, recognition, and respect for TGD individuals and communities. By reflecting on how TGD young people navigate risk and trust within the therapeutic relationship, practitioners can incorporate approaches to their practice that better signal safety to clients and foster understanding and recognition within the therapeutic work.

Introduction

The therapeutic relationship between a mental health practitioner and a client is the most consistent factor in predicting positive outcomes for clients (Norcross & Lambert, 2019). The safety, trust, and authenticity experienced in a counselling relationship can feel enormously helpful to individuals struggling with a range of challenges in their lives. While many authors have a range of perspectives on how the relationship can be important to the therapeutic work (e.g., Ellis et al., 2020; dickey & Singh, 2020; Norcross & Lambert, 2018; Norcross & Wampold, 2019), what remains consistent is an agreement is that the therapeutic relationship is a central part of supportive mental health practices. Counselling is grounded in the idea that the relationship or alliance between a client and their practitioner in and of itself can be healing. Especially in trauma-related counselling work, the idea of establishing safety is at the centre of trauma-informed approaches (e.g., Campbell et al., 2019; SAHMSA, 2014) and forms the foundation of processing traumatic experiences in a therapy setting (e.g., Brown, 1991; Herman, 1997; van der Kolk, 2014). But what happens when the therapeutic relationship does not feel safe? How is the therapy impacted when a practitioner does not recognize or respond appropriately to a client's identity and lived experience?

For trans and gender-diverse (TGD) people, interactions with mental health care providers have historically been complex with mental health settings often experienced as sites of negative experiences (Blodgett et al., 2017; Brown, et al., 2018; Gill-Peterson, 2018; Navarro, et al., 2022). TGD people continue to report experiences with mental health practitioners (MHPs) where they were misgendered, experienced microaggressions, or experienced overt transphobia from services providers (Blodgett et al., 2017; James, et al., 2016; Navarro, et al., 2022). Unsurprisingly, transphobic attitudes and behaviours from MHPs reduce the effectiveness of the therapy and impede a practitioner's ability to understand the needs of a TGD client (Acker, 2017).

TGD mental health care continues to be an under-researched area (Panchal et al., 2022). While there is a growing body of research promoting trans-affirmative mental health care (e.g., (Austin & Craig, 2015; Burnes et al., 2010; Ellis, 2020; Ellis, et al., 2020; Mascis, 2011; Mizock & Lewis, 2008; Mizock & Lundquist, 2016; Richmond et al., 2017; Singh & dickey, 2016; 2017) there are very few qualitative studies available that focus on the actual experiences of TGD people with MHPs (Hall & Delaney, 2021). There is a particular gap in research that looks at this topic from the perspective of TGD young people and research that explores experiences in specifically trauma-related mental health services. This article begins to address this gap by offering an exploration of TGD young people's experiences with trauma-related mental health care services and MHPs, with a specific focus on TGD young people's experiences and conceptualizations of safety related to their mental health needs. By understanding how TGD young people experience mental health care services and perceive safety in these services, this article offers insight into how mental health practitioners can engage in practices that offer opportunities for building safety and trust with their TGD clients.

Background

While there is a growing body of practitioner resources that may support MHPs working with TGD people (e.g., Austin & Craig, 2015; Chang & Singh, 2016; dickey et al., 2020; Kauth & Shipherd, 2018; Singh & dickey, 2017) there is a critical gap between practice guidelines and the therapy room (Hope et al., 2023; Livingston et al., 2020; Shipherd et al., 2019). Interactions with MHPs are one of the most cited factors impacting whether mental health care is experienced as affirming and helpful for TGD people (Holt et al., 2023). TGD people consistently report experiences of marginalization and negative experiences in mental health contexts (Anzani et al., 2019; Compton & Morgan, 2022; Mizock & Lundquist, 2019). Unsurprisingly, Puckett et al. (2023) found that TGD adults were more satisfied with their therapy and therapist when their providers were more knowledgeable about working with TGD people.

What is resoundingly present across the extant literature is that education on transgender topics is lacking across training programs for different health care practitioners, including doctors, nurses, and mental health professionals such as psychologists, psychiatrists, counsellors, and social workers (Brown et al., 2018). Many MHPs do not feel that they received adequate education in their graduate programs regarding 2S/LGBTQ (Two-Spirit[5], Lesbian, Gay, Bisexual, Transgender, and Queer) topics with a particular gap in TGD topics and experiences (Acker, 2017). Studies that have looked at education and training for MHPs and other health professionals have consistently found that students feel unprepared to work with TGD clients after graduating from their programs (Banks, 2021; Brown et al., 2018; Stryker et al., 2022).

There are major discrepancies in who is able to access MHPs who are respectful of their identities and experiences (Kattari, et al., 2020). While TGD people may seek mental health care to manage stress related to their gender or to navigate transition decisions and care, research demonstrates that TGD people often are seeking mental health care for the same reasons as cisgender people (Goldberg et al., 2019; Mizock & Lundquist, 2016). However, practitioners are often ill-prepared to provide adequate support and engage in behaviours that impede the therapeutic alliance (Mizock & Lundquist, 2016). Research over the past decade has found that TGD clients often experience negative treatment from medical professionals and mental health services leading to care not feeling safe or helpful to them, and in the worst-case services are

---

[5] For definitions and discussion of 2Spirit or Two-Spirit see: Lezard et al (2021)

experienced by TGD people as overtly harmful (Kattari, et al., 2020; Mizock & Lundquist, 2016). Kattari et al. (2020) found that trans and nonbinary people experiencing depression and suicidal thoughts were significantly less likely to experience a provider treating them with respect. These disparities in mental health care experiences are particularly important when considering the young TGD people accessing these services. While studies continue to report that young trans people, particularly those ages 18-25 may experience the highest levels of severe trans-related distress (James et al., 2016; Navarro, et al., 2022), they also have fewer experiences of trans-affirmative care (Navarro, et al., 2022). TGD young people may be especially likely to be exploring their gender, navigating coming out, and beginning to access gender-affirming care as compared with adults over 30 (Goldberg et al., 2019). In a Canadian study on trans health care, Navarro et al. (2022) found that TGD youth (ages 14-24) reported fair or poor mental health at rates that were significantly higher than the older sample. In addition to reporting lower mental health, youth participants had more experiences of discrimination by their care providers and were more often repeatedly misgendered by their care providers than were older participants (Navarro et al., 2022).

With studies consistently finding that TGD people have negative experiences in mental health care settings (Compton & Morgan, 2022; Mizock & Lundquist, 2016), research is needed that offers insight into how to improve mental health care for these communities. As MHPs continue to report that they feel underprepared to support TGD clients (Acker, 2017; Banks, 2021), research is needed that offers recommendations and insight into ways practitioners can shift their practices to be better address the needs of their TGD clients.

Current Study

This article presents findings from a community-based qualitative research project exploring TGD young people’s experiences with trauma-related mental health care. The project worked with young people across a variety of locations on the traditional, unceded territories of many Coast Salish First Nations in what is now referred to as part of British Columbia (BC), Canada. This includes the unceded territories of the lək̓ʷəŋən (Lekwungen) and W̱SÁNEĆ peoples in Victoria, and lands of the Sḵwx̱wú7mesh (Squamish), səl̓ilw̓ətaʔɬ (Tsleil Waututh), and xʷməθkʷəy̓əm (Musqueam) peoples in Vancouver.

Methods

Community-Based Research

Utilizing community-based participatory research principles (Boilevin et al., 2019; Israel, et al., 1998; 2005; Katz-Wise et al., 2019) and following recommendations for research with TGD people (Bauer et al., 2013) the project activities were informed by a community advisory committee and community consultations with trans, Two-Spirit, and gender-diverse young people. The advisory committee was comprised of four trans and nonbinary individuals who had experience being clients in mental health care services; three of the members were also service providers themselves. The community consultations were held with the support of an Indigenous youth Two-Spirit collective in Vancouver. These consultations engaged with TGD young people who shared their perspectives and questions for research on this topic area, which then informed the focus of the qualitative interviews, priorities for sharing project findings, and directions for future work. All community advisors, community consultation participants, and interview participants were compensated for their time and work with the project. All study protocols were approved by the Human Research Ethics Board at the University of Victoria (22-0210) and all participants provided verbal informed consent prior to participating.

Recruitment

Participants were recruited to complete an online, semi-structured, qualitative interview sharing their experiences with and perspectives on trauma-related mental health care. Recruitment information was shared through digital and physical posters in community locations and events and through social media, listservs, and community organizations that offer mental health services and/or 2S/LGBTQ-focused services. Eligibility requirements included: being aged 19-30; having experience attending or wanting to attend trauma-related mental health supports in BC; and identifying as trans or gender-diverse.

The term *trauma* and *trauma-related mental health supports* were used to identify experiences that individuals have identified in their life as feeling traumatic and mental health supports that individuals have sought to support them with these experiences. Participants were not asked to share what experiences led them to seek trauma-related mental health supports. To sign-up for the project, participants completed a short online survey to indicate if they had experience with trauma-related mental health care, and their accessibility needs for participation. The survey also included an open textbox where participants could share any demographic or relevant information, they wanted to share about themselves. All participants who completed the survey were contacted to inform them if they fit the eligibility criteria, confirm consent to participate, and to arrange interviews. Thirty-two screening surveys were completed, and a total of 19 participants were eligible and consented to participate in an interview.

Data Collection and Analysis

Demographic information was collected using the short online screening survey. Semi-structured, qualitative interviews were conducted by the first author, using trauma-informed principles for research (Campbell, et al., 2019). Following their interview, participants were offered the option to debrief their interview with a TGD mental health care provider from a list of practitioners hired by the project.

Data was analyzed by the first author using reflexive, thematic analysis (Braun & Clarke, 2006; 2014; 2019). Analysis was informed by the first author's professional experience as a counsellor and positionality. Further, analysis was informed by approaches that emphasize lived experience as legitimate forms of knowing (Ahmed, 2006; Aultman, 2018; Million, 2008; Salamon, 2014) and intersectionality to pay specific attention to structural and systemic contexts in which participants are accessing trauma-related mental health support (Cho et al., 2013; Clark, 2016; Collins, 2015; Crenshaw, 1989; 1991). This article presents findings from the interviews regarding participants experiences with and perception of safety in trauma-related mental health services. Participants were first asked to describe their definitions for and understandings of what safety is, what it feels like, and what helps them feel safe in a general sense. Following this, participants were asked about their experiences with trauma-related mental health supports, focusing on what experiences felt helpful and/or safe, what helped them feel safe as well as experiences that felt unhelpful and unsafe and what led them to feel unsafe while attending these services.

Interviews were transcribed verbatim by a professional transcriber and analyzed by the first author using reflexive, inductive thematic analysis (Braun & Clarke, 2006; 2014; 2019). The following sections present the themes identified related to safety, starting with the *descriptions of* *safety (subthemes: being able to be myself; being understood and seen; absence of vigilance;* and *safety as an action*); followed by: *trust and risk;* and *signals of safety*. Participants indicated what demographic information they wanted connected with any direct quotations used. They were given the option to use a pseudonym, their own name, or to use an anonymized participant number. All information included with quotations and used to described participants' identities uses the participant's own wording and choice of included information.

Findings

Most participants (n=11/19) were aged 19-25 and 8 participants were over 25 at the time of the interviews. Participants used a variety of terminology to describe their genders: trans (n=6), trans woman (n=1), trans man/guy (n=2), trans masculine (n=1), Two Spirit (n=1), transsexual (n=1), nonbinary (n=12), agender (n=1), gender fluid (n=2), and androgyne (n=1). Participants represented a range of cultural, racial, and ethnic identities and heritages, that they described using the terms (presented in alphabetical order): Indigenous (n=3), Jewish (n=2), Métis (n=1), mixed race (n=3), person of colour (n=2), Peruvian (n=1), settler (n=1), Sudanese (n=1), Taiwanese (n=1), Vietnamese (n=1), and white (n=1), 3 participants did not share any information about their cultural, racial, or ethnic identity.

Several participants shared about their lived experience as disabled individuals/people living with disabilities as well as experiences of professionally diagnosed and self-diagnosed autism/being autistic, neurodivergence, and Attention-Deficit Hyperactivity Disorder (ADHD). Participants noted the importance of class and socio-economic status for their experiences with many participants sharing they were poor or working class and struggled to find services they could afford. Participants also noted the importance of location in relation to their experiences of services, naming their experiences in large urban areas, small urban areas, rural, and remote locations.

The participants described their experiences with a range of trauma-related mental health services, including: health authority services such as hospitals, emergency care, in-patient psychiatric care and community programming; school-based supports at their high schools or postsecondary institutions; community organizations and services such as sexual assault centres, domestic violence centres, Indigenous services, cultural groups, addictions supports, trauma counselling groups, youth outreach, and suicide prevention; and private paid services with counsellors, psychiatrists, psychologists, social workers, and online programs; and peer support groups. All participants shared about their experiences with professional or formal counselling and mental health services. The findings described below focus on the participant responses related to interactions with mental health professional and are not specific to peer supports.

Descriptions of Safety

Participants were asked to describe their understandings and definitions of what safety is meant to be and what safety means to them. The following section outlines the four sub-themes identified related to these descriptions of safety: *Being able to be myself; being understood and seen; absence of vigilance;* and *safety as an action*.

Being Able to Be Myself

One of the most commonly mentioned components of safety for participants was the idea of being able to be themselves. For participants, this included being able to show-up and express themselves as they would like and to feel that they would not be judged or that there would not be negative consequences for being themselves. For example, Participant 1 (trans, age < 25) shared, “When I feel safe, I very much feel like myself.” This feeling was echoed amongst many participants, with others sharing things like safety feels like “I can exist as myself – where I can show up as me” (Participant, 5, nonbinary, age > 25); “Everyone is supposed to feel safe in society and be able to move through the world authentically and without fear” (Participant 13, transmasculine, age > 25); and “just be able to be who I am” (Participant 17, trans woman, age > 25); and “can openly be myself and not have to hide myself for anything” (Participant 12, nonbinary, age < 25).

They described the importance of feeling like they can express themselves without judgement, not needing to hide parts of themselves or perform in particular ways to avoid harm and having a right to exist in a space. Several participants used the word “authentic” to describe this experience. Participants also described the importance of feeling that their practitioner was being authentic and showing up as themselves as well. Participant 12 (nonbinary, age < 25) articulated this as when people, including their practitioners are “bringing their own true selves.”

Participants emphasized the importance of being able to be all of who they are related to the diversity and multiplicity of their identities. Many participants shared stories of not feeling safe when they felt they had to choose which parts of their identities they could acknowledge or mention to a mental health practitioner. For example, Participant 6 (anonymous) shared, “You either get treated as a trans person and you get accepted as that but you have to leave everything cultural at the door unless you’re the dominant culture. Or, you don’t get treated right as a trans person, but then you get to engage in culturally proper things.”

For many participants, being able to be themselves was a rare experience in their lives and particularly with services providers. The situations where they felt like they could be themselves in mental health care settings stood out as unique and participants often described these experiences as feeling really “lucky” or by contrasting them to times when they felt were not able be authentically themselves. This desire to be able to be authentic in who they are was central to many participants' definitions and understandings of safety both within mental health care settings and in their lives more generally.

Being Understood and Seen

In addition to safety being connected to authenticity and feeling able to be themselves, participants emphasized the importance of being understood and seen in who they were. This builds on the idea of feeling able to be themselves but is distinct in that it shifts the focus to the perception that their practitioner actually understands and affirms who they are in addition to feeling that they can show up as they are. For one participant (Maveric, nonbinary, age < 25, disabled), this was described as "not only being seen but being respected . . . there's a difference if someone is like ok yeah, you exist, versus like I see you."

Participants shared that when they felt recognized and respected by their practitioner, they felt safe. For example, Participant 6 (anonymous) described, "safety for me is being recognized and respected for myself." This included not having to explain things to or educate practitioners about their identities and experiences. Having a shared sense of experience and understanding was very important to feeling safe and understood in the counselling or mental health setting. Safety was described as a feeling of being understood and seen in who they are, being recognized in their identities and their experiences. Participant 2 (POC, agender, age < 25) framed this as "understanding, it's not just listening . . . being able to sense recognition in somebody that I'm talking to about the things that I'm dealing with and knowing that their advice comes from a place of lived experience, or just of a genuine understanding of the things that I'm talking about."

Participants described that being able to be in spaces with other people that looked like them or shared experiences with them was important for a sense of safety because they felt that it brought a shared understanding and mutual recognition. Participant 12 (nonbinary, age < 25) articulated this as “safety is community.” Participants said that recognizing that others were part of the communities where they felt like they belonged was an important signal of safety, for example seeing a counsellor that looked like them or shared identities or experiences with them. Again, this was a rare experience for participants in mental health settings, so specific moments stood out to the people who had experienced this, or it felt aspirational, or like an ideal that had yet to be experienced by most participants.

Absence of Vigilance

For almost all participants, safety was described by contrasting it to what it is not. Most commonly, this was framed as safety feeling like an absence of anxiety, fear, and vigilance. Participants used phrases such as: “neutral,” “lack of anxiety,” “absence of fear,” “not feeling tense,” “without fear,” and “ability to relax.” The feeling of fear, vigilance, and anxiety was a common experience for all participants across multiple settings in their lives. They described their experiences with mental health services as feeling scary, feeling fear about how they would be treated, and feeling anxious about how to present themselves to their practitioners to get the support they wanted and needed. When sharing about being trans, Participant 13 (transmasculine, age > 25) stated, “it adds another layer of difficulty, it adds to the amount of vigilance you have to have even just accessing a first-time support . . . you never know what you’re walking into, you never know if somebody’s going to be safe or not.” Many individuals shared needing to be vigilant about how they talked, how they looked, who they interacted with, what parts of their identities and experiences they shared, and how they described the challenges and mental health experiences they were facing. Because of the common experience of fear and vigilance in various contexts for the participants, the felt sense of safety was noticeable when vigilance, anxiety and fear were not present.

Safety as an Action

An important nuance in how participants described safety was that for many participants, safety was more than a feeling or an expectation; safety was seen as an action or a practice in which individuals can engage to support a sense of security, control, and absence of fear and vigilance in a particular context. Two participants (Participant 15, Two-Spirit, nonbinary, age < 25; and Participant 18, transsexual, nonbinary trans guy, age >25) used the metaphor of safety as a “blanket” that can be laid over a situation to create a sense of security, being held, and being cared for. This was used to describe creating a feeling where the individual could know that they would be okay. This theme was articulated by other participants through describing safety as an “approach” that required “working to create spaces” that have the opportunity to feel safe and not replicate harm. Many participants mentioned the idea that accountability and having a plan to reduce harm or address harm if it occurred was essential to safety, emphasizing that safety is not always an absence of harm but a sense of trust that there is a way to address harm if harm occurs. This understanding of safety as an action was important to participants in how they viewed the services they attended and the practitioners with whom they interacted. Many participants recognized that safety is not a complete absence of risk or challenge, but instead a sense that difficult situations and experiences can be held and supported through a practice and intentional creation of safety and accountability within the relationship with their practitioners.

Trust and Risk

Participants shared that they experienced risk and fear of being confronted with discrimination or anti-trans attitudes when connecting with mental health supports. Many participants shared that there was always a risk when starting with a new service or practitioner that they would experience some form of anti-trans behaviour, ranging from ignorance and microaggressions to blatant transphobic actions (e.g. refusing to use the individuals chosen name or pronouns; hateful comments; suggestion that mental health concerns or experiences of violence were the individual's fault because the individual was trans). Stories from others in their communities and online built a sense of fear with the consensus being that mental health supports are generally not experienced as safe or accepting and that there will also be some form of risk. The regularity of these experiences was highlighted by the shared sentiment of feeling lucky when services were even a little accepting or when a practitioner was not overtly transphobic. Participants would identify that they had mental health needs with which they wanted support but that they would need to consider how to balance their need for support with the risk of meeting a new practitioner. Participants spoke to the experience of meeting new practitioners and being faced with experiences of anti-trans attitudes, lack of understanding of TGD experiences and identities, and facing racist or ableist attitudes. For participants, meeting a new mental health practitioner was a risk.

When thinking about their experiences with safety in the context of this risk, participants described a feeling of safety as a "feeling comfortable taking a risk to trust you" (Participant, 5, nonbinary, age > 25). Many of the participants described that this was a real risk, particularly when they faced multiple barriers when trying to locate and access the care that they needed. The risk to trust a practitioner with their needs and their experiences felt very present and was something they consciously planned how to navigate when starting with new practitioners and services. For example, Participant 18 (transsexual, nonbinary trans guy, age > 25) described "testing" new practitioners out, "I might drop something that's a little bit heavy, or a little bit strange, before going into the really deep stuff and then I kind of get a sense of: if you're weird about this kind of minor thing you're definitely not gonna be okay with something else." This was a common strategy for how individuals brought up certain topics, particularly around identity or experiences of trauma. Many participants shared they would test out practitioners to see how they reacted to certain topics and then decide if they wanted to share further or seek different support based on the practitioner's reaction.

