

EXAMINING MENTAL HEALTH DISPARITIES AMONG TRANSGENDER AND/OR
GENDER NONCONFORMING YOUNG PEOPLE: A MIXED-METHODS APPROACH

by

RACHAL PATTISON

BA, The University of Calgary, 2008
MSc.OT, The University of Alberta, 2012

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Rehabilitation Sciences)

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

September 2020

© Rachal Pattison, 2020

The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the thesis entitled:

Examining Mental Health Disparities Among Transgender and/or Gender Nonconforming Young People: A Mixed-Methods Approach

submitted by Rachal Pattison in partial fulfillment of the requirements for

the degree of Master of Science

in Rehabilitation Sciences.

Examining Committee:

Dr. Skye Barbic, Occupational Science and Occupational Therapy

Supervisor

Dr. Joseph H. Puyat, School of Population and Public Health

Supervisory Committee Member

Dr. W. Ben Mortenson, Occupational Science and Occupational Therapy

Supervisory Committee Member

Abstract

Introduction: Transgender and gender nonconforming (TGNC) young people are vulnerable to a range of negative health outcomes (Reisner, Vettes, et al., 2015; Rider et al, 2018).

Additionally, our health systems are recognized as contributing to gendered health inequities (Payne, 2009). It is important that we understand the health outcomes and needs of TGNC young people, if we are to ensure delivery of effective integrated youth mental health services to this vulnerable population.

Objectives: The study compared rates of mental health distress between TGNC and cisgender youth and sought to understand how TGNC youth experience mental health services.

Methods: Adopting an intersectional framework, I used a mixed-methods, sequential explanatory approach. I conducted a secondary analysis of data of youth accessing a network of BC community health centers. I analyzed the difference in rates of mental health distress between TGNC and cisgender youth using a two-sample t-test. Next, I used stratified simple linear regression to test the association of race with TGNC identity and mental health distress. Finally, I conducted interviews with a purposive sample of TGNC young people to understand their experiences using mental health services. Qualitative data were analysed using qualitative description with overtones of constructivist grounded theory.

Results: The quantitative sample (n=727) had a mean age of 21 years (SD=2), 48% were non-white, 51% were white and 77% were from Metro Vancouver. Compared to cisgender youth, TGNC youth reported significantly higher levels of mental health distress. TGNC youth were more distressed than cisgender youth across both race strata but non-white TGNC youth were not more distressed than white TGNC youth. From the qualitative sample (n=5), TGNC participants revealed themes of upsetting interactions with health providers, barriers and facilitators to services, and their experiences of the gender binary as a form of tyranny. They provided simple, practical advice on

how to better support and affirm TGNC young people accessing care. **Conclusions:** The findings from this study emphasize the need for increased education and understanding of TGNC concepts and health concerns as well as on promoting intersectoral collaboration of social service organizations beyond simply health care.

Lay Summary

This study used survey methods to examine rates of mental health distress among transgender and/or gender nonconforming (TGNC) young people and qualitative interviews to explore the experiences of TGNC young people using mental health services in British Columbia. It looked at whether young people who identify outside the gender binary (for example, trans, nonbinary, gender nonconforming) report more mental health distress than their cisgender peers. TGNC young people were interviewed in order to understand their experiences using mental health services. The results showed that TGNC young people report more mental health distress than their cisgender peers. It also found that TGNC young people often reported upsetting interactions with health professionals and that they sometimes faced barriers when using health and mental health services. The youth interviewed provided simple advice to enable health professionals to be respectful and supportive when serving TGNC people.

Preface

The conception of this study was based on discussions with my supervisor Dr. Skye Barbic on issues related to gender identity and youth mental health, as this was a new area of study. The study design was developed by me, with guidance and input from Dr.'s Skye Barbic, Joseph H. Puyat and W. Ben Mortenson. The study's quantitative phase involved secondary analysis of data and data collection for this phase was part of a separate study. All data analysis for the quantitative phase and all data collection and analysis for the qualitative phase was done by me, with consultation from committee members, Dr.'s W. Ben Mortenson, Joseph H. Puyat and my supervisor, Dr. Skye Barbic. Approval for access to the existing dataset for the quantitative phase of the study was obtained from the University of British Columbia's Research Ethics Board [certificate # H17-00127]. The qualitative phase of the study was approved by the University of British Columbia's Research Ethics Board [certificate #H19-01072]. At present time, the work presented in this thesis has not been submitted for any publications.

Table of Contents

<i>Abstract</i>	<i>iii</i>
<i>Lay Summary</i>	<i>v</i>
<i>Preface</i>	<i>vi</i>
<i>Table of Contents</i>	<i>vii</i>
<i>List of Tables</i>	<i>ix</i>
<i>List of Figures</i>	<i>x</i>
<i>List of Abbreviations</i>	<i>xi</i>
<i>Glossary</i>	<i>xiii</i>
<i>Acknowledgments</i>	<i>xvi</i>
<i>Chapter 1: Introduction and Rationale</i>	<i>1</i>
Literature Review	5
Theoretical Framework.....	15
Objectives of proposed research.....	20
<i>Chapter 2: Methods</i>	22
Overall Study Design	22
Study Design and Data Source.....	24
Questions # 1 and 2	24
Inclusion/Exclusion Criteria:.....	25
Independent/Exposure Variable	26
Dependent/Outcome Variable	26
Other Variables	29
Data Quality	30
Power Calculation	33
Data Analysis Strategy	34
Question #3	36
Sampling and Recruitment Strategy:.....	36
Inclusion Criteria.....	37
Procedures	38
Qualitative Data Analysis.....	39
Quality Considerations.....	42
Reflexivity and Situating the Researcher	44
Ethical Approval and Data Management.....	45
<i>Chapter 3: Results</i>	47
Questions #1 & 2 Results.....	47
Demographics.....	47
Results of Statistical Analyses	52
Question #3 Results.....	53
Demographics of Qualitative Sample	53