This risk of trusting practitioners was integrally connected to whether participants experienced a sense of safety with their MHPs, particularly related to each of the above-mentioned descriptions of safety. Participants would test out if they could be themselves with their practitioner and gauge if this was possible based on the practitioner's reactions and comments. Furthermore, participants would evaluate if they felt their practitioner would be able to support them with their needs by whether or not they perceived a sense of understanding and being seen.

Trust was also built for participants when MHPs demonstrated that they could navigate misunderstandings or situations that may have caused harm to the participant. This experience of 'safety as an action' was seen as important for practitioners to demonstrate to the participants. It helped the participants feel like trust might be possible. For example, how a practitioner handled misgendering or using terminology that did not align with what the participant used was an important indicator to the participants that their practitioner might be worth the risk to trust. Many participants emphasized that they understood mistakes can and do happen, but having a practitioner authentically address the missteps was key to a feeling of trust and safety in the therapeutic relationship for the participants.

Signals of Safety

With risk being at the forefront of participants' planning when starting with new practitioners, participants would develop strategies for navigating this risk. A primary strategy was looking for signals of safety with their practitioners and the services they were attending. Participants looked for clues that this practitioner might be safe enough to work with and safe enough to risk engaging with them as a client. This search for signals started before first contact with the mental health practitioner, when participants were searching online for providers. Signals included imagery on the website, wording in the provider biography, visual clues about how the practitioner looked and what others at the agency or organization looked like. Participants were looking for things that signalled to them that they might share experiences or community with the practitioners, be able to be themselves, be seen and understood, and be engaging with practitioners who understood building safety and trust over time. This could include, but was not limited to: race, ethnicity, Indigenous identity, gender presentation, perceived gender, clothing, style of photo, indicators in the biography regarding pronouns, belonging to 2S/LGBTQ communities, disability, educational background, and how the practitioner talked about what they could help the individual with.

While starting to work with a MHP, this search for signals of safety continued. Participants named that visual signals, such as 2S/LGBTQ signage and pride stickers, posters, and imagery were a helpful clue within the physical environment of the service. Participant were also sometimes wary of visual clues, and they often waited to see follow-through from the services and practitioners to demonstrate that they also practiced in ways that were aligned with what they were visually signalling. Other visual clues and environmental signals were an important signal of safety for participants. Participants named things such as the space and environment of the service, emphasizing that non-clinical settings felt safer and more comfortable. Participants also named visual clues about how their practitioners presented, such as clothing, gender presentation, and similar appearances racially or culturally as the participants. Participants named that practitioners and services felt potentially safer when there were people who looked similar to the participants there.

Similarly, to navigating risk by testing out practitioners, participants shared that they would look for clues in how MHPs reacted when participants talked about particular topics related to their identities, the language the practitioner used, and the comfort with talking about things related to TGD experiences. Self-disclosure from the practitioner about their own identity was often a signal to the participant that their practitioner may be worth the risk to trust, particularly when this disclosure revealed some shared lived experiences or identities.

Participants also described how they perceived practitioners' attitudes towards them, their identities, and their experiences as a potential signal of safety or as a red flag identifying a practitioner who would not feel safe or trustworthy to them. Practitioner bias showed up in what was felt by participants as an over-interest in their TGD identity or other aspects of their experience that may be considered marginalized. Practitioners demonstrating this bias might present as approaching with good intentions; however, participants were left feeling uncomfortable. If a participant felt that their practitioner was too interested in them, or keen about their experiences, they felt a lack of trust and safety. As one participant (Participant 5, nonbinary, age > 25) described, "I just kind of sensed from her keenness to take me on as her client, I kind of got this vibe of like, 'ooh, this is going to be an exciting and interesting client to have because you know, they fit these identities, and would be such a good learning experience' . . . it comes off the wrong way, or it just rubs you the wrong way." Similarly, participants shared experienced where their practitioners were overly interested in them as young people. One participant identified this as "saviourism" (Participant 3, trans, age > 25) and noted that this was especially felt when they were in their teens, with adult professionals taking what felt like a special interest in them which was neither comfortable nor helpful to the participant.

In contrast, participants shared the importance of being able to talk about their experiences and identities with practitioners and have it feel normal or straightforward. This experience of mutual understanding about experience, or that their experiences or identities were not remarkable but instead just their everyday lived experiences, signalled to participants that practitioners may be safe or worth the risk to trust.

Discussion

The relationship between a therapist and the client has been consistently demonstrated to be an essential element of predicting positive outcomes in psychotherapy (Fraser, 2018; Gnaulti, 2019; Norcross & Lambert, 2019; Norcross & Wampold, 2011). It has been described as being central to the therapeutic work as it creates a sense of safety for the client. However, for TGD young people in this study, safety was often elusive within the therapeutic relationship with their MHPs, a rare experience that they described as feeling lucky to have encountered. When participants did experience a sense of safety with their practitioners, they described this as being able to be themselves, be recognized as who they are, and perceiving practitioners as being worth the risk to trust. For the participants, practitioners had to demonstrate through their actions that they are worth this risk and signal to their clients that they are potentially safe people for the young people to engage with. The following sections outline considerations for mental health practitioners working with TGD young people through discussing practice implications regarding *safety and recognition; power; authenticity; and competency training.*

Safety and Recognition

Participants described that safety was the ability to be seen and recognized in who they are, what their lives are like, and what their needs are. It was important for them to be seen not only in their gender, but in all of who they are, and in their lived experience. This felt sense of recognition was linked to a sense of safety that supported the participants' ability to engage with the mental health practitioners and have services feel helpful. The perceived experience of being recognized by their practitioner was either fostered or impeded by how the practitioner interacted with them as a client throughout their work together. The experience of these participants echoes findings in the literature (Mizock & Lundquist, 2016) that describe how the practitioner's questions and attitudes about gender and trans identity can greatly impact how TGD clients experience the therapeutic relationship. When therapists do not recognize and validate that individuals bring a range of diverse experiences to the therapeutic space, this contributes to a feeling of alienation (Goldberg et al., 2019) and, therefore, impacts feelings of trust and safety, ultimately impeding the therapeutic relationship. This is particularly felt by TGD young people when the practitioner does not have an adequate knowledge base about TGD experiences and identities (McCullough et al., 2017; Mizock & Lundquist, 2016). Jarring questions and experiences where clients do not feel recognized or understood by their practitioners directly impacts the therapeutic relationship. When practitioners pose what are felt as out of place or inappropriate questions about TGD experiences and identities, this impacts a client's ability to have a felt sense of recognition.

Practitioners should reflect on the ways they demonstrate recognition to their clients through actions such as micro-affirmations (Anzani, et al., 2019) and focusing on the issue the client was bringing to therapy without an undue focus on gender or other marginalized realities. As Chang and Singh (2016) suggested, recognition also must include practitioners paying attention to the ways in which intersections of identity, such as age, race, ethnicity, gender, and culture, class, and ability, shape their clients' experiences.

Power

As Panchal et al. (2022) note, the historical positioning of MHPs within psychology and psychiatry has not been conducive to the development of supportive and effective care because training has often framed TGD experience as a pathology to be fixed. The legacy of this history is still felt because many TGD people continue to have fearful relationships with mental health services, and stigma and pathologizing continues to be a regular experience for TGD people. Those working in mental health services may be coming to this work from a variety of training backgrounds, including counselling psychology, social work, nursing, or other helping professions. Nevertheless, they must contend with this history of mental health fields pathologizing TGD identities and the current context of MHPs as gatekeepers to gender-affirming medical care for TGD individuals (Anzani, et al., 2019). This history and context enters the therapeutic space, even when a client is seeking support for something unrelated to gender-affirming care, such as support for trauma-related mental health needs. With this historical legacy of the mental health field, how power shows up in the therapeutic relationship is a crucial consideration for practitioners working in mental health care settings and is especially necessary to reflect on and engage with for practitioners working with TGD young people.

Practitioners must be cautious of the ways that microaggressions can enter the therapeutic relationship and how they can be experienced as extremely harmful to the client and damaging to the therapeutic relationship (Mizock & Lundquist, 2016; Morris et al., 2020). These microaggressions can be especially present when a practitioner brings up gender-affirming care or an over-focus on gender into the therapy when a client has not identified that this is an important focus for them (Mizock & Lundquist, 2016). Microaggressions are experienced differently across identities and Morris et al. (2020) suggest that it is important to consider how this may be amplified when considering the substantial power differential that exists in a counselling relationship. This is further amplified when we consider the experience of young people working with practitioners who are almost always older than them while also holding positions of power as mental health professionals. The intersections of these systems of power have an enormous effect on the opportunity for a felt sense of safety for TGD young people accessing mental health supports.

Young people and particularly young TGD people, continually have their experiences and ideas dismissed or infantilized (Gill-Peterson, 2018) based on their age. Young people have to contend with working with adults who are older than them and who often do not recognize young people's experiences as valid or believable. Approaches to care that aim to ensure that a future self is protected or shielded from decisions made by a naïve or uninformed young person often ignore the current living experience of the young person. This often leads to deferring decision-making power to adults while dismissing and ignoring the opinions, ideas, and needs of the young person. As the participants in this study described recognition and being seen and understood as one's self is centrally important to safety. Specifically in the context of mental health care and trauma-related mental health care for TGD young people, if recognition is crucial for a felt sense of safety in the therapeutic relationship, than MHPs working with young people must actively reflect on the ways in which their practice approaches must create space for truly recognizing and seeing the young people they work with and their current living experiences.

Authenticity

Finding a MHP that that feels safe and supportive plays a crucial role in the therapeutic relationship. Similarly to the stories shared by participants in the present study, Hall and Delaney (2021) found that their transgender and gender-expansive adult participants often took measures to protect themselves against expected challenges of accessing health care, such as microaggressions, gate-keeping, and explicit challenges to their identities. Participants in this study practiced this through what they described as searching for "signals of safety" from their services and practitioners that could indicate to them that these practitioners may be potentially safe people or worth the risk of trusting. Further, participants engaged in strategies where they would compromise their care needs by choosing which part of their identities they felt they could present and be seen in, often opting to leave other parts of their identities silent or to hide these from practitioners in order to feel a sense of connection based on other shared identities. When practitioners were not demonstrating to clients that clients could show up as their full selves in the therapeutic space, clients chose to withhold parts of their identities and experiences from their practitioners as a self-preservation strategy. While this supported the client to feel a sense of control and choice for themselves, feeling that this is necessary impedes the client's sense of safety and increases a feeling of vigilance towards the practitioner by having to decide which parts of their identities and experiences can be recognized and understood by their practitioners.

As Rosati et al. (2022) found, who the therapist is, in terms of their gender and sexual orientation, can impact the therapeutic process even before it starts. Similarly to McCullough et al. (2017), the participants in this study shared that practitioner identity is extremely important to young TGD people when looking for a therapist. As Erby and White (2022) explore, in spaces of “assumed safety” (p. 123) such as community spaces or shared-identity spaces, marginalization by race, gender or sexuality can feel more profound and isolating. Practitioners need to consider how they can demonstrate or signal safety to their clients, and the ways they may be unintentionally or unknowingly impeding the sense of recognition of the full self and space for authenticity so crucial to a sense of safety for TGD clients in the therapeutic relationship. Beyond individual practice, professional bodies must also consider ways that they can structurally support training, hiring, and sharing information on the availability of therapists of diverse identities, including TGD therapists and therapists from diverse racial, ethnic, cultural, backgrounds and therapists with experience of disability. Further, professional bodies can consider the ways they support communities of practice, where therapists of all identities can share referrals and connections in order to support clients to be better able to find a therapist that feels like a fit for them and their experiences. If recognition and being seen is an essential element to a felt sense of safety, but the systems that individuals navigate require them to edit their presentation of themselves in order to access care or to compromise their care needs, then how are they expected to find useful, helpful care? A key starting place for increasing appropriate useful mental health care is to foster ways that both practitioners and potential clients can show up authentically and be seen as themselves.

Competency Training

Recommendations across the literature emphasize the need for providers to demonstrate respect for their TGD clients, maintain flexibility, and follow the client’s needs (Goldberg et al., 2019; Mizock & Lundquist, 2016; Morris, et al., 2020). Despite these often being the basic tenets of an effective therapeutic approach regardless of the client’s identity, these foundational approaches seemingly become difficult for many providers to engage in when they encounter TGD clients, pointing to ongoing systemic and ubiquitous anti-trans attitudes and transphobia even within helping professions (Acker, 2019). Much of the literature regarding supporting TGD people calls for more training for practitioners. While real shifts to practitioners’ attitudes and approaches are possible through education and training (e.g., Boot-Haury, 2023), the findings from this study suggest that trainings should move beyond a basic ‘trans 101’ model and shift training to focus on the ways that practitioners can engage in ongoing, self-reflexive practices that consider how they signal safety to their clients, demonstrate recognition, and are engaging in the action or practice of building safety in the therapeutic relationship.

Research has shown that approaches to training that focus specifically on TGD experiences and identities can be effective for shifting practitioner attitudes with TGD clients (Boot-Haury, 2023). However, practitioners should not assume that education of this type will offer them complete competency; MHPs require ongoing engagement and reflection on their own lived experiences and biases that they bring with them to their therapeutic work. Competency models present specific challenges when training practitioners in that they can lead to an over-focus on gender identity and move practitioners away from paying attention to what clients actually want to focus on in a therapeutic environment. Practitioners may miss or ignore the important complexity of the experiences clients are bringing with them. These trainings must also be wary of covering up practitioner bias by teaching “the right language” or the “correct words.” Models for training practitioners may benefit TGD clients more by framing this through a literacy model, training practitioners to build an awareness of the structural and systemic barriers and build a practice approach that encourages them to reflect on the intersection of experiences their clients may bring to the therapeutic relationship. Practitioners can and should develop literacy around diverse experiences their clients may experience as this offers MHPs a basic level of knowledge from which they can build relationships with their clients. This may help practitioners to recognize personal biases and build a self-reflexive practice that requires the practitioner to consider their own lived experiences, how they show up in their work and how they are signaling safety to their clients. Successful training should also support practitioners to consider how to navigate practice scenarios where they make mistakes, helping practitioners demonstrate to their clients that the concept of safety is an ongoing practice in which they are engaging and building with their clients.

Beyond individual practice, professional bodies may consider the ways that they can foster practitioner learning and sharing through reflexive communities of practice. For example, intentionally structuring networks of practitioners working with particularly communities. Structurally supporting practitioners to engage in a community of practice approach can differ from individual practitioner competency models by encouraging ongoing learning and connection with a community of diverse practitioners, as opposed to a one-time demonstration of competency through a single training model approach. Further, professional bodies may consider the ways they incorporate approaches to demonstrating safety and literacy in diversity to clients through educational and training requirements, professional practice standards, and professional codes of ethics.

Conclusion

The therapeutic relationship is a crucial element to effective and helpful mental health support. Moreover, this therapeutic relationship can offer clients a sense of safety, from which they can begin to process and heal from traumatic experiences in their lives. However, for TGD people, the therapeutic relationship remains a fraught context, where safety is often elusive and requires the TGD client to balance the risk of trusting new practitioners with the real risk to their safety. This is particularly present for TGD young people, who must also navigate the challenges that come with the intersection of marginalized age and gender when working with professionals who may dismiss or not recognize the TGD young person’s experiences as valid. If the therapeutic relationship is crucial to mental health support feeling helpful and safe, practitioners must consider the ways that they can demonstrate recognition and understanding to their clients, and signal safety to their clients to communicate that they may be worth the risk of trusting. Practitioners must consider how creating safety in the therapeutic relationship with TGD young clients is an ongoing active process of intention, accountability, and demonstration of authentic understanding and recognition.

The current study presents findings from interviews with TGD young people regarding their understandings of safety within trauma-related mental health support with mental health practitioners. Because this is a qualitative study with a small number of participants from a specific geographic region, it is not possible to widely generalize findings. However, findings from this study do align with the current literature. This points to a shared experience of TGD people with mental health practitioners and can urge practitioners to consider the ways they are engaging in their practice with TGD clients.

Future research can build on these findings by working with TGD people to explore training and competency models in this area. Training for MHPs must encourage an ongoing practice of self-reflection for practitioners from which recognition and understanding for their clients may be possible as they work across difference in their practices. Future research can explore ways to build training that emphasize the need for literacy on systemic issues facing

TGD people and to build practice approaches that centre reflexivity and foster therapeutic relationships that consider the ways that safety is structured and signaled.

Chapter 4: Mental Health Care Research Priorities for Trans and Gender-Diverse Young People: Findings from Community Consultations on Improving Trauma-Related Mental Health Care for Trans and Gender-Diverse Communities

Authors: Mattie Walker, Owen Ballendine[6]*, Lors Heit*[7]*, Nathan Lachowsky, and Aaron Devor*

Formatted for submission to the *International Journal of Transgender Health*

Abstract

Introduction

Research on mental health care with trans and gender-diverse (TGD) people presents unique challenges as it brings together two historically complex contexts for TGD communities. While ethical standards and recommendations for research do exist (e.g. Bauer et al., 2019; Puckett et al., 2023, Veale et al., 2022), it is only recently that there has been a turn towards community-engaged research, with communities calling for research led by TGD people and focused on community goals and needs.

Method

This article presents findings from a qualitative, community-based project on TGD young people's priorities for future research related to improving mental health care. Thirty-four participants engaged across two data collection activities: in-person workshops; and online, semi-structured interviews. Eligibility criteria included: identifying as trans or gender-diverse; being aged 19-30 and having experience accessing, attending, or needing trauma-related mental health supports in British Columbia. Participants shared their experiences with trauma-related mental health care and their priorities for improving mental health care more broadly for TGD communities.

---

[6] Community partner at the Urban Native Youth Association

[7] Co-facilitator for community consultations and research assistant, University of Victoria

Results

Research priorities included: *Practitioner Education and Training; Indigenous Perspectives on Anti-Racism, Cultural Safety, and Reconciliation; Addressing Racism and Cultural Differences; Impact of Geography; Co-Occurring Needs; Understanding Trauma; Disability, Autism, and Neurodivergence; Pathways to Care;* and *Approaches to Therapy*. Participants emphasized that research should be led by TGD communities who are impacted by the research and needs to be based on community priorities.

Discussion

These findings provide novel insight from young TGD people into community priorities that can guide future research on mental health care. Findings suggest that future researchers be strategic in building projects that shift the focus from research on TGD people to research that focuses on mental health practitioners, practice approaches, and frameworks that acknowledge the multifaceted lived experiences of TGD people. Future research should pushback against deficit-focused narratives and an over-focus on harm experienced by TGD people.

Background

Many trans and gender-diverse (TGD) people find that mental health services do not feel helpful, safe, or accessible (Ellis, 2020; James et al., 2016; Shipherd et al., 2019). When seeking mental health care for a variety of needs including anxiety, depression, and trauma-related mental health needs, barriers include challenges to finding and accessing care (Ferlatte et al., 2019; Lange 2020; Mizock & Lewis, 2008; Scheim, et al., 2021), experiences of harm when attending or accessing care (Blodgett et al., 2017; Brown, et al., 2018; Navarro, et al., 2022), and care that is unhelpful or irrelevant due to lack of practitioner training and education (dickey et al., 2016; Mizock & Lundquist, 2016; Puckett et al., 2017; Ross et al., 2021). Further, TGD people can be required or forced into mental health care services when seeking gender-affirming medical care (Coleman, et la., 2022; Puckett et al., 2017). Despite an identified need for appropriate and safe care, there is a lack of research that works with TGD people to understand their needs and priorities for improving mental health care and more specifically, trauma-related mental health care. While there is a growing body of literature offering recommendations for practitioners regarding affirming approaches to practice (e.g., Austin et al., 2017; Burnes et al., 2010; Ellis, 2020; Ellis, et al., 2020; Mascis, 2011; Mizock & Lewis, 2008; Mizock & Lundquist, 2016; Richmond et al., 2017; Singh & dickey, 2016; 2017), there is a gap in research that draws on TGD people's perspectives and community-driven goals for research on improving trauma-related mental health care for TGD communities (LeBlanc et al., 2022; Ross et al., 2021).