Qualitative Findings	54
Theme 1: “These microaggressions will build up,” experiencing upsetting interactions with health providers	54
Theme 2: “Oh yea, I remember why I don’t wanna go there,” barriers and facilitators to care	60
Theme 3: “Oh, I feel completely invisible to society,” the tyranny of the gender binary.....	70
<i>Chapter 4: Discussion.....</i>	79
Synthesis of Findings from All Three Research Questions.....	79
Study Strengths and Limitations.....	95
Recommendations for Future Research	99
Implications for Policy and Programs	102
Implications for Clinical Practice.....	104
Knowledge Translation	105
Conclusion	106
<i>References</i>	108
<i>Appendices.....</i>	129
Appendix A: Study Demographic and Mental Health Outcome Survey.....	129
Appendix B: Written Consent Form.....	133
Appendix C: Verbal Consent Summary	139
Appendix D: Project Interview Script	141
Appendix E: COREQ Checklist	143
Appendix F: GRAMMS checklist	146
Appendix G: Qualitative Codes.....	148
Appendix H: Social Identity Map tool.....	149
Appendix I: Initial Contact Letter	150
Appendix J: Recruitment Poster	152
Appendix K: Online Learning Resources for Health Providers	153

List of Tables

Table 1 <i>Characteristics of study sample</i>	49
Table 2 <i>Univariable analysis of gender identity and mental health distress, stratified by race</i>	53
Table 3 <i>Multivariable analysis of gender identity, mental health distress and age, stratified by race</i>	53

List of Figures

Figure 1: <i>Distribution of K10 scores</i>	51
---	----

List of Abbreviations

BC: British Columbia

BMC: BioMed Central

CAOT: Canadian Association of Occupational Therapist

CCHS-MH: Canadian Community Health Survey-Mental Health component

CI: confidence interval

CIHR: Canadian Institute of Health Research

CINAHL: Cumulative Index of Nursing and Allied Health Literature

CSDH: Commission on the Social Determinants of Health

DSM-IV/V: Diagnostic and Statistical Manual of Mental Disorders-IV & V

IQR: interquartile range

K10: Kessler Psychological Distress Scale

KT: knowledge translation

2S/LGBTQ/I: Two Spirit, lesbian, gay, bisexual, transgender, queer, intersex.

MAR: missing at random

MCAR: missing completely at random

MNAR: missing not at random

MSS: Minnesota Student Survey

NSSI: non-suicidal self-injury

OT: occupational therapy/therapist

PRO: patient-reported outcome

RR: risk ratio

SPOR: Strategy for Patient Oriented Research

TGNC: transgender and/or gender nonconforming.

US: United States

UBC: University of British Columbia

WHO: World Health Organization

WPATH: World Professional Association for Transgender Health

Glossary

*all definitions taken from www.itspronouncedmetrosexual.com, “Defining LGBTQ+”

Commonly used terms related to gender identity	
agender	A person with no (or very little) connection to the traditional system of gender, no personal alignment with the concepts of either man or woman, and/or someone who sees themselves as existing without gender.
androgynous	A gender expression that has elements of both masculinity and femininity
cisgender	A gender description for when someone’s sex assigned at birth and gender identity correspond in the expected way (e.g., someone who was assigned male at birth, and identifies as a man). A simple way to think about it is if a person is not transgender, they are cisgender. The word cisgender can also be shortened to “cis.”
female-to-male transgender (FTM, FtM)	Female-to-male transgender or transsexual person. Related terms include transman, transmale, transmasculine, transmasc, transboy
gender binary	The idea that there are only two genders and that every person is one of those two or man/woman.
gender expression	The external display of one’s gender, through a combination of clothing, grooming, demeanor, social behavior, and other factors, generally made sense of on scales of masculinity and femininity. Also referred to as “gender presentation.”
gender fluid	A gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders
gender identity	The internal perception of one’s gender, and how they label themselves, based on how much they align or don’t align with what they

	understand their options for gender to be. Often conflated with biological sex, or sex assigned at birth.
gender nonconforming	1: A gender expression descriptor that indicates a non-traditional gender presentation (masculine woman or feminine man). 2: A gender identity label that indicates a person who identifies outside of the gender binary. A related term is nonbinary. Often abbreviated as “GNC.”
gender normative	Someone whose gender presentation, whether by nature or by choice, aligns with society’s gender-based expectations.
genderqueer	A gender identity label often used by people who do not identify with the binary of man/woman. An umbrella term for many gender nonconforming or nonbinary identities (e.g., agender, bigender, genderfluid).
male-to-female transgender (MtF, MTF)	Male-to-female transgender or transsexual person. Related terms include transwoman, transfemale, transfemme, transfeminine, transgirl
nonbinary	see gender nonconforming and genderqueer definitions
trans*	An umbrella term covering a range of identities that transgress socially defined gender norms. Trans with an asterisk is often used in written forms (not spoken) to indicate that you are referring to the larger group, and specifically including non-binary identities, as well as transgender men (transmen) and transgender women (transwomen).
transgender	An umbrella term for anyone whose sex assigned at birth and gender identity do not correspond in the expected way (e.g., someone who was assigned male at birth, but does not identify as a man) and who may or may not be seeking to transition.

transsexual	A person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to transform their bodies hormonally and surgically to match their inner sense of gender/sex.
Two Spirit	A modern English term that an Indigenous person might take for themselves that comes from the traditional knowledge of Indigenous peoples in Turtle Island (what is now called Canada/North America). It can mean a person who walks between genders; one who carries the gifts of both males and females, or one who is gender unique (not specific to any gender) and/or as a way to identify as 2STLGBQ+. (<i>definition from http://teentalk.ca/learn-about/gender-identity/</i>)
sex assigned at birth	A phrase used to intentionally recognize a person's birth-assigned sex (not gender identity).
questioning	An individual who is, or a time when, someone is unsure about or exploring their own gender identity.

Acknowledgments

First and foremost, I want to acknowledge the youth who contributed to this research study and shared their personal experiences with a complete stranger, in the hopes of making the way easier for younger TGNC people not yet fully exposed to the insidious whims of the world. In spite of your negative experiences, your strength, compassion and resilience are what shine through; I hope that my research can do justice to the force of change you bring to this world.

I would like to acknowledge my supervisor, Dr. Skye Barbic, for agreeing to take me on as a student and for giving me the freedom to work on a project that aligned with my interests and values. Thank-you, Skye, for representing mental health OT's in the academic world; keep fighting for us! I would also like to thank my committee member, Dr. Joseph H. Puyat, for sitting with me so patiently while I stumbled through R Studio, coding and quantitative data analysis; you are an excellent teacher! Thank-you to my committee member, Dr. W. Ben Mortenson, for helping me muddle through qualitative data analysis and for being so responsive to my random questions!

I would like to thank UBC Department of Psychiatry's Marshall's Scholar in Mental Health award for recognizing the value in my research project and for generously funding it. Thank-you as well to the Canadian Federation of Occupational Therapists for also recognizing the value in my research project and for awarding me the Invacare Masters Scholarship in 2019; I hope that my contribution to OT knowledge and practice will do you proud.

On a personal note, I would like to thank my parents for inviting me to move back home with them in order to get through graduate school; I cannot stress just how wonderful and supportive you both have been for me on this journey. Special thanks as well to my friends, Ally and Laura, who tolerated my rants on academia, graduate school and the problems with the

health and mental health systems, with humor and grace. I deeply appreciate both your support and friendship as a new person in the scary city of Vancouver. Lastly, I want to honor my own efforts in embarking on this massive life change whilst undergoing an intense personal evolution; you did it, you can do it and you can handle anything!

Chapter 1: Introduction and Rationale

In Canada, people aged 15 to 24 have the highest rates of mental disorders than any other age group and nearly 20% of young people experience a mental disorder compared to 9.8% of those aged 25 to 64 (Statistics Canada, 2019a). In addition, young people experience many barriers to accessing health services (Patton et al., 2016). With one in four Canadian young people experiencing a mental health difficulty each year, it is crucial that we develop a strong understanding of how to identify young people in distress and connect them to appropriate and youth-centered services.

How is a “young person” defined?

The World Health Organization (WHO) defines “adolescence” as between 10 and 19 years and “youth” as between 15 and 24 years, while “young people” is used to refer to those aged 10 to 24 years (Patton et al., 2016). There is some variety in the literature in terms of the definitions for “young people,” “youth,” or “young adult,” as these years typically include great change and exploration as individuals come to understand themselves and begin choosing their roles in life (Arnett, 2000). This thesis will utilize the age range 16 to 25 years as it coincides with what Arnett describes as a period when “many different directions remain possible, when little about the future has been decided for certain, when the scope of independent exploration of life’s possibilities is greater for most people than it will be at any other period of the life course” (Arnett, 2000, p. 469). The terms “young people” and “youth” will be used interchangeably throughout this thesis to refer to this age range of 16 to 25 years.

What are the social determinants of health?

Social determinants of health play a key role in predicting health outcomes for Canadian young people who experience mental health concerns. The social determinants of health are defined by the WHO's Commission on the Social Determinants of Health (CSDH) as, the key social conditions people face, from birth to death, which are shaped by the distribution of money, power and resources at all levels of society (CSDH, 2008). The recognition that the social environment plays a role in the relative health and wellbeing of individuals and groups has been long established in epidemiological research (Marmot & Bell, 2012; Rose, 2001; Syme, 1994). The social gradient of health, a concept originally established by the results of Dr. Michael Marmot's study of British civil servants (Marmot et al., 1978), demonstrated that sociodemographic factors impact health outcomes, in a stepwise fashion, down social categories (for example, education or occupational status). That is, after controlling for income, individuals in lower occupational/employment grades (e.g., trades or unskilled labour) are more likely to suffer poorer health outcomes than those in higher employment grades (e.g., executives, professional class). Findings from this study inspired a new conceptualization of understanding and addressing health inequities caused by factors outside of body structure and function. This led to the WHO Commission on the Social Determinants of Health (CSDH), whose goals were to improve population health, reduce health inequities and to reduce disadvantages due to ill health and it identified several critical social determinants (CSDH, 2008). One of the critical social determinants was an emphasis on gender and the understanding that gender inequities are a clear driver of disparate health outcomes. It recognized that due to the social nature of gender biases, there exists an

unequal distribution of resources, power, and access to services (CSDH, 2008). As Canadian health services works toward a more accessible system of care for youth, consideration of gender is critical.

Gender as a social determinant of health

Gender is defined as those “roles, behaviors, activities, attributes and opportunities that society considers appropriate for boys and girls, and men and women” (Manandhar et al., 2018, p. 644). Gender also affects how individuals are in relationship with one another and with social institutions like the health system. Within Canada, there is increasing focus on how to account for gender within health systems and health research. For example, the Canadian Institutes of Health Research (CIHR) has developed several policies for promoting and integrating sex- and gender-based analysis into health research (CIHR, 2018). According to Standing (1997) a gender inequality approach to health is specifically concerned with power relations between genders and how these can have differential impact on access to, and use of, the health system, leading to health inequities among genders. According to Morgan and colleagues (2016), such power relationships can impact health risks, service utilization, help-seeking behavior, the design of the health system as a whole and even how health policies are developed. With the recognition that gender differences contribute to health inequities, the WHO further stipulated that individuals or groups who do not fit into these socially constructed categories for gender (i.e., male & female) face stigma, discrimination and social exclusion, all of which have a negative impact on health outcomes (WHO, 2011). This is particularly pertinent to young people who identify as transgender (identifying with a gender different from the sex assigned at birth) and/or gender nonconforming (TGNC)

and whose gender expression may not conform to conventional notions of masculinity or femininity (please refer to the *Glossary* for a comprehensive list of terms and definitions).