Mental health care for TGD people continues to be an under-researched area (Panchal et al., 2022). Research on mental health care with TGD people presents unique challenges in that it brings together two historically complex contexts for this population: research and mental health care. With a complex history of having been pathologized, gatekept and stigmatized, many TGD people are wary of both researchers and mental health professionals (Gill-Peterson, 2018; Ross et al., 2021). Many professionals, such as in psychology and psychiatry, continue to be gatekeepers to care. In some contexts, gender-affirming medical interventions require an assessment by a mental health care provider prior to an individual receiving medical care, placing mental health care service providers in a gatekeeper role to gender-affirming medical care, which can lead to TGD people distrusting providers in this position (Coleman, et al., 2022; Puckett, et al., 2017). Further, mental health care providers often work within contexts that have been responsible for pathologizing TGD identities and producing harmful research that does not support accurate understandings of the humanity of TGD individuals (Ansara & Hegarty, 2012; Gill-Peterson, 2018). Mental health and medical contexts continue to often be sites of harm and negative experiences for many TGD people (Acker, 2017; Blodgett et al., 2017; Brown, et al., 2018; James, et al., 2016; Navarro, et al., 2022). While ethical standards and recommendations for research have been created to address these contexts of harm (e.g., Adams, et al., 2017; Bauer et al., 2019; Puckett et al., 2023; Vincent, 2018) , it is only recently that there has been a turn towards community-engaged research with TGD people, with communities calling for research led by TGD community members and focused on community goals and needs (Bauer et al., 2019). Research has historically been conducted *on* TGD individuals and not designed to be *in collaboration with* or led by TGD people (Ansara & Hegarty, 2012; Veale et al., 2022).

TGD people are often described as an over-researched group, with many community members sharing a sense of research fatigue (Bauer et al., 2019). With an abundance of literature noting the pervasive experience of marginalization, victimization, violence, and anti-trans violence experienced by TGD people, many TGD people share an exhaustion with research that is problem-focused or that lists devastating statistics as a way of proving the harm that TGD communities are facing within our current political and social climates. With a growing awareness of the importance of research driven by TGD communities' priorities (Bauer, et al., 2019; dickey et al., 2016; Veale, et al., 2022), community researchers have shared research goals and priorities based on TGD community members' perspectives (LeBlanc, et al., 2022; Ross et al., 2021; Veale, et al., 2022). These publications have emphasized the importance of research being based on TGD communities' priorities and building projects that engage with TGD people at all steps of research project designs. Veale (2017) called for continued research by trans researchers, stating that "having a greater voice in what is written and spoken about transgender people in the academic and health professional domains" (p. 121) will enhance not only a sense of empowerment for trans people and communities, but also will "enhance the health, research, education, respect, dignity, and equality regarding transgender people" (WPATH vision, para 3 cited in Veale, 2017).

LeBlanc et al. (2022) state that conducting research without the involvement of TGD community input can "contribute to disenfranchising the population, ignoring community needs, and causing investigators to miss key topics most influential to TGD population health" (p.2). TGD health research topics and priorities are rarely explicitly named as being directed by TGD patient or service user voices (LeBlanc, et al., 2022). Bauer et al. (2019) call for ethical research with trans people to include engagement with communities, suggesting that researchers "meaningfully engage trans communities at all stages of the research process" (p. 2) including engaging trans communities in the identification of research questions. By centring TGD voices in identifying TGD health research priorities, researchers can determine whether research goals and findings actually align with the needs TGD people (Bauer et al., 2019). Basing research on questions suggested directly from TGD communities is one step towards the attentiveness that Bauer et al. (2019) encourage.

The Current Study

This article presents the findings from a community-based research project that worked with TGD young people to identify their priorities and questions for future mental health care research for TGD people. The project seeks to improve mental health services that provide trauma support to TGD people by identifying areas of improvement, barriers to access, and directions for future research that are centred on community needs and priorities. The current article outlines the findings related to the research goals shared by participants, identifying topic areas of interest and perspectives on research approaches from TGD communities. These findings are presented with the intent to broadly share the research topics of interest coming directly from TGD young people in order to support researchers to design future projects based on recommendations and perspectives from TGD community members. Previous publications that have offered priorities for research with TGD people have had a medical or gender-affirming health care focus (e.g., Feldman, et al., 2007; Ross et al., 2021); this article aims to offer a different perspective on research priorities by focusing specifically on the mental health research priorities of young TGD people who sought out mental health care for trauma-related concerns.

Methods

Community-Based Research

This project utilized community-based participatory research principles (Boilevin et al., 2019; Israel, et al., 1998; 2005; Katz-Wise et al., 2019) and followed recommendations for research with TGD people (Bauer et al., 2019) with the main goal of designing and implementing a project that was led by and centred TGD people’s perspectives at all stages of the project. The project activities were informed by a community advisory committee. The advisory committee was composed of four trans and nonbinary individuals who had experience being clients in mental health care services; three of the members were also service providers themselves at various stages in their mental health careers (i.e., recently graduated and starting to practice as a counsellor; experienced counsellor offering training and mentorship to other practitioners; working in community healthcare organizations). Advisors were recruited through local listservs for trans-serving organizations and mental health care workers; digital poster recruitment; and by word-of-mouth. Eligibility for joining the advisory committee included: being trans or gender-diverse and having experience attending/accessing trauma-related mental health care services within British Columbia. Being a service provider was not an exclusion criterion. All community advisors were compensated for their time and work with the project.

Recruitment

Participants were recruited through digital and physical posters in community locations and events and through social media, listservs, and community organizations that offer mental health services and/or 2S/LGBTQ-focused services and through partnerships with the Community-Based Research Centre (cbrc.net) and with a Two-Spirit Collective at an Indigenous Youth organization, Urban Native Youth Association (unya.bc.ca) in Vancouver, British Columbia (BC), Canada. Participants were recruited from the southwestern part of the province of BC, Canada in Victoria, Vancouver and surrounding communities on the south coast, Vancouver Island, southern gulf islands, and towards the interior region of the province. Eligibility goals included: being aged 19-30; having experience attending or wanting to attend trauma-related mental health supports in BC; and identifying as trans or gender-diverse. Eligibility criteria was determined to invite participants who both had experiences with professional services and to not exclude individuals who had wanted services but could not attend services due to barriers. The description of services was intentionally broad and offered examples to participants such as: individual counselling or facilitated group support.

To sign-up for the project, participants completed a short online screener survey to indicate if they had experience with trauma-related mental health care, and their accessibility needs for their participation. Trauma-related mental health care was selected for inclusion criteria because these community consultations were done within the scope of a project specifically focusing on trauma-related mental health care. Trauma-related mental health care was chosen as the focus of the larger project because much of the available literature does not provide recommendations for providing trauma support for TGD communities with the most common recommendations being a need for more research and need for more training for mental health practitioners. There continues to be gaps in the available literature that address trauma-focused approaches for TGD people, understanding and definitions of trauma for TGD populations, and training and education for practitioners supporting TGD people with traumatic experiences (Ellis, 2020; Hendricks & Testa, 2012; Lange, 2020; Shipherd et al. 2019)

For the community consultations, participants were asked for their priorities on improving mental health care generally; however, this question was asked in the context of a larger study focusing on improving trauma-related mental health care. For the purpose of the study and recruitment, *trauma* was not defined by the study, instead the term was left open for participant interpretation so as to not limit what would be defined or included within a given definition of trauma. Participants were not required to share their experiences with trauma that had led them to seek trauma-related mental health care services. Participants were eligible if they identified that they had sought out mental health care services related to trauma. Service examples given in recruitment materials included: individual counselling for trauma or trauma-related concerns; crisis support; group counselling; mental health assessment; psychiatric care; psychological services; and community support groups for trauma-related concerns, such as domestic violence support groups; and intimate partner violence support groups.

The survey also included an open textbox where participants could share any demographic or relevant information they wanted to share about themselves. All participants who completed the screening survey were contacted to inform them if they fit the eligibility criteria and to confirm their consent to participate. Participants self-selected to participate in an in-person workshop or an online interview. A total of 34 TGD participants participated in the project activities: 15 people participated in the in-person workshops and 19 people participated in an online interview. All study protocols were approved by the Human Research Ethics Board at the University of Victoria (22-0210) and all participants provided verbal informed consent prior to participating.

Data Collection and Analysis

Data were collected from March 2023-August 2023. Demographic information was collected using the short online screening survey for both participant groups. All engagement with participants was done using trauma-informed principles for research (Campbell, et al., 2019).

The in-person community workshops were facilitated as interactive workshops and were hosted in collaboration with the Urban Native Youth Association's Two-Spirit collective. The first author co-facilitated with a white, non-Indigenous, queer and trans co-facilitator (third author) and with the support of two of the Two-Spirit Indigenous staff members from the community organization (second author). Cultural safety[8] was centrally important for these events (Curtis et al., 2019; Pruden, 2021). In recognition of the partnership with UNYA and in collaboration with the Indigenous co-facilitators, the workshops were designed to be culturally safe for Indigenous participants while being welcoming to all participants from diverse cultural backgrounds. Both a Two-Spirit elder and a trans community mental health worker were present and provided support for the workshop participants as needed, and the Two-Spirit elder opened the events with a welcome. The event also had a community artist facilitating art-making activities. For these workshops, we also wanted to support community-building and connection for the participants through sharing food and having nonstructured time for socializing. Participants engaged in small group discussion and activities, written activities, and larger group discussion. Data were collected through individual and group written activities and note-taking by the co-facilitators during the discussion activities.

Interviews were conducted by online video conferencing or by phone depending on the participant's preference. The interviews were semi-structured and conducted by the first author (white, queer, and nonbinary mental health practitioner and researcher). Interview data were collected through audio recordings that were transcribed verbatim.

In both the community workshops and the interviews, the first author asked participants what mental health services they had experience accessing and which services they wanted to access but were not able to due to barriers, what barriers they faced when seeking services, and what they felt would help or improve mental health services for their communities. Following these questions, participants were asked by the first author (lead facilitator of the workshop and interviewer for the interviews) and third author (co-facilitator for the workshops): "What would

---

[8] For definition of *cultural safety* see: Native Youth Sexual Health Network (https://www.nativeyouthsexualhealth.com/what-we-believe-in)

you like to see researched in the future related to mental health care and trauma supports for trans and gender-diverse people?" and: "How do you think these topics should be researched? What types of research would you like to be involved in or could see as helpful for future research on this topic area for trans and gender-diverse people?"

All participants in the community workshops and the interviews were compensated for their time with an honorarium. Following participation in the project, participants were offered the option to debrief their participation with a TGD mental health care provider from a list of practitioners hired by the research project. Participants were also given the option to stay connected with the project and receive updates over email and be invited to participate in community knowledge sharing events for the project.

Data were analyzed using reflexive thematic analysis (Braun & Clarke, 2006; 2014; 2019). Following the workshops, the first author and third author met to discuss initial patterns in the data. After the interviews were complete, the first author reviewed the transcripts and generated initial codes and themes. After this, the first author combined the themes and codes from the workshop and interview data and reviewed the patterns. From this the research priorities shared by the participants were grouped into topic themes. The first author engaged in a reflexive research process through the analysis of the data, considering how their positionality influenced participant engagement, data collection, and analysis.

The identities and experiences that participants shared about themselves are outlined below to contextualize the research priorities they identified. Participants were given the choice to share as much or as little about themselves as they wanted through an open text box on the online survey and through an open-ended question during the workshops and interviews. The goal of this method was to place more control and choice with participants to name the salient aspects of their identities and experiences that they thought about when joining the project.

Results

Participants

The majority of participants (n=25, 75%) had experience both accessing and attending mental health care services and wanting to access care but could not get the care they needed because of barriers. This is notable, in that while having one of these experiences was an eligibility criterion, the majority of participants reported both *negative* experiences with mental health services and facing barriers to the care they needed. The majority of participants spoke to their experience with professional counselling services and mental health services accessed through hospitals and public community organizations. Participants lived mostly in large urban areas, with the majority of participants living in Vancouver (n=13) and Victoria (n=5), while others were located in smaller communities with populations between 14,000 – 120,000.

Gender Identities

Participants were asked what words they used to describe their gender and were invited to use as many terms as they wished. Participants used a variety of terminology and represented a range of gender identities. The most commonly used terms were trans (n=18), nonbinary (n=17), Two-Spirit (n=5), and gender fluid (n=3). Participants also used the terms agender, male, female, androgyne, and transsexual faggot.[9]

---

[9] All terminology used to describe gender identity, sexual orientation, and other identity categories use the participants own terminology and phrasing.

Race, Culture, Ethnicity, and Indigeneity

Participants represented a range of cultural, racial, and ethnic identities. They described these identities (listed in alphabetical order) as: African, Algerian, Arab, Black, European ancestry, Filipinx-Canadian, Indigenous (specific nations were mentioned but not listed here to protect anonymity), Japanese, Jewish, Latin American, mixed race, Palestinian, Peruvian, POC (person of colour), Russian, Taiwanese, Vietnamese, and white. Many participants emphasized that these aspects of their identities were important to their experience of mental health services, with many participants experiencing racism and specifically anti-Indigenous bias from service providers and organizations.

Other Lived Experiences

Participants shared a range of lived experiences that they indicated shaped their perspectives on mental health care and their experiences with mental health providers and services. They shared that their sexual orientation was an important aspect of their identity and their experience with service providers. They described these aspects of their identities as queer, Indigiqueer, bisexual, and polyamorous. Participants also represented a range of experiences with mental health diagnoses, sharing having experiences with bipolar disorder, depression, anxiety, post-traumatic stress disorder, borderline personality disorder, and eating disorders. Participants also shared experiences with being neurodivergent, Attention Deficit Hyperactivity Disorder (ADHD), and/or autistic. They shared that their experiences with living with disabilities and chronic illness shaped their experiences with mental health care, as well as experiences with being able-bodied, having mobility challenges, or being a fat person.

Participants also emphasized that their perspectives on mental health care were shaped by other experiences and roles in their life such as being a child of immigrants, recently moving to a city, being working class, being a sex worker, being low income, having experience in foster care, or being a community service worker while also seeking community health care.

The participants described their experiences with a range of mental health services, including: health authority services such as hospitals, emergency care, in-patient psychiatric care and community programming; school-based supports at their high schools or postsecondary institutions; community organizations and services such as sexual assault centres, domestic violence centres, Indigenous services, cultural groups, addictions supports, trauma counselling groups, youth outreach, and suicide prevention; private paid services with counsellors, psychiatrists, psychologists, social workers, and online programs; and peer support groups.

Research Priorities

Participants were asked to share their research questions and priorities for topics related to improving mental health care for trans and gender-diverse people. They shared a range of topics that were grouped into the nine themes: *Practitioner Education and Training; Indigenous Perspectives on Anti-Racism, Cultural Safety, and Reconciliation; Addressing Racism and Cultural Differences; Impact of Geography; Co-occurring Needs; Understanding Trauma; Disability, Autism, and Neurodivergence; Pathways to Care;* and *Approaches to Therapy.*

Practitioner Education and Training

The most commonly mentioned research topic of interest was related to practitioner education and training. Participants wanted to see research that explores how practitioners are trained, where they are finding the information and training on TGD experiences and identities, and how many practitioners are actually trained and knowledgeable in TGD topics. Participants were particularly interested in research that put the focus on practitioners, exploring questions of practitioner bias, prejudice, and competency. Further, participants wanted to know “what defines trans competency?" (workshop participant), noting that they often hear this term but are unaware of how this is defined, who gets to define it, and how people find and engage in trans-competency education. "It kind of goes back to the whole, like, having people know more about the more diverse spectrum of the people who will come in and talk to them, right, stuff like that would be huge" (interview participant).

Further, questions were identified related to diagnostic criteria across gender experiences. Participants wondered if sometimes individuals could be misdiagnosed, or symptoms could be missed, based on gendered expectations or biases present in diagnostic criteria for mental health disorders. They wanted sex-and-gender-based research that could explore this and identify clearer more accessible ways for individuals to receive a diagnosis if they wanted one for their mental health care.

Indigenous Perspectives on Anti-Racism, Cultural Safety, and Reconciliation

A shared experience for Indigenous participants was facing anti-Indigenous bias, stigma, and racism when navigating mental health services. They noted that there are important differences for Indigenous TGD people, especially nonbinary Indigenous people and people with culturally-related gender identity experiences, who are rarely discussed or represented in research. One interview participant shared their interest in seeing "how a study like this [meaning the current study] that centres more around Indigenous, non-binary identities, might differ. . . how does a culturally related gender identity add another dynamic"

Many participants shared challenges with finding services that felt culturally safe and appropriate while also understanding their TGD identities and experiences. These participants wanted research to address these specific experiences as well as research about how to train practitioners to build knowledge and cultural competency for their Indigenous service users and to build services that were not only free of anti-Indigenous bias but felt culturally safe. Participants called for "integrating Truth and Reconciliation"[10] (workshop participant) (Truth and Reconciliation Commission of Canada, 2015) into mental health services and hoped that research might be able to begin to ask how these principles can be brought into mental health services. However, it is important to note that currently the Truth and Reconciliation Commission calls to action exclude Two-Spirit and TGD people entirely. Future research may address this gap by addressing how these calls to action may be brought into mental health services and account for and recognize Two-Spirit and TGD people's experiences and specific needs.

Addressing Racism and Culture Differences

Participants emphasized the necessity for research to look at mental health care needs and access to care for marginalized communities, with many participants sharing experiences of racism, cultural bias, and stigma in mental health services. One interview participant shared:

> I would love more intersectional research, also have folks have a better understanding of here's all the things that go into being someone that exists at the intersections of something, that also have experienced trauma, and here are the different ways you can work with people, it's not prescriptive but here's an exploration of all of the different stories that have come out so that you understand that there is a lot of nuance and diversity in the stories.

---

[10] Truth and Reconciliation in Canada refers to the ongoing process of addressing the historical and ongoing harms caused by the colonization, colonial policies, and the residential school system (Truth and Reconciliation Commission of Canada, 2015). The Truth and Reconciliation Commission (TRC) released 94 calls to action outlining steps to address the legacy of harm and to advance reconciliation between Indigenous and non-Indigenous Canadians.

Participants wanted research that addressed the unique intersecting experiences of non-Indigenous racialized TGD people and wanted changes to mental health services and practitioner training that acknowledge cultural differences, practitioner bias, and stigma. Many participants noted how the practitioners with whom they were interacting seldom shared their cultural, ethnic, or racial identities and that many mental health services seemed to be dominated by white practitioners. Participants shared how 2S/LGBTQ+ (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, and Queer) spaces and services also need to consider the intersections of race, culture, and ethnicity with TGD experiences, naming that often these spaces did not feel culturally safe or felt largely white, leaving many participants feeling like outsiders in purportedly “safe” or trans-affirming spaces. They wanted research that could address these gaps and offer recommendations and improvements to services that take cultural, racial, and ethnic diversity into account.

Impact of Geography

Participants emphasized the importance of research that looked at mental health needs and improvements both for diverse experiences and for TGD people living in diverse contexts. Participants wanted to see research that addresses mental health care access and needs for TGD people in both large urban centres but also in rural and remote areas, noting the many Canadian TGD people live in remote places which drastically effects how people access community support, mental health care, and connection to 2S/LGBTQ+ communities. They shared that they wanted to see research that explores not only the differences in needs across diverse location, but also the difference in accessing support, availability of supports (either in-person, tele-health, or online), and training in TGD issues for mental health services in different locations.

Participants wanted to see national data. They shared that regional or location-specific data are helpful, but that larger data sets from national studies may have more political weight when using research findings to advocate for health care access and TGD community needs.

Co-Occurring Needs

Many participants shared that they struggled with co-occurring needs in their mental health journeys and faced barriers to finding mental health care that could address multiple needs. They wanted to know what research was available on the intersections of co-occurring needs and mental health needs for TGD people. For example, several participants noted that eating disorders are often common experiences for TGD people; participants wanted to know more about this, how TGD people could be better supported with eating disorders, how eating disorder support can move away from gendered services and gender-specific models of care, and how eating disorder support can better understand and support care-seekers who are also dealing with trauma.

Understanding Trauma

Understanding and defining trauma for TGD people was identified as a key research question for many participants. One interview participant shared,

> I am really curious, especially with all of the conversations around trans kids these days, really thinking through what does trauma actually look like for our community. Because thinking through my own childhood I'm like, oh a lot of the shit I dealt with from my family was actually abusive but wouldn't be considered emotional abuse or neglect because it's around gender specifically.

They wanted to know what was missing from current understandings and definitions of trauma and how these definitions might change or be different for TGD people. This was particularly connected to experiences for young TGD people who wanted research to explore what trauma is for a TGD child, especially for children who are not affirmed or supported in their gender or are living in situations with caregivers who are transphobic or have anti-trans bias. The understanding that trauma can look and feel different for TGD people was a shared experience, but participants had yet to see or be involved in research that explored this.

Disability, Autism, and Neurodivergence

Experiences of ableism in mental health care was a common experience for many participants. Participants stated that they wanted more research that addressed ableism within mental health services and research that explored how mental health services can be made more accessible for people with a variety of experiences with disability. When speaking about their experience with “disability and transness,” one interview participant urged that what is needed is “healthcare that starts to be able to adapt to and be sensitive to the multiple axis that are affecting people.”

Further, a common question for participants was about the intersection of autism and TGD experience. Workshop participants emphasized that they wanted research “across the whole spectrum” that understands different needs for people across the autism spectrum. Participants wanted research that can respectfully address questions related to this intersection. They particularly wanted research that can identify and better understand how mental health needs, such as trauma, may present differently for autistic people and for autistic TGD people. They emphasized that they wanted research that can improve counselling and mental health services for autistic people and address differences in needs and treatment approaches.

Pathways to Mental Health Care

Research that addressed pathways to care was identified as a priority. Participants want to know how TGD people are actually finding mental health care, how these pathways can be improved, and more understanding of the role and importance of preventative mental health care. Further, participants noted wanting research that could provide in-depth discussion of the positive impacts of gender-affirming care on mental health, the intersections of mental health needs and gender-affirming care, and specific research that can offer TGD people clearer information about health care needs. Participants also wanted more research on the need for accessible mental health care, noting the importance of research that can explore options for delivering mental health care services remotely, such as telehealth and video appointments. They wanted to understand how these approaches support a variety of accessibility needs including increasing availability of services to rural and remotely located TGD people and reducing barriers to attending in-person services.

Participants also highlighted how age was a major factor in barriers to care, highlighting how the intersection of youth and gender can place participants in a gap of available, competent care. One participant shared how understanding how to reach and educate trans youth about gender may be a way to address this gap by:

> . . . finding ways to give young people the tools they need to express and understand gender, I think that that needs more backing from research to prop up and be able to have it in schools and community spaces, and open the conversation up a little bit more so people understand, yeah, people can express that before they turn 18. . .

They wanted to see research that addressed how young people can better access the care they need, navigate age barriers to services, and how to manage moving from youth services to adult services and to support improved continuity of care.

Approaches to Therapy

Last, participants wanted more information and research on what types of therapy are effective and helpful for TGD people, particularly related to trauma. They shared that, in their experiences, not all modalities felt helpful and some felt harmful. They wanted more research that could explore this in-depth and research that can provide an evidence-base for approaches to therapy for which it currently may be harder to find funding or low-cost options (for example: Eye-Movement Desensitization and Reprocessing, Somatic Experiencing therapy, Dialectical Behavioural Therapy). They also noted the importance of approaches to mental health care that went outside of talk-based group therapy or one-on-one talk-based psychotherapy, such as movement-based or arts-based approaches, emphasizing a need for research that looks at community-based mental health supports, peer supports, and cultural supports.

Approaches to Research

Participants shared their perspectives related to how they believed research on the above-mentioned topics should be conducted. Central to all participant suggestions was that research needed to be led by TGD communities or by the more specific sub-communities who are impacted by the research and should be based on community priorities. For example, one participant shared, “I would like to see community-based research where the community determines what they want to be researched, how they want to research it, and what they want to explore” (interview participant). Participants emphasized that lived experience should define the goals of research and that research needs to be community-driven. Further, they shared that academics should be serving community, thinking of research as a service to community members.

Many participants shared wanting to shift the focus of research about TGD topics from TGD people themselves to the providers, for example, having surveys and projects where the participants are the service providers as opposed to the service users. For example, “definitely talking to other people who are accessing these services I think would be huge, but also talking to the people who are providing the service would be really good . . . That would be a really good idea to get both perspectives” (interview participant). The participants wanted research that worked with mental health care workers and medical professionals, such as doctors, nurses, counsellors, social workers, and psychologists to understand their knowledge about TGD people, where their knowledge gaps were, what biases they have, and what they need to know to be able to provide more helpful and accessible care.

The method of the research was also important to participants. They suggested that research that focuses on practitioners could take both quantitative and qualitative approaches, through surveys, interviews, and community events. When research projects have TGD participants, they wanted to see research approaches that showed their humanity. So that the research could offer service providers an understanding of the whole person, they suggested methods such as documentaries, videos, interviews, and storytelling. Further, they recommended that research with TGD people, particularly TGD young people, use lower barrier methods of data collection such as texting, verbal conversations, and art-based methods and involve young people under 18. “I would love to see more forms of non-traditional research, so like art-based, story-telling based, or group approaches would be nice” (interview participant). Participants wanted to see research methods that felt helpful and useful to the people involved. Participation in a research project should offers participants something (reciprocity) and not leave them feeling like they have had their information taken without being a part of the project or being able to benefit from their involvement.

Discussion

Trans and gender-diverse (TGD) communities have had historically complex relationships with both research and with the field of mental health care (Brown, et al., 2018; Gill-Peterson, 2018). Given this history, when considering engaging in research focusing on mental health for TGD people, it is essential that community perspectives be at the centre of the research and drive research goals, methodologies, and outputs. Despite this complex relationship to research, what our participants shared is that they have research topics they want addressed by researchers. They want to see research that is TGD community-led and that answers the questions they have about mental health care for their communities and that addresses gaps in appropriate and useful mental health care for TGD people. In this discussion, we will suggest ways in which researchers can take these priorities into account when engaging in research related to TGD people and their mental health care. While each topic area mentioned by the participants warrants its own discussion, for the purposes of this article, the focus is to summarize considerations for building projects that centre the priorities of the communities with whom researchers work.

Previous recommendations from TGD community-based research (LeBlanc et al., 2022) have urged researchers to combat harmful narratives, arguing that researchers need to focus on strengths, what is helpful, what supports resiliency, and strategies of resistance, and not just disparities. Deficit-focused research can perpetuate disempowering victim narratives (Westbrook, 2021) and unintentionally reinforce discourses that pathologize and stigmatize marginalized groups by focusing on defining groups by their oppression (Veale et al., 2022). Many researchers and community members are calling for future research to move away from (solely) harm-focused research (e.g., Bauer et al., 2019; Ross et al., 2021; Veale, et al., 2022; Westbrook, 2021). Further, researchers are being urged to examine community strategies for care (Bauer at al., 2019) that can not only be led by TGD people but can centre resilience and empowerment. Research would do well to shift to a focus on what is helpful and what strategies TGD communities are building to support resistance to ongoing systemic oppression. The participants in this study echo these calls for a move away from research on TGD people that only focuses on harms and deficits. The findings also push this call further by asking for future research to shift the focus from research on TGD people and their experiences to research that specifically looks at the practitioners and service providers working with these communities. Research that looks at the structures, systems, and organizations is also needed. A vital detail of this is that the youth felt that research must still be led by, and directed by, TGD people's voices and priorities. They wanted to see the focus of the research move from the research participants being TGD people themselves to placing practitioners, services, and systems as the focus of the research. The calls for research from the participants in this project ask that future researchers be creative in building projects that shift the focus to improving service provision and continue to centre the needs and priorities of TGD people. By calling for research that shifts the focus from TGD people accessing mental health care to a focus on providers, participants are pushing back against deficit-focused narratives and an over-focus on harm experienced by TGD people.

Some topics identified by participants, such as the intersection of autism and TGD experience, are areas of research that participants wanted more than ever to be driven by TGD people's priorities and direction. Misinformation (e.g., Rowling, 2020), misleading research (e.g., Littman, 2018), and misrepresentative expertise (e.g., see Montpetit & Gilchrist, 2023) can be used in the public sphere to fuel anti-trans discourse that can lead to revoking access to gender-affirming care for youth (e.g., Redfield, et al., 2023) and policies in schools that threaten the safety of TGD youth (e.g., Johnson, 2024). While there is continually effort to address harmful and misrepresentative research (e.g., Skinner et al., 2014; Restar, 2020), for future research on these topics, participants felt that it is essential that TGD people are engaged at all steps of the research process to avoid biased results or misrepresented findings.

Much of the available literature on TGD people, healthcare and mental health care focuses on gender-affirming medical care, such as hormone replacement therapy and gender-affirming affirming surgical procedures. Veale et al. (2022) call for researchers to look at trans health beyond medical and surgical transition. Throughout the conversations with participants in this project, when considering mental health research, very few of their research questions related directly to gender-affirming medical care. What the participants wanted was research that addresses barriers to accessing care and that addresses the multifaceted lived experiences of diverse TGD people. TGD people are more than just their medical care, and research needs to reflect the whole humanity of this population. It is important that research not conflate all mental health needs and experiences of TGD people with needs related to gender-affirming medical care (Veale et al, 2022). While gender-affirming medical care continues to be an important aspect of many TGD people’s experiences, for the participants in this project, it did not surface prominently when discussing mental health research priorities, even within the context of ongoing debates regarding access to medical care for TGD young people internationally (e.g. Redfield et al., 2023). As Veale and colleagues (2022) suggest, future health research for TGD people can and should look at health beyond medical and surgical care. It is important that future research not replicate narrow understandings of trans lived experiences by limiting research to solely focusing on gender-affirming medical care and associated barriers and challenges.

Findings from this study parallel similar research on TGD priorities for future research (e.g., LeBlanc, 2022; Ross et al., 2021; Veale et al., 2022) but, importantly, this study particularly examines priorities related to mental health care and the perspectives of young TGD people. Representation of diverse, multifaceted experiences was echoed throughout participants' questions and the experiences they shared in the project. Future research could approach these topic areas by considering how intersecting experiences place TGD people at unique gaps with structures and systems of care and create barriers that are often not discussed or given attention in the extant literature. In an article recounting research priorities from TGD community health centre patients, LeBlanc et al. (2022) report that the first priority for TGD community members is "understanding the complexity of identities," (p. 4) directing future researchers to consider intersectionality (Clark, 2016; Collins, 2015; Crenshaw, 1989; 1991) and diversifying demographics through intentional recruitment strategies. Future research that takes up intersectionality must be intentional about utilizing this framework to analyze power and avoid pitfalls of mis-applying intersectionality by only focusing on diversity in their participant sample. Ross et al. (2021) wrote that participants noted a need for research that explored topics such as trans people with disabilities/chronic illness and the impact of childhood trauma. These findings parallel priorities outlined by the participants in this project, emphasizing a need for research that explores trans people's experiences across intersections of experiences and identity, such as disability and gender. Further, Ross et al.'s (2021) findings related to childhood trauma speak to the participants' desire to understand and define the specific experiences in TGD people's childhoods that are felt as traumatic by the individual but currently would not be understood as such under typical definitions of trauma (e.g. childhood verbal abuse or gender-based child abuse). Advancing research about these unique experiences could help define new understandings of trauma specific to TGD young people's experiences.

Research priorities shared by the participants focusing on nonbinary identities and experiences echo previous priorities shared by Ross et al. (2021). Nonbinary experiences are often included under the umbrella of trans men and trans women; however, as many participants and other researchers (Goldberg et al, 2019; dickey et al., 2016; Matsuno, 2019; Matsuno & Budge, 2017) have noted, nonbinary people have unique experiences of gender and face unique experiences of stigma, discrimination, and erasure. Further, as Ross et al. (2021) found, many nonbinary people are frustrated by the lack of attention to nonbinary concerns in the research literature, despite a growing awareness of nonbinary identities. This was particularly important for Indigenous nonbinary participants in this project, who noted that nonbinary gender experiences that are connected to cultural identity, such as their experiences as Two-Spirit, nonbinary people, often are completely missing from discussions about trans and gender-diverse people.

The participants called for future research to centre Indigenous experiences and perspectives, particularly Two-Spirit experiences. Future research on these specific topics should be led by Indigenous Two-Spirit and TGD people and can follow the lead of work already being done by Indigenous scholars working in health and mental health related contexts (e.g., Clark, 2016; Laing, 2021; Pruden, et al., 2023). Attention to the importance of cultural and Indigenous identity is crucial in discussions about mental health and mental health services for Indigenous Two-Spirit and TGD people. Further, research in these areas must include attention to how the systemic context of colonialism and intergenerational trauma stemming from enforcement of colonial gender norms through institutions such as the residential school system (Hunt, 2016) continues to create gendered gaps in Indigenous health research. Currently, these discussions are often siloed, and future work should explore intersections of Indigenous scholarship and TGD mental health research while maintaining an analysis of the systemic and structural context.

Much previous research has identified that there is a crucial knowledge gap that TGD individuals are experiencing when they access services (Ellis, 2020; Lange, 2020; Mizock & Lewis, 2008; Morris et al., 2020; Richmond, Burnes, & Carroll, 2012; Shipherd et al., 2011). Future research can move beyond identifying this gap and actively work to offer practical and applicable recommendations for improving practice. The field of mental health care, across different professions such as psychology, psychiatry, psychotherapy, counselling, social work and youth work fields such as child and youth care, have relationships with TGD communities that are "deeply complex" (Kia, et al., 2022; p. 3173).). Mental health care settings can be sites of violence and harm for TGD people (Blodgett et al., 2017; Brown, et al., 2018; Navarro, et al., 2022). Research focused on providing evidence to inform these practices need to take into account this historical and contemporary complexity and actively work to center the perspectives and priorities of TGD communities. As Veale et al. (2022) note, there are guides and training programs that have been designed to make health care more inclusive, affirming and accessible for TGD people; however, there is limited research on whether or not these are effective (e.g., Boot-Haury, 2023) and how they can be more effective, while TGD people continue to experience harms in healthcare settings.

Similarly to findings in this study, Veale et al. (2022) also call for future research to look at how psychotherapy approaches can be better adapted to meet the needs of TGD clients. While there are some such studies (e.g., Hendricks & Testa, 2012; Matsuno, 2019), there remains a gap in evidence-based practice approaches specific to trauma that have been researched with TGD clients (Lange, 2020; Livingston, et al., 2020). As Veale et al. (2022) suggest, future research needs to evaluate the usefulness of adaptations from clients' and providers' perspectives.

Some of the topics of interest identified by the participants in this study are already being explored in research, for example, TGD young people's experiences of eating disorders (e.g., Hartman-Munick et al., 2021; Simone et al., 2022) and mental health care experiences of TGD people of colour (Erby & White, 2022; Sadika et al., 2020; Singh, 2017; Singh et al., 2023). This points to possible weaknesses and opportunities in knowledge mobilization/translation from the available literature to practice approaches and to the TGD community. While research may exist or be in progress on topics that are important to TGD communities, the practitioners and services with which TGD people are interacting and the programs training new practitioners are not always taking up this research into their approaches. This speaks to an ongoing challenge in health-related fields. Practitioners staying up to date on current research and practice approaches is a matter of individual motivation and availability to do so, among other barriers (e.g. Peters-Corbett et al., 2023; Rapp et al., 2009). This in turn, speaks to a larger systemic issue that practitioners do not always have the time to engage in continuing education or professional development that incorporates the most recent research and practice innovations into their work.

In order to facilitate future research on these priority areas, funders can target funding calls based on priorities articulated by community members. Funders who have already created mandates for sex-and-gender based research (for example, within Canada: Canadian Institutes of Health Research, 2021) can target funding calls based these findings and other evidence that centres community perspectives on research priorities (e.g. LeBlanc et al., 2022; Ross et al., Veale et al., 2022). Funders who are responsive to community-based priorities can better support researchers to be able to engage in research that addresses topics and utilizes methods that communities are calling for. Within contexts where federal or regional policies have been developed for advancing and protecting the rights of 2S/LGBTQ people, for example within Canada the *Federal 2SLGBTQI Action Plan* (Women and Gender Equality Canada, 2022), funders can draw on findings such as the ones from this project, to inform calls for funding and funding initiatives. Particularly when key funding bodies have mandates in place focused on sex- and gender-based research (e.g. Canadian Institutes of Health Research, 2021), funders can address these calls to action from community-based research to facilitate that future research can ensure a focus on community-driven perspectives and priorities.

Limitations

Findings presented represent the perspectives of this unique group of participants and cannot be generalized to TGD people as a whole nor to TGD people of all ages. While many of the findings parallel results in other studies focused on TGD priorities (LeBlanc et al., 2022; Ross et al., Veale et al., 2022), the participants were mostly young adults and represented a diverse range of gender, racial, and ethnic identities as well as a range of socio-economic backgrounds. Further, this was a qualitative study that engaged with a limited number of participants, while the findings align with other similar studies, future projects may consider how to reach broader audiences through the use of surveys or other quantitative approaches to incorporate more perspectives and direction from TGD communities. Additionally, future research may consider other methodologies that can synthesize existing data from community-based projects calling for similar changes to mental health care systems and structural barriers.

Participants were asked for their priorities for improving mental health care within the context of a study that was focused on trauma-related mental health care. Because participants were asked about their experience needed or wanting trauma-related mental health care, participant responses focused on voluntary experiences with mental health services. Experiences focused on involuntary mental health care is a critical area for future research to address.

The first author and three of the community advisors all have experience as mental health service providers. This speaks to the complexity of researching with our communities and with multiple roles and lived experiences, intersections of which can influence research processes and participant findings. While all of these contributors also have lived experience of mental health services and are trans and gender-diverse, participant engagement and responses, as well as analysis may have been influenced from the perspectives of services providers working on this topic area. Future research design may consider a community advisory committee that does not include any service providers or a design that has two advisory committees, one consisting of service providers, and one made up of service users.

This project engaged with participants who were recruited through online recruitment methods and community organizations. This limited the sample to individuals who had access to internet and social media and to young TGD people who were connected to community organizations. The project recruitment did not reach individuals who were incarcerated, which is more common among TGD people (Jacobsen et al., 2023). This limitation was identified by the community advisory committee and requested to be named in the dissemination of the results. Future research can seek to engage with TGD people who have experience with incarceration because their perspectives on mental health care research priorities and needs are important to include in the discourse. This project identified broad topic areas of interest based on the participants' experiences and perspectives, future research projects should work with TGD people to identify and refine specific questions and to finalize the appropriate methodological approach.

Conclusion

The goal of sharing these findings is to offer research funders and future researchers insight into what community goals and priorities are for TGD young people related to improving mental health. Throughout the discussions with the participants in this project, there was a resounding call for mental health care services for young TGD people to improve. They identified a dire need for better education so that practitioners and service providers that can offer all young TGD people competent care that is culturally appropriate and relevant, understands diverse experiences of people with TGD identities, and takes into consideration the multifaceted experiences people bring with them when attending mental health care services.

This article provides novel insights into the specific priorities of TGD young people related to mental health research. Building on the work of others who have outlined research priorities for TGD health through literature reviews (e.g., dickey et al., 2016), trans community perspectives (e.g., LeBlanc et al., 2022; Ross et al, 2021) and trans researcher and lived-experienced perspectives (Veale et al., 2022), this article adds to the literature by offering the perspectives of young TGD people on mental health research priorities outside of priorities related to medical or surgical care. Participants urged future researchers to consider how research can be led by TGD young people. By building research projects that centre TGD youth priorities, mental health services and interventions can be better prepared for and relevant to TGD young people.

Chapter 5: Conclusion

Returning to the question that opened this dissertation: what does it mean to have safe and accessible mental health care? For the participants in this project, it means having care that feels like it cares about you, that the service providers delivering that care recognize you and demonstrate an understanding and respect of your lived and living experiences. It means having care that is available when you need it, that listens to what you need, and prioritizes your voice and experience. It means having this sense of care reflected in the practitioners and systems within which the care occurs. And while obvious as it may seem to state that in order for care to feel safe and accessible, it needs to feel like it cares about you; it is apparent that this is not the perception that TGD young people have of the care with which they are currently interacting. Despite decades of research demonstrating the need for appropriate mental health for TGD communities (e.g., Shipherd et al., 2011; 2019; Mizock & Lewis, 2008; Scheim et al., 2021; Veale et al., 2015; 2017), existing systems of care still often fail to provide adequate, accessible, and affirming mental health care for TGD people (Ellis, 2020; Mizock & Lundquist, 2016; Navarro et al., 2022). As the current findings have offered, mental health therapeutic environments that foster trust, recognition, and safety for TGD young people are too few and far between.

This dissertation presented three empirical articles focused on the how TGD young people respond to the barriers they encounter when finding trauma-related mental health care, their experiences with mental health practitioners, and their priorities for future research on improving mental health care. The findings emphasize the need for structural changes that support TGD young people in finding and accessing equitable health care and underscores the importance of intersectional perspectives on delivering mental health care for TGD young people. These findings reveal a persistent lack of trust in mental health systems but also the perseverance of TGD young people to access the care they need. Despite repeated experiences of unhelpful and sometimes even harmful care, the participants demonstrated that they still were pushing to get the help they believed they needed and deserved despite interacting with a system that they felt was not seeing them or offering them support that was appropriate or felt safe.