To date, much of the research on gender and mental health outcomes has focused on the differences between men and women. A report by the WHO titled, *Women's Mental Health: An Evidence-Based Review* (2000), details evidence suggesting that women are twice as likely as men to receive a diagnosis of depression while men are more likely to receive a diagnosis of alcohol dependence. This report also found that women have higher prevalence rates than men in comorbidity of three or more disorders (e.g., depression, anxiety, posttraumatic stress disorder, agoraphobia etc.). Additionally, there may be gender differences among young people that could play a key role in health seeking behaviours (Georgakakou-Koutsonikou & Williams, 2017; Harris et al., 2015) and service provision and outcomes (Asher et al., 2017; Van de Velde et al., 2010). The WHO report on women's mental health also points toward the gendered nature of the social gradient of health and that low social status is a predictor of depression; however, no reference is made to gender disparities in mental health among TGNC people (WHO, 2000). As recently as May 2019, the WHO amended the International Classification of Diseases and removed "gender identity disorder" to replace it with "gender incongruence," in an attempt to emphasize that being trans and/or gender nonconforming is not a mental health condition (Papenfuss, 2019). This was following the removal of "gender identity disorder" as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) in 2012 (Heffernan, 2012). With this recognition, it is vital that the Canadian model of youth mental health services delivery be inclusive and

responsive to a wide range of needs and that health systems share in the responsibility of addressing health disparities (Payne, 2009).

Literature Review

Health outcomes for TGNC young people

Research in the area of mental health outcomes and access to services for TGNC young people is a small but growing area. Studies have found significant mental health disparities between TGNC young people and their cisgender peers (individuals who identify with a gender related to the sex assigned at birth) (A. Brown et al., 2016; B. A. Clark, Veale, Townsend, et al., 2018; T. Clark et al., 2014; Corliss et al., 2007; Johns et al., 2017; Reisner, Vetters, et al., 2015; Rider et al., 2018; Snyder et al., 2017; Van Donge et al., 2018; Wagaman, 2014). A search of the following databases, from 1985-2020: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Library, MEDLINE (OVID) and PsycINFO revealed ten studies on mental health outcomes and service utilisation in TGNC young people: three qualitative studies (Corliss et al., 2007; Guss et al., 2019; Wagaman, 2014), one mixed-methods (Snyder et al., 2017), one systematic review (A. Brown et al., 2016) and five quantitative studies (Goldenberg et al., 2019; Johns et al., 2017; Reisner, Vetters, et al., 2015; Rider et al., 2018; Van Donge et al., 2018). These studies suggest that TGNC young people experience higher rates of mental health concerns and have reported a range of experiences, predominantly negative, within health and mental health services.

Review of the studies on mental health outcomes for TGNC young people

Of the five quantitative studies found, a cross-sectional study by Rider and colleagues (Rider et al., 2018) found that 59% of TGNC youth self-reported having long-term mental health problems, compared with 17% of their cisgender peers. The study analyzed data from the Minnesota Student Survey (MSS), which consisted of 80,929 student responses, comprised of 2,168 TGNC students and 78,761 cisgender students between grades 9 to 11. The MSS defined “long-term mental problems” by the survey question: “Do you have any long-term mental health, behavioral, or emotional problems? Long term means lasting 6 months or more” (Rider et al., 2018, p. 3). The MSS utilized a modified version of a two-step question process for determining gender identity, recommended by the World Professional Association for Transgender Health (WPATH), which involved an initial question on gender identity and a follow up question on sex assignment at birth (Deutsch et al., 2013; Reisner, Deutsch, et al., 2016). Use of such a method within this study allowed for a more accurate capture of the TGNC sample, since traditional health data methods for capturing gender identity can obscure those individuals who identify within the gender binary (i.e. man/woman) but who are transgender.

As well, this study’s use of the approach recommended by WPATH for identifying the TGNC population, along with the large sample size, helps maximize external validity and demonstrates a clear representation of frequency and distribution of the outcomes of interest (Reisner, Deutsch, et al., 2016). A disadvantage of this study was the narrow age range from which they sampled, in selecting survey data from only young

people attending school in grades 9 to 11, it may be difficult to generalise the results to older TGNC young people, aged 16-25 years.

A matched, retrospective cohort study out of the US (Reisner, Veters, et al., 2015) examined transgender youth, aged 12-29, accessing a community health clinic in the US and matched them to cisgender patient controls. The sample (n=108) was identified based on a review of medical charts that included the health record code for “transgender”, as self-reported by the individual to their care provider or as identified on patient registration forms (Reisner, Veters, et al., 2015). The findings demonstrated that TGNC youth are at almost 4 times the risk for depression (RR=3.95) and anxiety (RR=3.27) and that transgender youth disproportionately endorse suicide (suicide ideation: RR=3.61, suicide attempt: RR=3.20) when compared to cisgender controls. This method for identifying the exposure group, while not in-line with the method recommended by WPATH, is a common health-systems based approach utilized because of the ease of accessing such health data at various sites (Reisner, Deutsch, et al., 2016). However, limitations of this sampling method are that it may not capture those youth who are not disclosing their gender identity to a provider, those who are not able to access services at a community based clinic and/or those who are not seeking gender-specific medical care, which could lead to an underrepresentation of results. This study focused exclusively on transgender young people and did not provide an examination of the health outcomes of gender nonconforming (e.g., nonbinary, agender, genderfluid, genderqueer) individuals. The Standards of Care published by WPATH emphasizes that “the expression of gender characteristics, including identities, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally diverse

phenomenon” (Coleman et al., 2012, p. 4) and encourages the inclusion of a range of gender identities in medical and research approaches.