The challenges outlined in the first article demonstrate how specific barriers to care, such as eligibility requirements and the time it takes a young individual to locate an appropriate service, are compounded by health system issues such as high service costs and extensive wait times, which can further isolate young TGD individuals from accessing the care that they need. Even when services are available, they often fail to address the intersecting identities and unique lived experiences of young TGD individuals, such as their race, cultural background, socioeconomic status, and co-occurring mental health needs. Consequently, young TGD people frequently find that the (lack of) available mental health care does not adequately meet their needs or can even exacerbates their distress. TGD young people are navigating these barriers by developing their own mental health literacy through individual research and connection to community knowledge to help them understand what services they need and available pathways to care. Further, they are relying on their own persistence and self-advocacy to access the care they need. All of these strategies take time and energy that further burdens young TGD individuals seeking support for trauma-related needs. Together, the findings emphasize the need for structural and systemic changes that support young TGD individuals in achieving equitable mental health care, underscoring the importance of intersectional approaches within mental health services. While health systems change takes time, the immediate needs of TGD young people may be addressed by looking for ways to support and facilitate community-responses to mental health needs that are already taking place. For example, directing funding to community and peer organizations that are providing mental health interventions outside of the health system, building on community peer knowledge by funding and training peer navigators, and developing peer training programs that can support the peer-to-peer support that many TGD young people may be already relying on in the absence of being able to access professional services.

A common barrier articulated by participants was the experience of fragmented identity-focused services (e.g. single gender-based services, single culture-based services) which created dilemmas for choosing which part of themselves they should place as most relevant to the support they need. This speaks to the ways in which TGD young people are not feeling fully seen or recognized by the services and practitioners with whom they interact. Addressing this challenge means that services and systems of care must not further silo services based on identity nor focus on superficial models of diversity and inclusion when addressing barriers to care. Instead, systems of care must be built to respond to individuals in all the complexity that their experiences may hold.

Changes in access to care can look at a range of ways to address the gaps in service provision. Larger systemic issues such as under-funding and low prioritization of mental health lead to barriers in getting care such as long wait-times, lack of practitioners, and high costs for services. Changes that address these barriers must happen at multiple levels of the mental health care system, including at the individual practitioner level, organizational level, and larger policy, political, and social level.

While organizations may be able to address certain barriers such as availability of information about their programs, intake and eligibility requirements, or training for their staff, these changes will always fail to fully offer the scope of care needed when funding streams and political and social attitudes do not prioritize funding for mental health care services (or for TGD communities). TGD young people are seeking mental health services for trauma-related needs across a range of settings, including health authorities (hospitals, clinics, and community programming), community organizations, school-based services, private practice counselling, psychology, and psychiatry, and online programs. This means that changes to mental health care and shifts in practice need to be taken up across this range of settings, and that service providers working in a range of capacities can consider shifts in the ways that why show up and demonstrate safety to their young TGD clients and patients.

The second paper explored the idea of trust and recognition in the therapeutic relationship as a foundation to safety. While the safety and trust built in a therapeutic relationship can feel hugely helpful to individuals across a range of challenges, this felt sense of trust and recognition was few and far between for young TGD participants. Through describing what safety felt like within these contexts, they identified that feelings of being able to be seen, understood, and recognized within their own experience by their practitioner was critical to building trust and a sense of safety. Further, safety was not a passive feeling but rather an active engagement in building relationships and spaces where there were plans to address harm when harm occurred. Participants shared that there was always a risk when working with a practitioner, and that safety started from feeling able to take this risk to trust their practitioners. From this, practice recommendations were developed that include considerations for how practitioners can engage in intentional acts of accountability and recognition and demonstrate authentic understanding and recognition of their clients’ experiences and perspectives.

The third paper presented findings from the community consultation portion of the Transforming Supports project, focusing on the participants' priorities for future research related to improving trauma-related mental health care for TGD youth communities. While much of the available literature suggests more research is needed in this topic area (e.g., Ellis, 2020; Lange, 2020; Shipherd et al., 2019), this paper offers direct examples of research topics TGD young people wanted researchers to explore. By having specific topics articulated by community members, future research can ensure that it is focused on the topics that are a priority to TGD young people seeking mental health care services. The research priorities articulated by participants echo the calls to be seen and recognized in their mental health care experiences and urges future researchers to work with TGD communities to develop research projects that reflect the real lived experience of TGD people.

The findings from this study share an overarching theme: TGD young people do not feel seen, witnessed, or reflected by the mental health care systems with which they interact. This lack of witnessing within the mental health care system and from mental health care practitioners is creating a critical gap in services not currently feeling helpful or safe. The following section offer three perspectives on the role of witnessing: witnessing as the work of trauma recovery (Herman, 1997; Meyer, 2012), witnessing as integral to gender identity (Devor, 2004), and witnessing as methodology (Hunt, 2018). Bringing these perspectives together offers insight into the ways in which the current mental health care system is not witnessing TGD young people in their experiences and is creating a critical gap in the experience of safety within this system of care for TGD people. Following this, I offer some considerations for future directions for improving mental health care for TGD young people.

Witnessing

In my experience as a counsellor, the foundation of the therapeutic relationship is truly witnessing someone and their experience. Witnessing who they are, their emotions, their experiences, and who they see themselves to be and reflecting this back to them in a way to demonstrate seeing, understanding, and recognizing them. Witnessing is a key missing element from the mental health care experiences of TGD young people. This lack of witnessing impacts TGD people's ability to feel safe and to feel recognized and respected within mental health care contexts. When their experiences and their selves are not witnessed by those with whom they interact people feel unseen and unrecognized. Without feeling seen and without feeling recognized, safety is not possible in a therapeutic context. When we consider what it means to have safe and accessible mental health care, feeling seen and understood appears to be central to the possibility of safety. The participants articulated that being seen, recognized and understood was the crux of feeling safe with a practitioner. When practitioners could demonstrate to their clients that they understood them and saw them in their whole selves, clients experienced safety. What this tells the larger mental health system is that systems and services need to shift to be able to see and recognize and witness diverse experiences.

Witnessing as the Work of Trauma Recovery

A critical element of working with trauma is the act of witnessing (Herman, 1997; Meyer, 2012). "Witnessing is a powerful force that allows massively traumatic experiences to become known and communicated" (Goodman, 2012, p. 3). Part of the role of the mental health practitioner in this is to be the witness to the client's experience and their story. While the work of trauma recovery is in part being able to "speak the unspeakable" (Herman, 1997, p. 183), the role of the therapist is to hear the unheard and to be a witness to an individual's experience that has gone unwitnessed (Herman, 1997). What the findings from this project demonstrate is that TGD young people are not experiencing this with their mental health practitioners. When TGD young people have to choose which parts of their selves and their experiences they must hold back in order to get some services, they are not able to be witnessed in their full experience because the systems of care are not structured to see or recognize these experiences.

Practitioners have not been trained adequately to be able to demonstrate recognition and to fully witness TGD young people's experiences. The trauma industry has been built around a recognition of certain types of experiences as traumatic and has yet to respond effectively and appropriately to more complex and multifaceted experiences where trauma has affected a person. A system needs to recognize that something is traumatic in order to be able to provide trauma services or incorporate considerations for this into trauma-informed approaches. Practitioners need to be educated not just in TGD young people's identities but explicitly educated about TGD young people's experiences and the impacts of living in a society that does not see or recognize them. The mental health care field is (and foreseeably will be) contending with a complex history of negative experiences for young TGD people, including pathologization and stigmatization of trans identities (Gill-Peterson, 2018; Navarro, et al., 2022). Practitioners working in mental health care settings with young TGD people must contend with this complex history that often failed to witness and recognize TGD young people's experiences and perspectives. There is a long way to go for this system to truly be able to see and witness TGD young people's experiences in ways that feel safe and supportive. While practitioners can work to change their own individual approaches and attitudes with young TGD clients, this cannot combat a system that is not designed to see and respond to the needs of diverse populations. The mental health care systems need to address the structural barriers that do not see or recognize diverse experiences. A starting place may be to address the ways in which current training does not adequately train practitioners to see and witness TGD young people's experiences; however, larger scale changes related to policy and structural access must also address the ways in which the system as a whole does not recognize and witness TGD people's experiences and needs.

Witnessing as Integral to Gender Identity

Devor (2004) offers that two overarching themes present throughout trans identity formation are witnessing and mirroring. Being witnessed as oneself by others is integral to one's sense of gender and one's sense of self: "each of us has a deep need to be witnessed by others for whom we are" (Devor, 2004, p. 46). Existing in a world that does not want to see and recognize your experience is vastly isolating and can be profoundly traumatic.

Devor (2004) suggests that the effectiveness of witnessing is due in part to feeling seen by others outside an individual's own categories of self-definition, to be seen as valid by someone who is different from you. Incorporating this application of the role of witnessing to the therapeutic context, the practitioner as a witness with TGD clients is doubly important, not only do they serve as a witness to experiences and stories that have been unspeakable, but also as a witness as an outsider, that can witness and see as valid the TGD client's TGD identity and self. In the mental health context, the practitioner may be seen as an outsider to the young TGD client for several reason, for example: being the role of practitioner and not client, the practitioner may be older than the client, and the practitioner may also not share a TGD identity. When practitioners do not witness a TGD individual or do not demonstrate recognition, not only do they disrupt their role as a witness to the client's story in a therapeutic capacity, but also fail to act as a witness to the TGD person as the TGD person sees themself, failing to act as a witness to their identity and their sense of self.

Mirroring, as Devor (2004) uses it, suggests that seeing oneself in the eyes of others like oneself is a deep need integrally connected with developing one's self-identity and sense of self. What the participants shared in this project was that they felt safety and recognition from others like themselves, and this was often an easy starting point for seeking safety. What this can tell us about improving mental health care is that diverse experiences need to be welcomed and encouraged in training programs for mental health practitioners. Addressing systemic barriers that impede individuals accessing training and working in these fields can offer a wider range of practitioners with whom individuals can work, offer more opportunities to feel safety, recognition and feel mirrored by their practitioners. Mirroring is not something that can be taught, it is about thinking about who is being invited into the field and who is available to work in roles with which TGD young people interact.

Alongside this, witnessing may be the area of practice that can be taught. When a fundamental lack in the health care system is a sense of being witnessed, developing ways of training practitioners to not only see but to recognize and witness TGD people's experiences and own self-definitions is essential. A starting place may be to focus on the ways that practitioners can demonstrate their recognition and witnessing through signals of safety to their clients. This is an area of practice that must be explored further with TGD young people to develop training approaches and specific practice recommendations for practitioners. Further, systems of care need to be restructured to offer opportunities of recognition and witnessing. This focus of systems-level change is one where continued work and thinking needs to occur. Future research working with TGD young people, TGD communities more broadly, service providers can explore how to envision changes to the current health systems that can address the barriers TGD young people are currently facing.

One pathway towards this may be to structure access to care in ways that expect diverse experiences instead of placing intersectional experiences as the exception, creating pathways into care that do not rely on single categories of experience for eligibility or singular definitions of trauma and mental health needs. Systems of care must shift to bring to the centre the experiences that have been pushed to the periphery by society.

Witnessing as Methodology

Looking to the knowledge of Indigenous communities and scholars, witnessing can be seen as a deeply important relational responsibility. As Hunt (2018) describes, speaking of witnessing as methodology in Indigenous cultural contexts, "witnessing is about the persistent reintegration of voices of people who have been pushed to the periphery in processes of knowledge creation. It is about making visible and audible those members of our communities who are being silenced, forgotten, erased, and spoken over" (p. 293). Here, Hunt (2018) offers that witnessing is not only about witnessing the speaker's story but can offer a methodological approach to that is not just "simply hearing, seeing, or being told something. Witnessing here is taking up a specific role in maintaining the integrity of Indigenous knowledge and community. It entails not just an obligation to recall but to act" (p. 292). This approach to witnessing calls the witness to not only hold and uplift the stories that are witnessed but to take action to address the ways in which the witnessed story is being made invisible or silenced. Practitioners may look to this approach to as a means to understand the importance of witnessing their clients' experiences. This may be of particular importance for non-Indigenous practitioners to consider their role in the act of witnessing silenced stories. As Hunt (2018) suggests, self-reflection is vital to fulfilling responsibilities as a witness. Changes require that practitioners engage in deep reflection, thinking through the way in which practitioners and services currently approach care may not be seeing, understanding, recognizing, and responding to TGD young people's lived experiences.

These three theories of witnessing can overlap in the context of TGD young people's experiences of mental health and trauma services to offer a framework for understanding what is missing from this care right now. When being witnessed is not only crucial to a sense of being seen in one's gender but also fundamental to trauma work, when the mental health care system is not able to witness TGD young people and their experience, there is a fundamental flaw. The mental health care system is failing to witness TGD young people in their experience and their traumas, it is not witnessing them in their gender experience, and by not witnessing them it is failing relational responsibilities crucial to the therapeutic work and the work of maintaining the integrity of TGD peoples' knowledge, experience, and community.

Considerations for Practice and Future Directions

One of the primary goals of this project when I started this work was to be able to provide practical recommendations to practitioners working with young TGD people. Throughout all of this work, and shared throughout the participants' stories, the most prevalent and pressing recommendation is for practitioners to recognize and witness the humanity and complexity of young TGD people demonstrated through the actions and responsiveness of the practitioners. While this seems frustratingly obvious to name as the key finding from this project, what rings true is that this is resoundingly missing from current experiences of TGD young people searching for and experiencing trauma-related mental health care. While one of the primary goals was to provide practical recommendations to practitioners, there is not a clear answer on how to train practitioners to be able to witness and demonstrate recognition to their young TGD clients. This is an area that needs specific attention in future research, working with young TGD people to define research approaches and questions and shift the focus on how teaching witnessing can happen. Drawing on community knowledge and existing community-driven peer supports (e.g. Native Youth Sexual Health Network, 2021), training for professionals can complement the mirroring (Devor, 2004) work that is being done in peer community contexts. A future direction for this work can be understanding how we can teach recognition and witnessing of TGD experiences to current and aspiring practitioners. This is a step further than developing models that speak to trans competency, but a move towards developing practitioners' intersectional literacy to be able to respond to diverse experiences in ways that demonstrate recognition and foster a sense of being understood and seen across a range of experiences, not tied to specific identities or cultural competencies. Intersectional trauma support needs to acknowledge how current approaches to trauma-related mental health care are leaving a gap in appropriate responses and not acknowledging the diversity of experiences that may enter a therapeutic environment. A critical future direction for this work is exploring how these skills can be taught and what methods of training and education can truly teach and train practitioners to adequately and appropriate respond to the needs of their young TGD clients seeking support for trauma.

This project started from community experience, working with and hearing from TGD young people who were struggling to find mental health care that felt useful, safe, and accessible. As Hunt (2018) offers, "as witnesses, our role is not to take up the voice or story we have witnessed, not to change the story, but to ensure the truths of the acts can be comprehended, honored and validated" (Hunt, 2018, p. 292.) At the end of the project, what I realize is that this project serves as witness for the experiences of TGD young people and their mental health journeys. Looking at the work I completed in collaboration with the community advisors and community partners, I see that this can be considered an act of witnessing, an attempt to ensure that the truths of the participants experiences can be comprehended, and a call to mental health practitioners to act with this knowledge. It is my hope that by representing the stories and perspectives of the individuals that participated in this project and for others with similar experiences to read and see these stories that the work of witnessing can be offered as a means for this work, while difficult, to also add to healing and recovery, and resilience for TGD people and communities. TGD young people know these things already, their stories and experiences are being mirrored (Devor, 2004) within TGD communities. This information needs to reach the services and practitioners who are not seeing these issues. The experience of TGD young people need to be witnessed by the systems and the practitioners with whom they interact. When safety means being seen, then systems of care need to shift to be able to see and respond to TGD experiences. In all of this, a remarkable thing to witness is that TGD young people keep pushing for the care they know they deserve.

References

Chapter 1

Ahmed, S. (2006). *Queer phenomenology: Orientations, objects, others*. Duke University Press.

Alessi, E. J., & Martin, J. I. (2017). Intersectionality and policy research on homelessness. *Sexuality Research and Social Policy, 14*(4), 434–449.

Applegarth, L., & Nuttall, J. (2016). Understanding trauma: Reflections on trauma-informed care. *Australian Family Physician, 45*(5), 295–299.

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*(5), 469–480. https://doi.org/10.1037/0003-066X.55.5.469

Austin, A., Craig, S. L., & Alessi, E. J. (2017). Affirmative practice with LGBTQ+ people. *Psychology of Sexual Orientation and Gender Diversity, 4*(3), 334–347.

Barr, C. (2018). Trauma and recovery in a gendered context. *Journal of Trauma Studies, 24*(2), 14–32.

Blodgett, E., Boyce, W., & Sutherland, R. (2017). Using community-based participatory research methods. *Canadian Journal of Public Health, 108*(3), 235–240.

Boilevin, L., Alvardo, E., & Tijerina, G. (2019). Participatory approaches in marginalized communities. *Social Work Research, 41*(2), 148–157.

Brammer, R., & Ginicola, M. (2017). LGBTQ issues in counseling. Journal of Counseling *Research and Practice, 5*(1), 123–145.

Briere, J., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Sage Publications.

Campbell, R., Greeson, M., & Fehler-Cabral, G. (2019). Trauma-informed research principles in action. *Violence Against Women, 25*(5), 4757–4786.

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies. *Signs: Journal of Women in Culture and Society, 38*(4), 785–810.

Clark, A. (2016). Trans and nonbinary mental health experiences. *International Journal of Mental Health, 45*(3), 215–229.

Cole, A. (February 17 2025). 2SLGTBQ+ community worries about Trump's anti-trans rhetoric coming to Canada. *CBC News*. https://www.cbc.ca/news/canada/newfoundland-labrador/2slgbtq-rally-stjohns-1.7460883

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology, 41*, 1–20.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex. *University of Chicago Legal Forum, 1989*(1), 139–167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299.

dickey, L. M., Singh, A. A., & Burnes, T. R. (2020). Affirmative and trauma-informed care for transgender and nonbinary individuals. *Journal of Counseling Psychology, 67*(5), 588–602.

DiFulvio, G. T. (2015). Transgender youth and mental health. *American Journal of Public Health, 105*(5), e74–e81.

Ellis, S. J. (2020). Barriers to trans health care in mental health services. *Social Science & Medicine, 112*, 10–17.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477. https://doi.org/10.1002/jcop.20063

Ferlatte, O., Salway, T., Rice, S., Oliffe, J. L., Rich, A. J., Knight, R., Morgan, J., & Ogrodniczuk, J. S. (2019). Perceived barriers to mental health services among Canadian sexual and gender minorities with depression and at risk of suicide. *Community Mental Health Journal*, *55*(8), 1313–1321. https://doi.org/10.1007/s10597-019-00445-1

Gill-Peterson, J. (2018). *Histories of the transgender child*. University of Minnesota Press.

Hall, A., & Delaney, M. (2021). Trans youth in psychotherapy. *Journal of LGBTQ Issues in Counseling, 15*(1), 18–34.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence*. Basic Books.

Hunt, S. (2016). *An Introduction to the health of Two-Spirit people: Historical, contemporary and emergent issues*. National Collaborating Centre for Aboriginal Health.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research. *Annual Review of Public Health, 19*, 173–202.

Keating, A., & Muller, J. (2020). Trauma-informed approaches for LGBTQ youth. *Counseling LGBTQ Clients, 12*(3), 157–165.

Lange, C. (2020). Trauma therapy in the context of minority stress. *Trauma Studies Quarterly, 6*(4), 44–52.

LeBlanc, A., Frost, D. M., & Wight, R. G. (2022). Minority stress and resilience among LGBTQ people. *Journal of LGBT Health Research, 12*(1), 1–10.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Haworth Clinical Practice Press.

Lezard, P., Prefontaine, N., Cederwall, D-M., Sparrow, C., Maracle, S., Beck. A., & McLeod. A (April 2021). 2SLGBTTQIA+ Sub-Working Group. MMIWG2SLGBTTQIA+ National Action: Final Report. OFIFC: Toronto

Livingston, N. A., Berke, D. S., Scholl, J. L., Ruben, M. A., & Matza, A. R. (2020). Cultural considerations in trauma-focused care. *Journal of Clinical Psychology, 76*(7), 1160–1173.

Lumivero. (2024). *NVivo* (Version 15). Computer Software. https://lumivero.com/products/nvivo/

MacLeod, K. B., & Brownlie, E. B. (2014). Mental health and transitions from adolescence to emerging adulthood: Developmental and diversity considerations. *Canadian Journal of Community Mental Health*, *33*(1), 77–86. https://doi.org/10.7870/cjcmh-2014-007

Matsuno, E. (2019). Barriers to transgender mental health care. *Transgender Health, 4*(1), 87–95.