The study from Goldenberg et al., (2019) looked specifically at black TGNC young people and at the role of gender affirmation in health care in mitigating the effect of negative stigma on subsequent health care use. Using data from 110 black TGNC youth, recruited from across the US, the results revealed that in the absence of gender affirmation practices and with the presence of anticipated stigma (the belief that discrimination or prejudice will be directed at oneself in the future) in a healthcare setting, there was an increase in delayed or non-use of health care for this population (Goldenberg et al., 2019). Limitations of this study included a small sample size and recruiting exclusively from within an HIV/AIDS medical interventions network.

A cross-sectional study by Van Donge (2018) examined transgender young people whose parents or caregivers were members of the US military and who were currently being cared for within the US military health system. Fifty-three (53) young people participated in this study and results indicated similarly high rates of mental health conditions, like anxiety, depression, suicide and self-injury, as seen among civilian transgender youth. The authors recognized that this sub-population may not be representative of the wider youth transgender population and stated several potential confounding factors. Primary limitations of this study were its poorly described study design, unclear sampling procedures, and its poor reporting of bias.

Another cross-sectional study from the United States by Johns et al., (2017) looked at the sociodemographic factors associated with health outcomes in transfemale (individuals assigned male at birth who identify as a woman and/or present themselves in

a traditionally feminine manner) young people. This study utilized a secondary analysis of data from a larger study of trans female young people, aged 16-24 in the San Francisco Bay area in order to understand the barriers to accessing health and mental health care among trans female youth. It examined data from 250 trans female young people and found that unstable housing and homelessness were the most significant factors associated with barriers to accessing mental health care due to gender identity. A history of unstable housing was associated with higher odds of problems accessing medical care (odds ratio: 2.16) and mental health care (odds ratio: 2.65) due to gender identity. The study also indicated that being gender nonconforming meant the youth were less likely to report problems accessing care due to their gender identity than their trans female counterparts (Johns et al., 2017). This study is important because it implicates stigma (negative stereotyping) and discrimination (unfair treatment due to a person's identity) related to gender identity in the difficulties faced by trans youth in accessing medical and mental health care. Limitations to this study were the exclusive focus on trans female youth, limited description of sampling methods, and reliance on self-report survey data.

Three qualitative studies (Corliss et al., 2007; Guss et al., 2019; Wagaman, 2014) explored the lived experiences of TGNC youth within the health care system and results indicate a range of experiences, from negative to positive. The study by Wagaman (2014) found that LGBTQ (lesbian, gay, bisexual, transgender, queer) youth faced many barriers to accessing mental and physical health services and it described the youths' experience of feeling excluded from services that did not recognize their gender identity or provide care that acknowledged their multiple, intersecting identities. This study adopted an intersectional lens in its approach to understanding the youths' experiences, one that

honoured the multiple intersections of the different aspects of their identities, including race/ethnicity, class, and ability status. The fifteen young people who participated in this study were sampled from a community organization specifically serving LGBTQ youth in an urban area (Wagaman, 2014). The results of this study indicated that LGBTQ youth often face multiple risks related to stigma and marginalization when accessing health and social services, due to their sexual and/or gender identities. It also highlighted the importance of utilizing an intersectional approach to understanding how peoples' multiple identities may shape the experience they have with social and health services. A limitation of this study was its focus on a LGBTQ sample as a monolith. It bears mentioning that while sexual identity (as in sexual and romantic attractions, e.g., lesbian, gay) and gender identity (as in the intrinsic sense of one's own gender, e.g., transgender, gender nonconforming) can and do overlap within a person's overall identity, it may be relevant from a research perspective to examine the impact of the latter on how a person experiences mental health services.

The study by Guss et al., (2019) interviewed twenty TGNC adolescents from 13 – 21 years, who were all recruited from youth primary care and gender-specific clinics in two large US cities. The interviews focused on the young peoples' experiences using primary care services and sought their recommendations for physicians, health staff and health clinics. Results from this study showed that while these young people reported mostly positive experiences with primary care, the primary things that contributed to a negative experience were when health staff used the wrong name and/or pronouns for the person (Guss et al., 2019). Limitations of this study include recruitment from only one (predominantly urban) part of the US, majority white participants, and the recruitment of

TGNC people from clinics where providers had already received training related to TGNC care.

A qualitative study by Corliss (2007) conducted interviews with eighteen transwomen (individuals assigned male at birth who identify as a woman and/or present themselves in a traditionally feminine manner. See *Glossary* for related terms) from a trans-specific health clinic in Los Angeles about their experiences utilizing mental health services. One-third of these young people indicated that psychological counselling was beneficial as long as the therapist was knowledgeable regarding transgender issues and non-judgmental. However, 20% of respondents indicated counselling was unhelpful and uncomfortable due to a judgemental or disrespectful therapist. A limitation of this study was its sole focus on trans women's experiences.

The systematic review by A. Brown (2016) reviewed the literature on barriers and facilitators to accessing mental health services for young people from a variety of marginalized groups. This review (A. Brown et al., 2016) selected studies that focused on "emerging young adults" or those from the ages of 12 to 25 years and out of 62 total studies reviewed, four were from the "LGBTQI" (lesbian, gay, bisexual, transgender, queer, intersex) population. Results from this review highlighted that marginalized youth faced many barriers to accessing mental health care and emphasized that each of the identified groups presented with unique needs as it related to accessing that care; it called for the recognition of these distinct needs when considering improvements to the mental health care system.

A mixed-methods study by Snyder, Burack and Petrova (2017) examined sixty LGBTQ youths' experiences with primary care doctors in an effort to identify areas for

improvement. This study used questionnaires and focus groups to survey youth aged 14 years and older who were accessing services from five community-based organizations in New Jersey that provided LGBTQ-specific services. Results indicated that many participants reported poor communication with their health care providers and at times disrespectful or inappropriate comments by physicians regarding their sexual or gender identity. Limitations of this study included limited generalizability due to recruitment of participants from LGBTQ-specific services in only one US city.