Million, D. (2008). *Therapeutic nations: Healing in an age of Indigenous human rights*. University of Arizona Press.

Mizock, L., & Lewis, T. K. (2008). Mental health disparities for transgender individuals. Clinical *Psychology Review, 28*(8), 1049–1058.

Mizock, L., & Lundquist, C. (2016). Affirmative practices in clinical settings. *Professional Psychology: Research and Practice, 47*(1), 37–45.

Namaste, V. K. (2000). *Invisible lives: The erasure of transsexual and transgendered people.* University of Chicago Press.

Navarro, J., Lachowsky, N., Hammond, R., Burchell, D., Arps, F. S. E., Davis, C., Brasseur, J., Islam, S., Fosbrook, B., Jacobsen, H., Walker, M., Lopez, C., Scheim, A., Bauer, G., & on behalf of the Trans PULSE Canada Team. (2021). *Health and well-being among non-binary people*. https://transpulsecanada.ca/research-type/reports

Norcross, J. C., & Lambert, M. J. (2019). Psychotherapy relationships. *Journal of Clinical Psychology, 75*(3), 365–377.

Panchal, R., Shipherd, J. C., & Lang, K. (2022). Best practices for trans-inclusive care. Trauma-*Informed Clinical Practice, 14*(2), 211–225.

Pruden, H. & Salway, T. (2020). “What and who is Two-Spirit” in health research. *Meet the methods (2). CIHR: Institute of Gender and Health*. https://cihr-irsc.gc.ca/e/52214.html

Redfield, A. K., Zhang, Y., & Luo, T. (2023). Anti-transgender policies in global contexts. *Public Policy Research Quarterly, 15*(3), 411–428.

Richmond, K., Burnes, T., & Singh, A. (2012). Recommendations for supporting transgender survivors of trauma. *Journal of Trauma Studies, 18*(2), 49–60.

Ross, N., Westrup, Y., Hwang, B., Sierra, L., Nordstrom, A., & Kyriak, R. (2021). *Four corners: Health research priorities among TNB communities*. https://howardbrown.org/wp-content/uploads/2021/03/FourCorners-HealthResearchPrioritiesAmongTNBCommunities_Final_3_21.pdf

SAHMSA’s Trauma and Justice Strategic Initiative. (2014). *SAMHSA’s concept of trauma and guidance for a trauma-informed approach*. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

Scheim, A. I., Bauer, G. R., & Pyne, J. (2021). Transgender health inequities in Canada. *Canadian Journal of Public Health, 112*(5), 725–735.

Singh, A. A., & dickey, L. M. (2016). Affirmative approaches to trans mental health care. *Journal of Clinical Counseling Psychology, 62*(4), 588–602.

Singh, A. A., & dickey, L. M. (2017). *Affirmative counseling with transgender and gender nonconforming clients.* American Psychological Association.

Steinmetz, K. (2014). The transgender tipping point. Time. Retrieved from https://time.com/135480/transgender-tipping-point/

Thom, K. C. (2019). *I hope we choose love: A trans girl's notes from the end of the world.* Arsenal Pulp Press.

Thom, K.C. [@kaichengthom]. (2024, August 28). "Classic and essential work by one of the great thinkers and researchers of trans community – Vivian Namaste [photograph]. Instagram. https://www.instagram.com/p/C_N8bytx8s-/?igsh=NjU4YTNieWJyc2o3

Veale, J., Watson, R., & Murti, R. (2017). Resilience among transgender individuals. *Journal of Mental Health Research, 9*(3), 54–68.

van der Kolk, B. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma*. Viking Penguin.

Chapter 2

Bauer, G., Devor, A., heinz, m., Marshall, Z., Pullen Sansfaçon, A., Pyne, J., & for the CPATH Research Committee. (2013). *CPATH ethical guidelines for research involving transgender people & communities*. Canadian Professional Association for Transgender Health. http://cpath.ca/en/resources/

Boilevin, L., Chapman, J., Deane, L., Doerksen, C., Fresz, G., Joe, D., Leech-Crier, N., Marsh, S., McLeod, J., Neufeld, S., Pham, S., Shaver, L., Smith, P., Steward, M., Wilson, D., & Winter, P. (2019). *Research 101: A manifesto for ethical research in the downtown eastside*. Google Docs. https://www.homelesshub.ca/resource/research-101-manifesto-ethical-research-downtown-eastside

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1). https://doi.org/10.3402/qhw.v9.26152

Campbell, R., Goodman-Williams, R., & Javorka, M. (2019). A trauma-informed approach to sexual violence research ethics and open science. *Journal of Interpersonal Violence*, *34*(23–24), 4765–4793. https://doi.org/10.1177/0886260519871530

Canadian Mental Health Association (2025). Amplifying Voices: Six crucial action areas for mental health organizations to close the gap on care. *Canadian Mental Health Association.* https://ontario.cmha.ca/amplifying-voices/

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, *38*(4), 785–810. https://doi.org/10.1086/669608

Clark, N. (2016). Red intersectionality and violence-informed witnessing praxis with Indigenous girls. *Girlhood Studies*, *9*(2), 46–64. https://doi.org/10.3167/ghs.2016.090205

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology*, *41*(1), 1–20. https://doi.org/10.1146/annurev-soc-073014-112142

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(8), 139–167.

Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Standford Law Review*, *43*(6), 1241–1299. https://doi.org/10.2307/1229039

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477. https://doi.org/10.1002/jcop.20063

Ellis, A. E. (2020). Providing trauma-informed affirmative care: Introduction to special issue on evidence-based relationship variables in working with affectional and gender minorities. *Practice Innovations*, *5*(3), 179–188. https://doi.org/10.1037/pri0000133

Ferlatte, O., Salway, T., Rice, S., Oliffe, J. L., Rich, A. J., Knight, R., Morgan, J., & Ogrodniczuk, J. S. (2019). Perceived barriers to mental health services among Canadian sexual and gender minorities with depression and at risk of suicide. *Community Mental Health Journal*, *55*(8), 1313–1321. https://doi.org/10.1007/s10597-019-00445-1

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice*, *43*(5), 460–467. https://doi.org/10.1037/a0029597

Hunt, S. (2016). *An Introduction to the health of Two-Spirit people: Historical, contemporary and emergent issues*. National Collaborating Centre for Aboriginal Health.

Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2005). *Methods in community-based participatory research for health*. Jossey-Bass/Wiley.

Israel, B., Schultz, A., Parker, E., & Becker, A. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *Executive Summary of the Report of the 2015 U.S. Transgender Survey.* National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf

Katz-Wise, S. L., Pullen Sansfaçon, A., Bogart, L. M., Rosal, M. C., Ehrensaft, D., Goldman, R. E., & Bryn Austin, S. (2019). Lessons from a community-based participatory research study with transgender and gender nonconforming youth and their families. *Action Research*, *17*(2), 186–207. https://doi.org/10.1177/1476750318818875

Lange, T. M. (2020). Trans-affirmative narrative exposure therapy (TA-NET): A therapeutic approach for targeting minority stress, internalized stigma, and trauma reactions among gender diverse adults. *Practice Innovations*, *5*(3), 230–245. https://doi.org/10.1037/pri0000126

Lezard, P., Prefontaine, N., Cederwall, D-M., Sparrow, C., Maracle, S., Beck. A., & McLeod. A (April 2021). 2SLGBTTQIA+ Sub-Working Group. MMIWG2SLGBTTQIA+ National Action: Final Report. OFIFC: Toronto

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, *36*, 38–56.

Mizock, L., & Lewis, T. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse*, *8*(3), 335–354. https://doi.org/10.1080/10926790802262523

Moroz, N., Moroz, I., & D’Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287. https://doi-org.ezproxy.library.uvic.ca/10.1177/0840470420933911

Navarro, J., Lachowsky, N., Hammond, R., Burchell, D., Arps, F. S. E., Davis, C., Brasseur, J., Islam, S., Fosbrook, B., Jacobsen, H., Walker, M., Lopez, C., Scheim, A., Bauer, G., & on behalf of the Trans PULSE Canada Team. (2021). *Health and well-being among non-binary people*. https://transpulsecanada.ca/research-type/reports

Pruden, H. & Salway, T. (2020). “What and who is Two-Spirit” in health research. *Meet the methods (2). CIHR: Institute of Gender and Health*. https://cihr-irsc.gc.ca/e/52214.html

Scheim, A. I., Coleman, T., Lachowsky, N., & Bauer, G. R. (2021). Health care access among transgender and nonbinary people in Canada, 2019: A cross-sectional survey. *CMAJ Open*, *9*(4), E1213–E1222. https://doi.org/10.9778/cmajo.20210061

Shipherd, J. C., Maguen, S., Skidmore, W. C., & Abramovitz, S. M. (2011). Potentially traumatic events in a transgender sample: Frequency and associated symptoms. *Traumatology*, *17*(2), 56–67. https://doi.org/10.1177/1534765610395614

Shipherd, J. C., Berke, D., & Livingston, N. A. (2019). Trauma recovery in the transgender and gender diverse community: Extensions of the minority stress model for treatment planning. Cognitive and Behavioral Practice, 26(4), 629–646. https://doi.org/10.1016/j.cbpra.2019.06.001

Simeonov, D., Steele, L. S., Anderson, S., & Ross, L. E. (2015). Perceived satisfaction with mental health services in the lesbian, gay, bisexual, transgender, and transsexual communities in Ontario, Canada: An internet-based survey. *Canadian Journal of Community Mental Health*, *34*(1), 31–44. https://doi.org/10.7870/cjcmh-2014-037

Substance Abuse and Mental Health Service Administration (SAMHSA (2014). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Straube, W. Linander, I., & Henriksson, A., (2023). *Report: Care for Transgender People in Värmland.* Karlstads Universitet. Originally published in Swedish: *Vård för transpersoner i Värmland.*

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances, 24(5),* 319–333. https://doi.org/10.1192/bja.2018.29

Trans Care BC (2024). Navigating Care: Trans Care BC's Health Navigation Team. http://www.phsa.ca/transcarebc/care-support/access-care/navigate-care

The Trans PULSE Canada Team. Health and health care access for trans and non-binary people in Canada.2020-03-10. Available from: https://transpulsecanada.ca/research-type/reports

Tishelman, A., & Neumann-Mascis, A. (2018). Gender-related trauma. In *The gender affirmative model: An interdisciplinary approach to supporting transgender and gender expansive children* (pp. 85–100). American Psychological Association. https://doi.org/10.1037/0000095-006

Veale, J. F., Saewyc, E., Frohard-Dourlent, H., Dobson, S., Clark, B., & Canadian Trans Youth Health Survey Research Group. (2015). *Being safe being me: Results of the Canadian trans youth health survey*. Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia. https://apsc-saravyc.sites.olt.ubc.ca/files/2018/04/SARAVYC_Trans-Youth-Health-Report_EN_Final_Web2.pdf

Veale, J. F., Watson, R. J., Peter, T., & Saewyc, E. M. (2017). Mental health disparities among Canadian transgender youth. *Journal of Adolescent Health*, *60*(1), 44–49. https://doi.org/10.1016/j.jadohealth.2016.09.014

Wells, A., Walker, M., Hu, A., Stark, A., Huda, F., Klassen, B., Lachowsky, NJ. (2024) Mental health experiences of young gay, bisexual, transgender, Two Spirit, queer and nonbinary people in Canada. Canadian Journal of Human Sexuality. 10.3138/cjhs.2023-0023

Chapter 3

Acker, G. M. (2017). Transphobia among students majoring in the helping professions. *Journal of Homosexuality*, *64*(14), 2011–2029. https://doi.org/10.1080/00918369.2017.1293404

Ahmed, S. (2006). *Queer phenomenology: Orientations, objects, others*. Duke University Press.

Anzani, A., Morris, E. R., & Galupo, M. P. (2019). From absence of microaggressions to seeing authentic gender: Transgender clients' experiences with microaffirmations in therapy. *Journal of LGBT Issues in Counseling*, *13*(4), 258–275. https://doi.org/10.1080/15538605.2019.1662359

Aultman, B. L. (2018). *Feeling as knowing: Trans phenomenology and epistemic justice* [Doctoral Dissertation]. The City University of New York.

Austin, A., Craig, S., & Alessi, E. (2017). Affirmative cognitive behavior therapy with transgender and gender nonconforming adults. *Psychiatric Clinics of North America*, *40*(1), 141–156. https://doi.org/10.1016/j.psc.2016.10.003

Bauer, G., Devor, A., heinz, m., Marshall, Z., Pullen Sansfaçon, A., Pyne, J., & for the CPATH Research Committee. (2013). *CPATH ethical guidelines for research involving* *transgender people & communities*. Canadian Professional Association for Transgender Health. http://cpath.ca/en/resources/

Blodgett, N., Coughlan, R., & Khullar, N. (2017). Overcoming the barriers in transgender healthcare in rural Ontario: Discourses of personal agency, resilience, and empowerment. *International Social Science Journal*, *67*(225–226), 83–95. https://doi.org/10.1111/issj.12162

Boilevin, L., Chapman, J., Deane, L., Doerksen, C., Fresz, G., Joe, D., Leech-Crier, N., Marsh, S., McLeod, J., Neufeld, S., Pham, S., Shaver, L., Smith, P., Steward, M., Wilson, D., & Winter, P. (2019). *Research 101: A manifesto for ethical research in the downtown eastside*. Google Docs. https://www.homelesshub.ca/resource/research-101-manifesto-ethical-research-downtown-eastside

Boot-Haury, J. W. (2023). A preliminary study of intensive transgender-specific cultural competency training: Implications for social workers and psychologists who work with rural transgender clients. *Journal of Gay & Lesbian Social Services*, *36*(3), 1–27. https://doi.org/10.1080/10538720.2023.2266399

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can “thematic analysis” offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1). https://doi.org/10.3402/qhw.v9.26152

Brown, L. (1991). Not outside the range: One feminist perspective on psychic trauma. *American Imago*, *48*(1), 119–133.

Brown, S., Kucharska, J., & Marczak, M. (2018). Mental health practitioners' attitudes towards transgender people: A systematic review of the literature. *International Journal of Transgenderism*, *19*(1), 4–24. https://doi.org/10.1080/15532739.2017.1374227

Campbell, R., Goodman-Williams, R., & Javorka, M. (2019). A trauma-informed approach to sexual violence research ethics and open science. *Journal of Interpersonal Violence*, *34*(23–24), 4765–4793. https://doi.org/10.1177/0886260519871530

Chang, S. C., & Singh, A. A. (2016). Affirming psychological practice with transgender and gender nonconforming people of color. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 140–147. https://doi.org/10.1037/sgd0000153

Compton, E., & Morgan, G. (2022). The experiences of psychological therapy amongst people who identify as transgender or gender non-conforming: A systematic review of qualitative research. *Journal of Feminist Family Therapy*, *34*(3–4), 225–248. https://doi.org/10.1080/08952833.2022.2068843

dickey, lore m., & Singh, A. A. (2020). Evidence-based relationship variables: Working with trans and gender nonbinary clients. *Practice Innovations*, *5*(3), 189–201. https://doi.org/10.1037/pri0000116

Ellis, A. E. (2020). Providing trauma-informed affirmative care: Introduction to special issue on evidence-based relationship variables in working with affectional and gender minorities. *Practice Innovations*, *5*(3), 179–188. https://doi.org/10.1037/pri0000133

Ellis, A. E., Meade, N. G., & Brown, L. S. (2020). Evidence-based relationship variables when working with affectional and gender minority clients: A systematic review. *Practice Innovations*, *5*(3), 202–217. https://doi.org/10.1037/pri0000118

Erby, A. N., & White, M. E. (n.d.). Broaching partially-shared identities: Critically interrogating power and intragroup dynamics in counseling practice with trans people of Color. *International Journal of Transgender Health*, *23*(1–2), 122–132. https://doi.org/10.1080/26895269.2020.1838389

Fraser, L. (2018). Integrative and ethical mental health care of transgender and gender diverse adults. In A.F. Carlozzi & K.T. Choate (Eds.), *Transgender and Gender Diverse Persons* (pp. 94 – 115). Routledge. 10.4324/9781351207119-7

Gill-Peterson, J. (2018). *Histories of the transgender child*. University of Minnesota Press. https://doi.org/10.5749/j.ctv75d87g

Gnaulti, E. (2019). The ethics of neglecting clinical relationship and alliance building in trauma-focused treatments. *Ethical Human Psychology & Psychiatry*, *21*(2), 104–116.

Goldberg, A. E., Kuvalanka, K. A., Budge, S. L., Benz, M. B., & Smith, J. Z. (2019). Health care experiences of transgender binary and nonbinary university students. *The Counseling Psychologist*, *47*(1), 59–97. https://doi.org/10.1177/0011000019827568

Herman, J. (1997). *Trauma and recovery the aftermath of violence: From domestic abuse to political terror*. Basic Books.

Holt, N. R., Hope, D. A., Mocarski, R., & Woodruff, N. (2023). The often-circuitous path to affirming mental health care for transgender and gender-diverse adults. *Current Psychiatry Reports*, *25*(3), 105–111. https://doi.org/10.1007/s11920-023-01410-2

Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2005). *Methods in community-based participatory research for health*. Jossey-Bass/Wiley.

Israel, B., Schultz, A., Parker, E., & Becker, A. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 US Transgender Survey*. National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Kattari, S. K., Bakko, M., Hecht, H. K., & Kattari, L. (2020). Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults. *SSM - Population Health*, *10*, 100525. https://doi.org/10.1016/j.ssmph.2019.100525

Katz-Wise, S. L., Pullen Sansfaçon, A., Bogart, L. M., Rosal, M. C., Ehrensaft, D., Goldman, R. E., & Bryn Austin, S. (2019). Lessons from a community-based participatory research study with transgender and gender nonconforming youth and their families. *Action Research*, *17*(2), 186–207. https://doi.org/10.1177/1476750318818875

Kauth, M. R., & Shipherd, J. C. (Eds.). (2018). *Adult transgender care: An interdisciplinary approach for training mental health professionals* (First edition). Routledge, Taylor & Francis Group.

Lezard, P., Prefontaine, N., Cederwall, D-M., Sparrow, C., Maracle, S., Beck. A., & McLeod. A (April 2021). 2SLGBTTQIA+ Sub-Working Group. MMIWG2SLGBTTQIA+ National Action: Final Report. OFIFC: Toronto

Livingston, N. A., Berke, D., Scholl, J., Ruben, M., & Shipherd, J. C. (2020). Addressing diversity in PTSD treatment: Clinical considerations and guidance for the treatment of PTSD in LGBTQ populations. *Current Treatment Options in Psychiatry*, *7*(2), 53–69. https://doi.org/10.1007/s40501-020-00204-0

Mascis, A. N. (2011). Working with transgender survivors. *Journal of Gay & Lesbian Mental Health*, *15*(2), 200–210. https://doi.org/10.1080/19359705.2011.553782

McCullough, R., Dispenza, F., Parker, L. K., Viehl, C. J., Chang, C. Y., & Murphy, T. M. (2017). The counseling experiences of transgender and gender nonconforming clients. *Journal of Counseling & Development*, *95*(4), 423–434. https://doi.org/10.1002/jcad.12157

Mizock, L., & Lewis, T. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse*, *8*(3), 335–354. https://doi.org/10.1080/10926790802262523

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Morris, E. R., Lindley, L., & Galupo, M. P. (2020). “Better issues to focus on”: Transgender microaggressions as ethical violations in therapy. *The Counseling Psychologist*, *48*(6), 883–915. https://doi.org/10.1177/0011000020924391

Navarro, J., Lachowsky, N., Hammond, R., Burchell, D., Arps, F. S. E., Davis, C., Brasseur, J., Islam, S., Fosbrook, B., Jacobsen, H., Walker, M., Lopez, C., Scheim, A., Bauer, G., & on behalf of the Trans PULSE Canada Team. (2021). *Health and well-being among non-binary people*. https://transpulsecanada.ca/research-type/reports

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, *48*(1), 98–102. https://doi.org/10.1037/a0022161

Norcross, J. C., & Wampold, B. E. (2019). Relationships and responsiveness in the psychological treatment of trauma: The tragedy of the APA Clinical Practice Guideline. *Psychotherapy*, *56*(3), 391–399. https://doi.org/10.1037/pst0000228

Panchal, Z., Piper, C., Whitmore, C., & Davies, R. D. (2022). Providing supportive transgender mental health care: A systemized narrative review of patient experiences, preferences, and outcomes. *Journal of Gay & Lesbian Mental Health*, *26*(3), 228–264. https://doi.org/10.1080/19359705.2021.1899094

Puckett, J. A., Holt, N. R., Lash, B., Zachary Huit, T., Ralston, A. L., Hope, D. A., Mocarski, R., & Zachary DuBois, L. (2023). Transgender and gender diverse adults' self-reported mental health diagnoses, engagement in mental health services, and perceptions of therapists. *Psychotherapy Research*, *33*(1), 84–95. https://doi.org/10.1080/10503307.2022.2091961

Richmond, K., Burnes, T. R., Singh, A. A., & Ferrara, M. (2017). Assessment and treatment of trauma with TGNC clients: A feminist approach. In A. Singh & lore m. dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender nonconforming clients* (pp. 191–212). American Psychological Association. https://doi.org/10.1037/14957-010

Rosati, F., Lorusso, M. M., Pistella, J., Giovanardi, G., Di Giannantonio, B., Mirabella, M., Williams, R., Lingiardi, V., & Baiocco, R. (2022). Non-binary clients' experiences of psychotherapy: Uncomfortable and affirmative approaches. *International Journal of Environmental Research and Public Health*, *19*(22), 15339. https://doi.org/10.3390/ijerph192215339

Rubin, H. S. (1998). Phenomenology as method in trans studies. *GLQ: A Journal of Lesbian and Gay Studies*, *4*(2), 263–281. https://doi.org/10.1215/10642684-4-2-263

SAHMSA's Trauma and Justice Strategic Initiative. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

Scheim, A. I., Coleman, T., Lachowsky, N., & Bauer, G. R. (2021). Health care access among transgender and nonbinary people in Canada, 2019: A cross-sectional survey. *Canadian Medical Association Open Access Journal*, *9*(4), E1213–E1222. https://doi.org/10.9778/cmajo.20210061

Shipherd, J. C., Berke, D., & Livingston, N. A. (2019). Trauma recovery in the transgender and gender diverse community: Extensions of the minority stress model for treatment planning. *Cognitive and Behavioral Practice*, *26*(4), 629–646. https://doi.org/10.1016/j.cbpra.2019.06.001

Singh, A. A., & dickey, lore m. (2016). Implementing the APA guidelines on psychological practice with transgender and gender nonconforming people: A call to action to the field of psychology. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 195–200. https://doi.org/10.1037/sgd0000179

Singh, A. A., & dickey, lore m. (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming client*. American Psychological Association.