Studies from a Canadian context

There are a small number of studies from a Canadian context that look at health outcomes of Canadian TGNC young people that were not captured from the original search but that are relevant here (B. A. Clark, Veale, Greyson, et al., 2018; B. A. Clark, Veale, Townsend, et al., 2018; Veale, Watson, et al., 2017). One study used nonprobability sampling to obtain data on transgender youth in order to compare various mental health outcomes with existing population-based estimates (Veale, Watson, et al., 2017). Data from the Canadian Trans Youth Health Survey were compared with data from the British Columbia Adolescent Health Survey (for 14 to 18-year old's) and the 2012 Canadian Community Health Survey Mental Health component (for 19 to 25-year old's). Outcomes included mental health distress, suicidality (ideation and attempts), self-harm in the past year and general self-reported mental health and compared these among youth aged 14 to 18 years and young people aged 19 to 25 years. The results from this study highlighted significantly higher mental health disparities among transgender youth for both age groups (Veale, Watson, et al., 2017). Estimates from the nonprobability sample for suicide attempts in the past year and instances of major depression in the past

year indicated 16 times and 9 times the risk (RR:16.16 and RR: 9.11), respectively, compared to population-based estimates for those aged 19 to 25 years. Transgender people, 19 to 25-years old, scored more than two standard deviations higher on the Kessler Psychological Distress Scale (K10), compared to cisgender young people of the same age.

Another study examined the differences in health outcomes and health service experiences between non-binary trans youth (individuals who experience gender in a way that does not coincide with the sex assigned at birth and somewhere outside the masculine/feminine binary) and binary trans youth (B. A. Clark, Veale, Townsend, et al., 2018). Using data from the Canadian Trans Youth Health Survey, respondents were put into 3 groups based on their responses to the gender identity item: non-binary, trans girl/woman, and trans boy/man. Demographically, non-binary youth and binary youth were similar, however a significant proportion of non-binary youth were assigned female at birth (81.6% compared to 69.9% for binary youth). Results demonstrated that non-binary youth had significantly lower odds of reporting their general mental health as “excellent” or “good,” that non-binary youth had increased odds of reported non-suicidal self-injury (NSSI) and that they experienced more barriers to accessing gender affirmative care than binary youth (B. A. Clark, Veale, Townsend, et al., 2018). Limitations of this study included a potential over-representation of non-binary youth connected to trans communities, as the recruitment focused on youth accessing gender-specific care from trans health organizations.

Another study by B.A. Clark and colleagues (B. A. Clark, Veale, Greyson, et al., 2018) examined primary care use and forgoing health care by TGNC young people aged

14-25 years, in Canada. This study used data from the Canadian Trans Youth Health Survey (n=923), which surveyed young people from all Canadian provinces on their self-reported health, access to primary care, comfort level with doctors and on items related to forgoing health care. The results indicated that Canadian trans youth report lower levels of self-reported health than cisgender young people and higher levels of forgoing health care services. The study also revealed that a lack of comfort with primary care physicians often lead TGNC young people to avoid needed medical and specifically, mental health, care. Limitations of this study included online survey administration, a medium that could possibly lead to the exclusion of young people who do not have internet access, are from lower socioeconomic backgrounds or rural and remote areas.

Summary of the reviewed literature

This literature points toward the mental health disparities among TGNC young people, on a range of different mental health outcomes, including mental health distress. The current literature also sampled from a variety of populations, in that some papers examined exclusively transgender *and* gender nonconforming young people (Reisner, Veters, et al., 2015; Rider et al., 2018; Van Donge et al., 2018), some sample from transwomen/females only (Corliss et al., 2007; Johns et al., 2017), while the others sample from the broader LGBTQ umbrella (A. Brown et al., 2016; Snyder et al., 2017; Wagaman, 2014). Most of the qualitative studies reviewed fell within the latter category and did not distinguish gender from sexual minorities with the LGBTQ label. It is relevant to differentiate between sexual (as in LGBQ) and gender identities (as in TGNC), both from a research and health inequity perspective, as TGNC youth may experience key differences in mental health outcomes and services access., compared to

LGBQ youth. The majority of the qualitative studies reviewed identified that the negative experiences with health services providers were characterised by judgmental attitudes, disrespectful and/or inappropriate comments regarding a youth's gender identity, a lack of understanding about gender and transgender issues, and/or invalidating of the youth's gender identity. This underscores the importance of better understanding both the mental health outcomes and the lived experiences of TGNC young people accessing integrated mental health services, if we are to improve health service access and delivery for this vulnerable population in British Columbia (BC).

This research project used a mixed-methods approach to compare mental health outcomes of TGNC and cisgender young people accessing integrated youth mental health services in a Canadian context. Specifically, this study: 1) tested whether TGNC young people accessing integrated mental health services experience a higher burden of mental health distress compared to cisgender peers, and 2) sought to understand the lived experience of TGNC young people accessing mental health.

Theoretical Framework

I approached this research from the ontological position of interpretivism/constructivism, which posits that there is no unifying reality or truth. Instead, reality is created by individuals and groups and must be interpreted by the researcher who is seeking to understand the multiple perspectives within an issue. Within an interpretive ontological position, there are “socially constructed multiple realities” (Adbul Rehman & Alharthi, 2016, p. 55) that are co-constructed by the research participants and the researcher, neither of whom can maintain an objective stance. With

this understanding, I acknowledge that my own values, privileges, worldview, and experiences colour any interpretation of data and results. This interpretivist/constructivist position informed both the quantitative and qualitative aspects of this study, as I consider the quantitative results to be one of many perspectives that may exist. My study was also guided by an intersectional framework (Bowleg, 2012; Crenshaw, 1991).

Intersectionality.

Intersectionality is a theoretical framework with roots in critical race studies and legal scholarship that considers how “how multiple social identities at the individual level of experience (i.e. micro level) intersect with multiple-level social inequalities at the macro structural level” (Bowleg, 2012, p. 1269). This term was originally coined by legal scholar, Kimberle Crenshaw, in her work on the systemic exclusion of the experience of black women in both feminist and anti-racist movements (Bowleg, 2012; Crenshaw, 1991). Crenshaw (1991) examined how the forces of racism and sexism intersect for women of color and how this produces a further marginalized experience that neither anti-racist nor anti-sexist movements can address. As a theoretical framework, it examines the intersections of belonging to multiple, marginalized groups and how this translates into a subordinated experience which cannot be explained by focus on the individual’s position in either marginalized group alone. Intersectionality encourages a departure from the view that categories like race, gender, class, or sexual orientation are separate entities and instead, invites an examination of how these categories can be understood as multiple and intersecting forces that interact to produce inequalities both at the individual and at the structural level. It has been a popular theoretical framework for feminist and critical race theorists, despite the debate over its status as a unifying theory;

“some suggest that intersectionality is a theory, others regard it as a concept or heuristic device and others see it as a reading strategy” (Davis, 2008, p. 68). Some scholars see the perceived ambiguity of intersectionality to be its strength and an important contribution to how we analyse social disparities (Crenshaw, 1991; Davis, 2008). For example, Davis (2008) argues that its postmodern approach of deconstructing the polarities within social categories can help to break apart the universalism inherent in Western notions of science. Intersectionality can act as a key framework for examining health disparities and can be used to improve the public health approach to redressing health inequalities (Bauer, 2014). As Bowleg (2012, p. 1267) argues, “acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities of health disparities”.

Capturing the complexity of inequality is an elaborate challenge, especially within quantitative methods and an intersectional approach would reject a purely data driven approach to analyzing differences between groups like gender, race, or class (Bauer, 2014). Instead, inequalities need be assessed in a contextual or multilevel approach that “focuses on the complexity of relationships among multiple social groups within and across analytical categories” (McCall, 2005, p. 1786). McCall (2005) argues for an inter-categorical approach to the complexity of intersectionality, which would posit that different social and historical contexts can yield inequality constellations that vary across different social locations, e.g., patterns of racial or gender inequality can evolve in a different manner across various economic contexts. Therefore, the focus of analysis is on the relationship between social categories and how these relations can shift and change within the context of various social conditions to produce inequalities. For this reason,

this project not only asked about the effect of TGNC identity on mental health distress, but also how this effect might be different for people within different racial categories.

Intersectionality & Race

In keeping with an intersectional approach, I opted to examine the effect of gender identity on mental health within the context of race. The variable of race was chosen because of evidence that shows being exposed to social advantage and disadvantage (as in adverse experiences like victimization, harassment, discrimination and/or bullying for example) is implicated in overall mental health and wellbeing (WHO & Calouste Gulbenkian Foundation, 2014). Studies have also found that race and racism are implicated in the elevated rates of HIV in trans people in general and in trans women of color specifically, both in Canadian adults (Longman Marcellin et al., 2013) and US youth (Garofalo et al., 2006). It has been established in existing literature that experiences of racism are consistently related to poorer mental health outcomes, in both adults (Paradies et al., 2015) and school aged youth (Priest et al., 2014). Beyond health and mental health outcomes are the more troubling social statistics out of the US, by the Human Rights Campaign Foundation, who found that since 2013, 157 TGNC people have been killed, of which 89% (n=139) are people of color, including 77% (n=122) black and African-American (Human Rights Campaign Foundation, 2019). Recognizing the intersecting force of race in the relationship between TGNC identity and mental health distress is in keeping with an intersectional approach to understanding complexities inherent in health outcomes.

Integrated youth mental health services in British Columbia

There is growing recognition of the importance of integrated mental health services for young people in Canada. The recent announcement of BC's 10-year vision for mental health care prioritizes the wellness of youth and young adults in A Pathway to Hope roadmap (Office of the Premier, 2019), which cites a vision to transform the province's mental health and substance use care. Within the Pathway to Hope roadmap, a three-year, BC-wide, plan is outlined to establish easily accessible health, mental health and social services for the province's young people, in an effort to bring services to individuals who need it most and in a manner in which they may feel safe and comfortable. Core to this roadmap is an investment in "integrated youth health services."

Integrated youth health services recognize the need for a holistic approach to health services that include early intervention, ease of access, utilization of evidence-based treatments, and support for front-line health staff (Fusar-Poli, 2019). The framework for integrated youth health services proposes to develop a system that responds to the needs of young people, rather than require young people to fit into existing services (Mughal & England, 2016). In 2015, following a period of consultation with diverse stakeholders across BC, an integrated youth health service was conceptualized and branded as Foundry (foundrybc.ca). The Foundry service model stipulates that health and social services are provided all in one location, thus easing the difficulties associated with accessing multiple services at multiple sites. In serving young people from ages 12 to 24 years, Foundry strives to reach individuals, including TGNC young people, as early as possible in order to better support them in their health and wellness journey. As Foundry continues to serve BC's young people, an understanding of

the mental health outcomes and diverse lived experiences of TGNC youth is critical in developing tailored services, accessible to all young people, where and when they need it.

Objectives of proposed research

The overall objective of the research is to compare rates of mental health distress between TGNC and cisgender young people and to understand the experiences of TGNC young people using mental health services.

The **specific objectives** of this project are to:

- 1) **Compare levels of mental health distress** between TGNC and cisgender young people. *Hypothesis: TGNC young people will have significantly higher scores on the Kessler Psychological Distress Scale (K10) compared to cisgender young people.*
- 2) **Understand how mental health distress** scores among TGNC young people are associated with social categories like race. *Hypothesis: TGNC youth at the intersection of TGNC identity and non-white race will report higher levels of mental health distress.*
- 3) **Gain an understanding of how TGNC youth experience mental health services** and what challenges they face being TGNC within the health system. *This will expand on the quantitative data by exploring how the youths' different, intersecting identities influence their experiences of mental health services.*

Research Questions

Question #1: To what extent is mental health distress different in TGNC young people as compared to cisgender young people?