Singh, A. A., Hwahng, S. J., Chang, S. C., & White, B. (2017). Affirmative counseling with trans/gender-variant people of color. In A. Singh & lore m. dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender nonconforming clients* (pp. 41–68). American Psychological Association. https://doi.org/10.1037/14957-003

Stryker, S. D., Pallerla, H., Yockey, R. A., Bedard-Thomas, J., & Pickle, S. (2022). Training mental health professionals in gender-affirming care: A survey of experienced clinicians. *Transgender Health*, *7*(1), 68–77. https://doi.org/10.1089/trgh.2020.0123

van der Kolk, B. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma*. Viking Penguin.

Chapter 4

Acker, G. M. (2017). Transphobia among students majoring in the helping professions. *Journal of Homosexuality*, *64*(14), 2011–2029. https://doi.org/10.1080/00918369.2017.1293404

Adams, N., Pearce, R., Veale, J., Radix, A., Castro, D., Sarkar, A., & Thom, K. C. (2017). Guidance and ethical considerations for undertaking transgender health research and institutional review boards adjudicating this research. *Transgender Health*, *2*(1), 165–175. https://doi.org/10.1089/trgh.2017.0012

Ansara, Y. G., & Hegarty, P. (2012). Cisgenderism in psychology: Pathologising and misgendering children from 1999 to 2008. *Psychology & Sexuality*, *3*(2), 137–160. https://doi.org/10.1080/19419899.2011.576696

Austin, A., Craig, S., & Alessi, E. (2017). Affirmative cognitive behavior therapy with transgender and gender nonconforming adults. *Psychiatric Clinics of North America*, *40*(1), 141–156. https://doi.org/10.1016/j.psc.2016.10.003

Bauer, G., Devor, A., heinz, m., Marshall, Z., Pullen Sansfaçon, A., Pyne, J., & for the CPATH Research Committee. (2019). *CPATH ethical guidelines for research involving transgender people & communities*. Canadian Professional Association for Transgender Health. https://cpath.ca/wp-content/uploads/2019/08/CPATH-Ethical-Guidelines-EN.pdf

Blodgett, N., Coughlan, R., & Khullar, N. (2017). Overcoming the barriers in transgender healthcare in rural Ontario: Discourses of personal agency, resilience, and empowerment. *International Social Science Journal*, *67*(225–226), 83–95. https://doi.org/10.1111/issj.12162

Boilevin, L., Chapman, J., Deane, L., Doerksen, C., Fresz, G., Joe, D., Leech-Crier, N., Marsh, S., McLeod, J., Neufeld, S., Pham, S., Shaver, L., Smith, P., Steward, M., Wilson, D., & Winter, P. (2019). *Research 101: A manifesto for ethical research in the downtown eastside*. Google Docs. https://www.homelesshub.ca/resource/research-101-manifesto-ethical-research-downtown-eastside

Boot-Haury, J. W. (2023). A preliminary study of intensive transgender-specific cultural competency training: Implications for social workers and psychologists who work with rural transgender clients. *Journal of Gay & Lesbian Social Services*, *36*(3), 1–27. https://doi.org/10.1080/10538720.2023.2266399

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can “thematic analysis” offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1). https://doi.org/10.3402/qhw.v9.26152

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Brown, S., Kucharska, J., & Marczak, M. (2018). Mental health practitioners' attitudes towards transgender people: A systematic review of the literature. *International Journal of Transgenderism*, *19*(1), 4–24. https://doi.org/10.1080/15532739.2017.1374227

Burnes, T. R., Dexter, M. M., Richmond, K., Singh, A. A., & Cherrington, A. (2016). The experiences of transgender survivors of trauma who undergo social and medical transition. *Traumatology*, *22*(1), 75–84. https://doi.org/10.1037/trm0000064

Campbell, R., Goodman-Williams, R., & Javorka, M. (2019). A trauma-informed approach to sexual violence research ethics and open science. *Journal of Interpersonal Violence*, *34*(23–24), 4765–4793. https://doi.org/10.1177/0886260519871530

Canadian Institutes of Health Research. (2021). *Sex and Gender in Health Research.* https://cihr-irsc.gc.ca/e/50833.html

Clark, N. (2016). Red intersectionality and violence-informed witnessing praxis with Indigenous girls. *Girlhood Studies*, *9*(2), 46–64. https://doi.org/10.3167/ghs.2016.090205

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*, 174. https://doi.org/10.1186/s12939-019-1082-3

dickey, lore m., Hendricks, M. L., & Bockting, W. O. (2016). Innovations in research with transgender and gender nonconforming people and their communities. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 187–194. https://doi.org/10.1037/sgd0000158

Ellis, A. E. (2020). Providing trauma-informed affirmative care: Introduction to special issue on evidence-based relationship variables in working with affectional and gender minorities. *Practice Innovations*, *5*(3), 179–188. https://doi.org/10.1037/pri0000133

Erby, A. N., & White, M. E. (2022). Broaching partially-shared identities: Critically interrogating power and intragroup dynamics in counseling practice with trans people of Color. *International Journal of Transgender Health*, *23*(1–2), 122–132. https://doi.org/10.1080/26895269.2020.1838389

Feldman, J., Brown, G. R., Deutsch, M. B., Hembree, W., Meyer, W., Meyer-Bahlburg, H. F. L., Tangpricha, V., T'Sjoen, G., & Safer, J. D. (2016). Priorities for transgender medical and healthcare research. *Current Opinion in Endocrinology, Diabetes, and Obesity*, *23*(2), 180–187. https://doi.org/10.1097/MED.0000000000000231

Ferlatte, O., Salway, T., Rice, S., Oliffe, J. L., Rich, A. J., Knight, R., Morgan, J., & Ogrodniczuk, J. S. (2019). Perceived barriers to mental health services among Canadian sexual and gender minorities with depression and at risk of suicide. *Community Mental Health Journal*, *55*(8), 1313–1321. https://doi.org/10.1007/s10597-019-00445-1

Gill-Peterson, J. (2018). *Histories of the transgender child*. University of Minnesota Press. https://doi.org/10.5749/j.ctv75d87g

Goldberg, A. E., Kuvalanka, K. A., Budge, S. L., Benz, M. B., & Smith, J. Z. (2019). Health care experiences of transgender binary and nonbinary university students. *The Counseling Psychologist*, *47*(1), 59–97. https://doi.org/10.1177/0011000019827568

Harner, V. (2021). Trans intracommunity support & knowledge sharing in the United States & Canada: A scoping literature review. *Health & Social Care in the Community*, *29*(6), 1715–1728. https://doi.org/10.1111/hsc.13276

Hartman-Munick, S. M., Silverstein, S., Guss, C. E., Lopez, E., Calzo, J. P., & Gordon, A. R. (2021). Eating disorder screening and treatment experiences in transgender and gender diverse young adults. *Eating Behaviors*, *41*, 101517. https://doi.org/10.1016/j.eatbeh.2021.101517

Hunt, S. (2016). *An Introduction to the health of Two-Spirit people: Historical, contemporary and emergent issues*. National Collaborating Centre for Aboriginal Health.

Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2005). *Methods in community-based participatory research for health*. Jossey-Bass/Wiley.

Israel, B., Schultz, A., Parker, E., & Becker, A. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173

Jacobsen, K., Hu, A. T. Y., Stark, A., Klassen, B. J., Lachowsky, N. J., & Hébert, W. (2023). Prevalence and correlates of incarceration among trans men, nonbinary people, and Two-Spirit people in Canada. *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care*, *29*(1), 47–59. https://doi.org/10.1089/jchc.21.10.0117

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 US Transgender Survey*. National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Johnson, L. (2024, August 15). Alberta Premier Danielle Smith says legislation on school pronouns to come after classes begin | Globalnews.ca. *Global News*. https://globalnews.ca/news/10701155/alberta-danielle-smith-school-pronoun-legislation/

Katz-Wise, S. L., Pullen Sansfaçon, A., Bogart, L. M., Rosal, M. C., Ehrensaft, D., Goldman, R. E., & Bryn Austin, S. (2019). Lessons from a community-based participatory research study with transgender and gender nonconforming youth and their families. *Action Research*, *17*(2), 186–207. https://doi.org/10.1177/1476750318818875

Kia, H., Göncü, K., Nation, K., Gray, J., & Usher, D. (2022). A conceptualisation of equitable social work practice with transgender and gender diverse communities. *The British Journal of Social Work*, *52*(6), 3171–3190. https://doi.org/10.1093/bjsw/bcab230

Laing, M. (2021). *Urban Indigenous Youth Reframing Two-Spirit* (1st ed.). Routledge. https://doi.org/10.4324/9781003094296

Lange, T. M. (2020). Trans-affirmative narrative exposure therapy (TA-NET): A therapeutic approach for targeting minority stress, internalized stigma, and trauma reactions among gender diverse adults. *Practice Innovations*, *5*(3), 230–245. https://doi.org/10.1037/pri0000126

LeBlanc, M., Radix, A., Sava, L., Harris, A. B., Asquith, A., Pardee, D. J., & Reisner, S. L. (2022). "Focus more on what's right instead of what's wrong:" research priorities identified by a sample of transgender and gender diverse community health center patients. *BMC Public Health*, *22*(1), 1741. https://doi.org/10.1186/s12889-022-14139-z

Lezard, P., Prefontaine, N., Cederwall, D-M., Sparrow, C., Maracle, S., Beck. A., & McLeod. A (April 2021). 2SLGBTTQIA+ Sub-Working Group. MMIWG2SLGBTTQIA+ National Action: Final Report. OFIFC: Toronto

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE*, *13*(8), e0202330. https://doi.org/10.1371/journal.pone.0202330

Livingston, N. A., Berke, D., Scholl, J., Ruben, M., & Shipherd, J. C. (2020). Addressing diversity in PTSD treatment: Clinical considerations and guidance for the treatment of PTSD in LGBTQ populations. *Current Treatment Options in Psychiatry*, *7*(2), 53–69. https://doi.org/10.1007/s40501-020-00204-0

Matsuno, E. (2019). Nonbinary-affirming psychological interventions. *Cognitive and Behavioral Practice*, *26*(4), 617–628. https://doi.org/10.1016/j.cbpra.2018.09.003

Matsuno, E., & Budge, S. L. (2017). Non-binary/genderqueer identities: A critical review of the literature. *Current Sexual Health Reports*, *9*(3), 116–120. https://doi.org/10.1007/s11930-017-0111-8

Mizock, L., & Lewis, T. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse*, *8*(3), 335–354. https://doi.org/10.1080/10926790802262523

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

Navarro, J., Lachowsky, N., Hammond, R., Burchell, D., Arps, F. S. E., Davis, C., Brasseur, J., Islam, S., Fosbrook, B., Jacobsen, H., Walker, M., Lopez, C., Scheim, A., Bauer, G., & on behalf of the Trans PULSE Canada Team. (2021). *Health and well-being among non-binary people*. https://transpulsecanada.ca/research-type/reports

Panchal, Z., Piper, C., Whitmore, C., & Davies, R. D. (2022). Providing supportive transgender mental health care: A systemized narrative review of patient experiences, preferences, and outcomes. *Journal of Gay & Lesbian Mental Health*, *26*(3), 228–264. https://doi.org/10.1080/19359705.2021.1899094

Peters-Corbett, A., Parke, S., Bear, H., & Clarke, T. (2024). Barriers and facilitators of implementation of evidence-based interventions in children and young people's mental health care – a systematic review. *Child and Adolescent Mental Health*, *29*(3), 242–265. https://doi.org/10.1111/camh.12672

Pruden, H. (2021). Decolonizing research: collecting Two-Spirit data in culturally affirming ways. [webinar]. Health Research BC. https://healthresearchbc.ca/webinar/decolonizing-research-collecting-two-spirit-data-in-culturally-affirming-ways/

Pruden, H., Ira, M., & Salway, T. (2023). Two (Spirit)-Eyed Seeing: Honouring gender and sexual diversity for those Indigenous to Turtle Island. In *Routledge Handbook of Sexuality, Gender, Health and Rights* (pp. 71–80). Routledge. https://doi.org/10.4324/9781003278405-10

Pruden, H. & Salway, T. (2020). "What and who is Two-Spirit" in health research. *Meet the methods (2). CIHR: Institute of Gender and Health*. https://cihr-irsc.gc.ca/e/52214.html

Puckett, J. A., Cleary, P., Rossman, K., Mustanski, B., & Necomb, M. E. (2017). Barriers to gender-affirming care for transgender and gender nonconforming individuals. *Sexuality Research and Social Policy*, 1–12.

Puckett, J. A., Holt, N. R., Lash, B., Zachary Huit, T., Ralston, A. L., Hope, D. A., Mocarski, R., & Zachary DuBois, L. (2023). Transgender and gender diverse adults' self-reported mental health diagnoses, engagement in mental health services, and perceptions of therapists. *Psychotherapy Research*, *33*(1), 84–95. https://doi.org/10.1080/10503307.2022.2091961

Puckett, J. A., Matsuno, E., Dyar, C., Mustanski, B., & Newcomb, M. E. (2019). Mental health and resilience in transgender individuals: What type of support makes a difference? *Journal of Family Psychology, 33*(8), 954–964. https://doi.org/10.1037/fam0000561

Puckett, J. A., Wiklund, L. O., Louis, C., Gallik, C., Brown-Wren, L., Chu, H., Rodriguez, J., Langeni, N. S., & Strong, E. (2023). Clinical practice with transgender and gender diverse clients: Setting up an inclusive practice and training considerations. *Practice Innovations*, *8*(4), 265–276. https://doi.org/10.1037/pri0000209

Rapp, C. A., Etzel-Wise, D., Marty, D., Coffman, M., Carlson, L., Asher, D., Callaghan, J., & Holter, M. (2010). Barriers to evidence-based practice implementation: Results of a qualitative study. *Community Mental Health Journal*, *46*(2), 112–118. https://doi.org/10.1007/s10597-009-9238-z

Redfield, E., Conron, K. J., Tentindo, W., & Browning, E. (2023). *Prohibiting gender-affirming medical care for youth*. UCLA School of Law William Institute. https://williamsinstitute.law.ucla.edu/publications/bans-trans-youth-health-care/

Restar, A. J. (2020). Methodological critique of Littman's (2018) parental-respondents accounts of "Rapid-Onset Gender Dysphoria." *Archives of Sexual Behavior*, *49*(1), 61–66. https://doi.org/10.1007/s10508-019-1453-2

Richmond, K., Burnes, T. R., Singh, A. A., & Ferrara, M. (2017). Assessment and treatment of trauma with TGNC clients: A feminist approach. In A. Singh & lore m. dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender* *nonconforming clients* (pp. 191–212). American Psychological Association. https://doi.org/10.1037/14957-010

Ross, N., Westrup, Y., Hwang, B., Sierra, L., Nordstrom, A., & Kyriak, R. (2021). *Four corners: Health research priorities among TNB communities*. https://howardbrown.org/wp-content/uploads/2021/03/FourCorners-HealthResearchPrioritiesAmongTNBCommunities_Final_3_21.pdf

Rowling, J. K. (2020, June 10). J.K. Rowling Writes about Her Reasons for Speaking out on Sex and Gender Issues. *In My Own Words*. file:///Users/mattiew/Zotero/storage/WE4QZBPG/j-k-rowling-writes-about-her-reasons-for-speaking-out-on-sex-and-gender-issues.html

Sadika, B., Wiebe, E., Morrison, M. A., & Morrison, T. G. (2020). Intersectional microaggressions and social support for LGBTQ persons of color: A systematic review of the Canadian-based empirical literature. *Journal of GLBT Family Studies*, *16*(2), 111–147. https://doi.org/10.1080/1550428X.2020.1724125

Scheim, A. I., Coleman, T., Lachowsky, N., & Bauer, G. R. (2021). Health care access among transgender and nonbinary people in Canada, 2019: A cross-sectional survey. *Canadian Medical Association Open Access Journal*, *9*(4), E1213–E1222. https://doi.org/10.9778/cmajo.20210061

Shipherd, J. C., Berke, D., & Livingston, N. A. (2019). Trauma recovery in the transgender and gender diverse community: Extensions of the minority stress model for treatment planning. *Cognitive and Behavioral Practice*, *26*(4), 629–646. https://doi.org/10.1016/j.cbpra.2019.06.001

Simone, M., Hazzard, V. M., Askew, A. J., Tebbe, E. A., Lipson, S. K., & Pisetsky, E. M. (2022). Variability in eating disorder risk and diagnosis in transgender and gender diverse college students. *Annals of Epidemiology*, *70*, 53–60. https://doi.org/10.1016/j.annepidem.2022.04.007

Singh, A. A., & dickey, lore m. (2016). Implementing the APA guidelines on psychological practice with transgender and gender nonconforming people: A call to action to the field of psychology. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 195–200. https://doi.org/10.1037/sgd0000179

Singh, A. A., & dickey, lore m. (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming client*. American Psychological Association.

Singh, A. A., Finan, R., & Estevez, R. (2023). Queer and trans resilience: Moving from affirmation to liberation in our collective healing. In J. M. Koch, E. E. Townsend-Bell, & R. D. Hubach (Eds.), *Identity as Resilience in Minoritized Communities: Strengths-Based Approaches to Research and Practice* (pp. 1–22). Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-38977-1_1

Skinner, S. R., McLamore, Q., Donaghy, O., Stathis, S., Moore, J. K., Nguyen, T., Rayner, C., Tait, R., Anderson, J., & Pang, K. C. (2024). Recognizing and responding to misleading trans health research. *International Journal of Transgender Health*, *25*(1), 1–9. https://doi.org/10.1080/26895269.2024.2289318

Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to Action*. Truth and Reconciliation Commission of Canada. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf

Veale, J. F. (2017). Reflections on transgender representation in academic publishing. *International Journal of Transgenderism*, *18*(2), 121–122. https://doi.org/10.1080/15532739.2017.1279868

Veale, J. F., Deutsch, M. B., Devor, A. H., Kuper, L. E., Motmans, J., Radix, A. E., & St. Amand, C. (2022). Setting a research agenda in trans health: An expert assessment of priorities and issues by trans and nonbinary researchers. *International Journal of Transgender Health*, *23*(4), 392–408. https://doi.org/10.1080/26895269.2022.2044425

Veale, J. F., Peter, T., Travers, R., & Saewyc, E. M. (2017). Enacted stigma, mental health, and protective factors among transgender youth in Canada. *Transgender Health*, *2*(1), 207–216. https://doi.org/10.1089/trgh.2017.0031

Veale, J. F., Watson, R. J., Peter, T., & Saewyc, E. M. (2017). Mental Health Disparities Among Canadian Transgender Youth. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *60*(1), 44–49. https://doi.org/10.1016/j.jadohealth.2016.09.014

Vincent, B. W. (2018). Studying trans: Recommendations for ethical recruitment and collaboration with transgender participants in academic research. *Psychology & Sexuality*, *9*(2), 102–116. https://doi.org/10.1080/19419899.2018.1434558

Westbrook, L. (2021). *Unlivable lives: Violence and identity in transgender activism*. University of California Press.

Woman and Gender Equality Canada. (2022). *Federal 2SLGBTQI Action Plan: Building Our Future with Pride.* https://www.canada.ca/en/women-gender-equality/free-to-be-me/federal-2slgbtqi-plus-action-plan.html

Chapter 5

Ellis, A. E. (2020). Providing trauma-informed affirmative care: Introduction to special issue on evidence-based relationship variables in working with affectional and gender minorities. *Practice Innovations*, *5*(3), 179–188. https://doi.org/10.1037/pri0000133

Devor, A. H. (2004). Witnessing and Mirroring: A Fourteen Stage Model of Transsexual Identity Formation. *Journal of Gay & Lesbian Psychotherapy*, *8*(1–2), 41–67. https://doi.org/10.1300/J236v08n01_05

Gill-Peterson, J. (2018). *Histories of the transgender child*. University of Minnesota Press. https://doi.org/10.5749/j.ctv75d87g

Goodman, N. R. (2012). The Power of Witnessing. In N.R. Goodman and M.B. Meyers (Eds.) *The Power of Witnessing* (pp. 3-26). Routledge.

Herman, J. (1997). *Trauma and recovery the aftermath of violence: From domestic abuse to political terror*. Basic Books.

Hunt, S. (2018). Chapter 17. Researching within Relations of violence: witnessing as methodology. In. Eds. D. McGregor, J.P. Restoule, and R. Johnston, *Indigenous Research: Theories, Practices, and Relationships.* Canadian Scholars.

Lange, T. M. (2020). Trans-affirmative narrative exposure therapy (TA-NET): A therapeutic approach for targeting minority stress, internalized stigma, and trauma reactions among gender diverse adults. *Practice Innovations*, *5*(3), 230–245. https://doi.org/10.1037/pri0000126

Meyers, M. B. (2012). Trauma, Therapy, and Witnessing. In N.R. Goodman and M.B. Meyers (Eds.) *The Power of Witnessing* (pp. 289-303). Routledge.

Mizock, L., & Lewis, T. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse*, *8*(3), 335–354. https://doi.org/10.1080/10926790802262523

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Native Sexual Health Network. (2021). *You are made of medicine: A mental health peer support manual for indigiqueer, two-spirit, lgbtq+ and gender non-conforming indigenous youth.* https://www.nativeyouthsexualhealth.com/yamom

Navarro, J., Lachowsky, N., Hammond, R., Burchell, D., Arps, F. S. E., Davis, C., Brasseur, J., Islam, S., Fosbrook, B., Jacobsen, H., Walker, M., Lopez, C., Scheim, A., Bauer, G., & on behalf of the Trans PULSE Canada Team. (2021). *Health and well-being among non-binary people*. https://transpulsecanada.ca/research-type/reports

Richmond, K. A., Burnes, T., & Carroll, K. (2012). Lost in trans-lation: Interpreting systems of trauma for transgender clients. *Traumatology*, *18*(1), 45–57. https://doi.org/10.1177/1534765610396726

Scheim, A. I., Coleman, T., Lachowsky, N., & Bauer, G. R. (2021). Health care access among transgender and nonbinary people in Canada, 2019: A cross-sectional survey. *CMAJ Open*, *9*(4), E1213–E1222. https://doi.org/10.9778/cmajo.20210061

Shipherd, J. C., Maguen, S., Skidmore, W. C., & Abramovitz, S. M. (2011). Potentially traumatic events in a transgender sample: Frequency and associated symptoms. *Traumatology*, *17*(2), 56–67. https://doi.org/10.1177/1534765610395614

Shipherd, J. C., Berke, D., & Livingston, N. A. (2019). Trauma recovery in the transgender and gender diverse community: Extensions of the minority stress model for treatment planning. *Cognitive and Behavioral Practice*, *26*(4), 629–646. https://doi.org/10.1016/j.cbpra.2019.06.001

Veale, J. F., Peter, T., Travers, R., & Saewyc, E. M. (2017). Enacted stigma, mental health, and protective factors among transgender youth in Canada. *Transgender Health*, *2*(1), 207–216. https://doi.org/10.1089/trgh.2017.0031

Veale, J. F., Saewyc, E., Frohard-Dourlent, H., Dobson, S., Clark, B., & Canadian Trans Youth Health Survey Research Group. (2015). *Being safe being me: Results of the Canadian trans youth health survey*. Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia. https://apsc-saravyc.sites.olt.ubc.ca/files/2018/04/SARAVYC_Trans-Youth-Health-Report_EN_Final_Web2.pdf

Appendix A: Trauma-Informed Research Approach

Adapted from: Campbell, R., Goodman-Williams, R., & Javorka, M. (2019). A trauma-informed approach to sexual violence research ethics and open science. *Journal of Interpersonal Violence*, *34*(23–24), 4765–4793. https://doi.org/10.1177/0886260519871530

Trauma-Informed Principle	**Brief Description**	**Application in Current Project**
1. Recognize the impact of violence and victimization on development and coping strategies	Be aware that interpersonal violence and child abuse have ongoing negative impacts Trauma affects many aspects of a person's identity, relationships, worldview, and coping behaviors	*Overall:* Researchers in this project bring an understanding that trauma can impact many aspects of an individual's life and impacts individuals in different ways. People develop a wide range of coping strategies to support themselves and this can show up in behaviours, communication, priorities, etc. *Recruitment:* Recruitment strategies will focus on respecting that potential participants may have a range of experiences and perspectives regarding research. *Data Collection:* Data collection processes will bring an understanding to how people engage, and answer questions may vary, including how they understand the questions or what their priorities are in talking about their own experiences. Researchers will be prepared to hear a wide variety of experiences and continued impacts of traumatic events. Researchers will be prepared to listen to and respect what participants are sharing as their own experience and not assume that because the researcher may not understand the situation as challenging or confusing, it may feel differently for the participant. *Dissemination:* Sharing findings from the study will ensure that participants behaviours, attitudes, and perspectives are not pathologized in the results. The goal of this study is to provide insight into trans and gender-diverse people's experiences with mental health care services in order to improve services for these communities. Dissemination of findings will avoid sensationalizing participants experiences with trauma and instead

		centre dignity and respect for participants throughout the process and in the dissemination of the findings.
2. Identify recovery from trauma as a primary goal	Provide trauma-specific resources to aide in survivors' recovery	*Overall:* A list of community resources will be provided to participants to support with connection to supportive, trauma-specific and relevant community supports. Mental health support will be available during and after the research activities for participants.
3. Employ an empowerment model	Give participants choice and control over their actions As a researcher, engage in a partnership with the participant in which each person's knowledge is valued	*Overall:* Participants choice and control will be prioritized throughout the project *Recruitment:* Recruitment materials will use transparent language that is clear about what the project is about and what participants will be asked to do so that participants can make an informed choice about joining the project. *Data Collection:* Participants will be informed that they can choose to skip any questions they would like and that they may withdraw at any time. Participants will be informed that what they share is up to them and they can decide what they feel comfortable sharing. *Dissemination:* Participants will be asked for their input on who findings are shared with and how.
4. Frame the researcher–participant relationship as a relational collaboration	Recognize and aim to reduce power imbalances in the researcher participant relationship	*Overall:* Participants choice and control will be prioritized throughout the project. Researchers will take a collaborative approach to the study employing community-based research principles that centre community knowledge and experience. *Recruitment:* Recruitment information will inform participants that they participation is completely voluntary and that they can opt out at any time with no loss of compensation. Recruitment information will include information about the community-based research approach. *Data Collection:* Interview and consultations will be framed as a collaborative process. Participants can add additional information or choose to not answer questions. Participants can offer different ideas for topics related to the research project that they want to

		share. Participants will have the option to review their own transcripts for accuracy and to ensure that the information they shared is information they would like included in the study. *Dissemination:* Participants will be asked for their input on who findings are shared with and how.
5. Create an atmosphere that is respectful of individuals' need for safety, respect, and acceptance	Strive for comfort, privacy, and psychological and physical safety in the research space Protect participant confidentiality and provide clear information about roles and expectations	*Overall:* Researchers will strive to create a research environment that is comfortable, private, and safe for participants. This includes giving participants the information they need to feel safe participating in the project. *Recruitment:* Recruitment information will be an invitation and strive to present all the needed information for participants to feel comfortable reaching out if they have further questions or do not understand something about the project. *Data Collection:* Interview and consultations will centre participants' comfort and safety as a priority. Researchers will spend time introducing themselves and the project before starting the interviews or consultations. Expectations will be reviewed at the beginning of the research activities, including consent processes. Participants will be provided with food and beverages and accommodations for different needs to make the interviews or consultation process feel accessible and safe for them. *Analysis:* Analysis of the data will respect the humanity and dignity of all participants. *Dissemination:* No identifying information or information that participants indicated they did not want shared will be included in the dissemination of the findings. Dissemination will prioritize knowledge translation methods that benefit the participants and trans and gender-diverse communities more broadly. All findings will be presented in a way that respects the dignity and humanity of all research participants.
6. Emphasize individuals' strengths, highlighting adaptations over	Validate individuals' resilience, recognizing that trauma symptoms	*Overall:* This project focuses on participants sharing their knowledge and experiences about mental health services. The

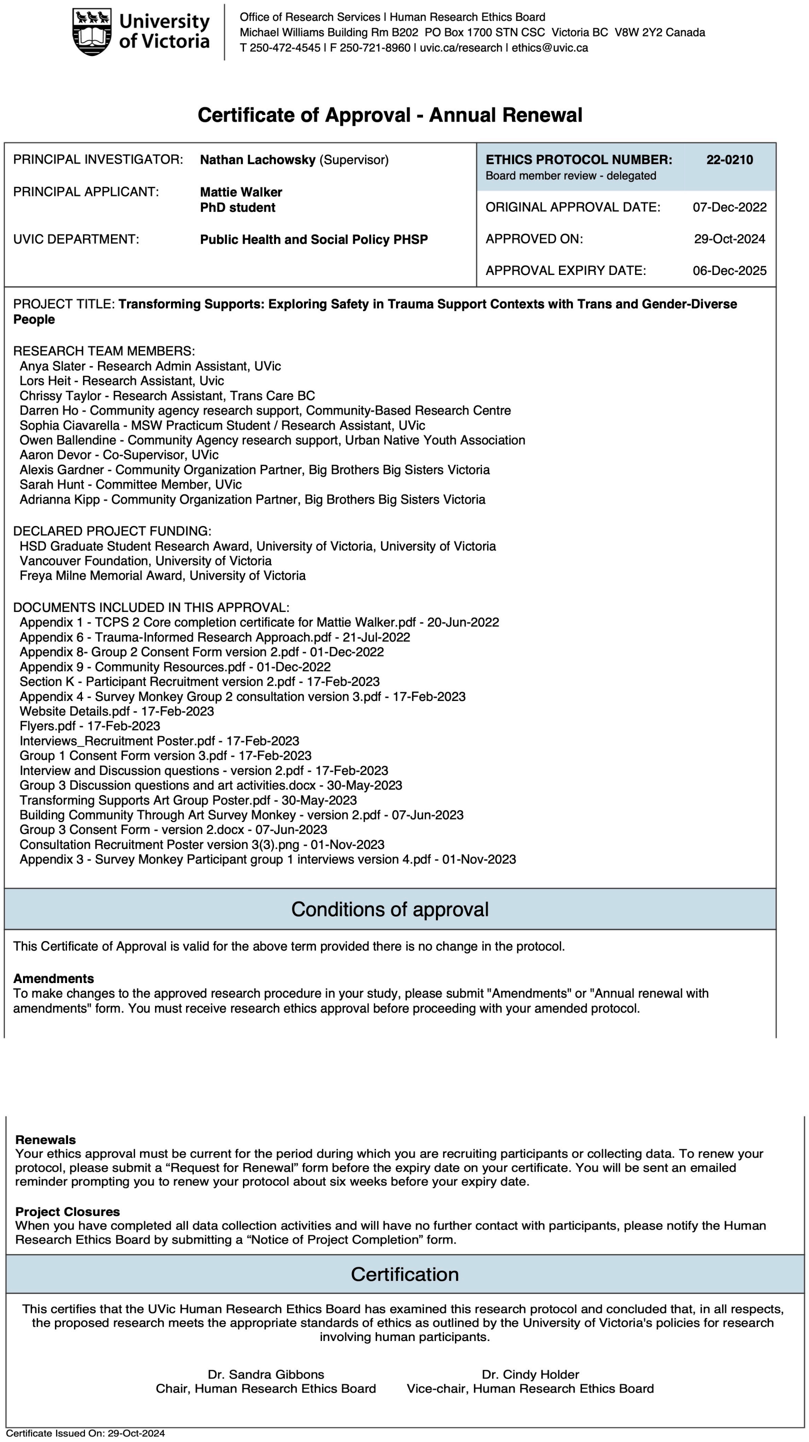
symptoms and resilience over pathology	may come from survivors' efforts to cope with the trauma	researcher will prioritize valuing participants strengths and respecting the knowledge that they share with the project. *Recruitment:* Recruitment will focus on inviting participants who have experience with mental health services and does not focus on a diagnosis criteria for inclusion. *Data Collection:* Interview and consultations will ask questions about experiences, including participants adaptions when services did not meet their needs. Questions will also ask about participants experiences of safety and joy more generally to offer time to talk about resilience and strength. *Analysis:* Analysis of the data will focus on valuing participants strengths and respecting the knowledge that they share with the project. Analysis will be reflexive and challenge understandings of the data that pathologize or are disrespectful to the participants. *Dissemination:* Dissemination will prioritize knowledge translation methods that benefit the participants and trans and gender-diverse communities more broadly. All findings will be presented in a way that respects the dignity and humanity of all research participants. This includes highlighting the strengths that participants share.
7. Minimize the possibilities of re-traumatization	Recognize ways in which the research may be retraumatizing Avoid intrusive or insensitive research procedures that could trigger trauma-related symptoms	*Overall:* The project does not ask participants to share information about what led them to seek mental health supports. *Data collection:* Researchers will not ask specific questions about traumatic events that led to participants seeking mental health support. If participants share experiences with mental health supports that were traumatic to participants, researchers will ask participants what they feel comfortable sharing and inform participants that they do not need to share any information that feels too upsetting or difficult to talk about. Participants will be given all questions before they engage in the research activities so they can decide beforehand what they would like to share and review the questions to see if there are any they do not want to the researcher to ask.

8. Strive to be culturally competent and to understand individuals in the context of their life experiences and cultural backgrounds	Develop the knowledge and skills needed to understand participants' cultural contexts Consider how participants' identities and backgrounds intersect with their trauma Recognize that different cultures have different ways of conceptualizing and healing from trauma	*Overall:* This project takes an intersectional perspective to this topic area, emphasizing that trans and gender-diverse communities are not homogenous and that diverse aspects of identity can and will impact experiences of mental health care. Understanding that participants will be coming from diverse cultural backgrounds will be a priority for the researchers. Project materials including recruitment materials will include land acknowledgements to acknowledge the ancestral Indigenous territories on which the research activities are possible. Specific attention will be paid to ensure that research processes are made to feel relevant and inclusive of Indigenous individuals. *Data collection:* Participants will be asked about what accommodations or supports will be helpful to them to facilitate their participation in the project. This will include informing participants (from group 1) that they can bring a support person with them to interview. Diverse perspectives about trauma and healing from trauma will be respected, including asking participants about their own experiences with safety and what feels helpful to them. Participants will be provided with a list of community resources, including a variety of resources that may be culturally-relevant. *Analysis:* Data analysis will take an intersectional lens, taking into account structural and systemic factors that impact mental health care experience. Analysis will take into consideration different ways of knowing that participants bring to the project. *Dissemination:* Dissemination will prioritize knowledge translation methods that benefit the participants and trans and gender-diverse communities more broadly. All findings will be presented in a way that respects the dignity and humanity of all research participants. Participants will have input into how findings are shared and with what audiences.
9. Solicit participant input	Consider ways that	*Overall:*

on the research process and involve participants in various stages of research	participants can be involved in the research process, such as using participatory research methods or forming research advisory boards	This project uses community-based research principles and prioritizes participants' input in the research process. This project will also engage with a community advisory committee comprised of trans and gender-diverse community members with experience accessing/attending mental health services and/or working in mental health care. This community advisory committee will provide feedback and recommendations throughout the process. Participants will be asked for their input about how findings will be shared and with who as well as future directions for research. Participants will be asked how their experience was answering the questions in the interview or the consultation to provide immediate feedback and input to the researcher as well as reflect on their own experience.

Adapted from Campbell et al. (2019) pp. 4769-4770.

Appendix B: Research Ethics Board Protocol



University of Victoria
Office of Research Services | Human Research Ethics Board
Michael Williams Building Rm B202 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Certificate of Approval - Annual Renewal

PRINCIPAL INVESTIGATOR:	**Nathan Lachowsky** (Supervisor)	**ETHICS PROTOCOL NUMBER:** Board member review - delegated	**22-0210**
PRINCIPAL APPLICANT:	**Mattie Walker** **PhD student**	ORIGINAL APPROVAL DATE:	07-Dec-2022
UVIC DEPARTMENT:	**Public Health and Social Policy PHSP**	APPROVED ON:	29-Oct-2024
		APPROVAL EXPIRY DATE:	06-Dec-2025

PROJECT TITLE: **Transforming Supports: Exploring Safety in Trauma Support Contexts with Trans and Gender-Diverse People**

RESEARCH TEAM MEMBERS:
Anya Slater - Research Admin Assistant, UVic
Lors Heit - Research Assistant, Uvic
Chrissy Taylor - Research Assistant, Trans Care BC
Darren Ho - Community agency research support, Community-Based Research Centre
Sophia Ciavarella - MSW Practicum Student / Research Assistant, UVic
Owen Ballendine - Community Agency research support, Urban Native Youth Association
Aaron Devor - Co-Supervisor, UVic
Alexis Gardner - Community Organization Partner, Big Brothers Big Sisters Victoria
Sarah Hunt - Committee Member, UVic
Adrianna Kipp - Community Organization Partner, Big Brothers Big Sisters Victoria

DECLARED PROJECT FUNDING:
HSD Graduate Student Research Award, University of Victoria, University of Victoria
Vancouver Foundation, University of Victoria
Freya Milne Memorial Award, University of Victoria

DOCUMENTS INCLUDED IN THIS APPROVAL:
Appendix 1 - TCPS 2 Core completion certificate for Mattie Walker.pdf - 20-Jun-2022
Appendix 6 - Trauma-Informed Research Approach.pdf - 21-Jul-2022
Appendix 8- Group 2 Consent Form version 2.pdf - 01-Dec-2022
Appendix 9 - Community Resources.pdf - 01-Dec-2022
Section K - Participant Recruitment version 2.pdf - 17-Feb-2023
Appendix 4 - Survey Monkey Group 2 consultation version 3.pdf - 17-Feb-2023
Website Details.pdf - 17-Feb-2023
Flyers.pdf - 17-Feb-2023
Interviews_Recruitment Poster.pdf - 17-Feb-2023
Group 1 Consent Form version 3.pdf - 17-Feb-2023
Interview and Discussion questions - version 2.pdf - 17-Feb-2023
Group 3 Discussion questions and art activities.docx - 30-May-2023
Transforming Supports Art Group Poster.pdf - 30-May-2023
Building Community Through Art Survey Monkey - version 2.pdf - 07-Jun-2023
Group 3 Consent Form - version 2.docx - 07-Jun-2023
Consultation Recruitment Poster version 3(3).png - 01-Nov-2023
Appendix 3 - Survey Monkey Participant group 1 interviews version 4.pdf - 01-Nov-2023

Conditions of approval

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Amendments
To make changes to the approved research procedure in your study, please submit "Amendments" or "Annual renewal with amendments" form. You must receive research ethics approval before proceeding with your amended protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria's policies for research involving human participants.

Dr. Sandra Gibbons	Dr. Cindy Holder
Chair, Human Research Ethics Board	Vice-chair, Human Research Ethics Board

Certificate Issued On: 29-Oct-2024