Question #2: To what extent does race amplify the association between TGNC identity and mental health distress?

Question #3: What are the lived experiences of TGNC young people accessing mental health services in BC?

Chapter 2: Methods

This section details the methods and methodology I utilized to address my research objectives. I start with overall study design and then report on the specific quantitative and qualitative methods I used as part of this study. The relevant research questions are referenced at the start of each section.

Overall Study Design

To answer these research questions, I used a mixed-methods study design. Within the health science research field, there has been growing interest in utilizing mixed methodologies to explore the complexity of health issues alongside a recognition that the complicated nature of studying health disparities calls for a multiplicity of research approaches (Creswell et al., 2011). As defined by Creswell and colleagues (2011, p. 4), mixed-methods research focuses on incorporating “rigorous quantitative research assessing magnitude and frequency of constructs and rigorous qualitative research exploring the meaning and understanding of constructs.” Mixed-methods research goes beyond simply using both quantitative and qualitative methods to answer a research question, instead it attempts to integrate the findings from both aspects into a nuanced, “third” interpretation (Fetters & Molina-Azorin, 2017; O’Cathain et al., 2010). O’Cathain, Murphy & Nicholl (2010, para. one) refer to integration as a “conversation between the qualitative and quantitative components of a study” and assert that this conversation occurs at each stage of the study, from background, to design, analysis and interpretation of findings. Integration at these different levels has been referred to as the “mixed-methods integration trilogy” (Fetters & Molina-Azorin, 2017, p. 291), which

conceptualizes how quality mixed-methods research can be conducted, with the overall goal of generating a whole that is greater than the sum of its parts.

Of the variety of mixed-methods designs available, I utilized a sequential explanatory approach (Tashakkori et al., 2010). The sequential nature of the quantitative methods followed by qualitative methods was meant to bring to life the numbers and statistics through the voices of study participants. The sequential explanatory design is one of the core designs outlined by Creswell & Plano-Clark (2011) and in using it, I wanted to determine whether the quantitative results compared or not to the themes that emerged from the qualitative results, through the approach of “merging” (Creswell & Plano Clark, 2011; Fetters et al., 2013). The sequential explanatory approach is a popular one with health researchers who are attempting to provide an in-depth examination of quantitative results, especially for unobservable health constructs or to describe differences between populations (Creswell et al., 2011). In the Discussion section of this thesis (Chapter 4), I integrated the findings of my mixed-methods approach using a “weaving approach,” wherein I related the “qualitative and quantitative findings together on a theme-by-theme or concept-by-concept-basis” (Fetters et al., 2013, p. 2142).

I selected this particular mixed-method design to try offer insight into the quantitative data and to recognize how the different dimensions of an individual’s identity influences their experiences using mental health services. This helped to generate a nuanced picture of the research objectives that considered the complex context as well as the diverse perspectives among the sample population. Rather than emphasizing the importance of gender identity alone, this research also explored how different aspects of an individual’s identity shaped their experiences (for example, race).

The application of the theoretical frames of reference to the research.

According to Hankivsky & Christoffersen (2008, p. 276), “examinations of health inequities that are reduced to any one single determinant or marker of difference [are] inadequate for understanding the various dimensions that are always at play shaping and influencing social positions and power relations.” In utilising an intersectional framework to conceptualise the interplay between the different aspects of young peoples’ identity on their mental health distress and subsequent experience with health services, this research sought an expanded understanding of health inequities among Canadian TGNC young people. The use of mixed-methods research was well-suited to the intersectional framework because it examined the intersection of quantitative and qualitative knowledge in an attempt to “generate meta-inferences beyond what either approach could alone” (Guetterman et al., 2017, p. 1).

Study Design and Data Source

Questions # 1 and 2

Question #1: To what extent is mental health distress different in TGNC young people as compared to cisgender young people?

Question #2: To what extent does race amplify the association between TGNC identity and mental health distress?

Using a descriptive, cross-sectional design, I conducted a secondary analysis of an existing dataset from Foundry. As noted previously, Foundry is a new integrated health initiative in British Columbia (BC) designed to support young people with their mental health and wellness needs. The dataset for this study was pulled from an existing study

funded by CIHR, that looked at the mental health and recovery needs of Foundry youth using the Strategy for Patient-Oriented Research (SPOR) protocol (Barbic et al., 2019). A more detailed description of this dataset can be found elsewhere (Barbic et al., 2019), but briefly, it purposively sampled youth from a variety of both urban and rural settings from Foundry locations across BC, including Vancouver-Granville, Vancouver-North Shore, Victoria, Kelowna, Campbell River and Prince George. Of note, the Campbell River data were not included in this study as the data were not ready in time for analysis. Key variables included demographic and gender identity information and a range of mental health patient-reported outcome (PROs) measures, including the Kessler Psychological Distress Scale (K10). The gender identity information included expanded options, beyond solely female/male. The survey assessment package was completed by youth using either a paper copy or on an electronic tablet. A youth research assistant, trained for the purposes of this study, assisted all participants to complete the survey package. This dataset focused on individuals accessing Foundry centers and included youth from 16-25 years old.

Inclusion/Exclusion Criteria:

For the quantitative phase, young people aged 16-25 years who participated in the previously mentioned study looking at the recovery and mental health needs of youth (Barbic et al., 2019) and completed this study's survey assessment package were included in this arm of the study. Young people who did not consent to their health survey data being used for research purposes were not included.

Independent/Exposure Variable

Gender was explored as the primary independent variable. Please see Appendix A for the complete demographic survey and the specific gender item. The dataset (Barbic et al., 2019) defined gender categorically with the following levels: “male,” “female,” “non-binary,” “Two Spirit,” “trans female,” “trans male,” “not sure/questioning,” “prefer not to answer” and “I don’t identify with any of these options/other.” For my study, the cisgender group was characterized by those youth who indicated either “male” or “female” on the primary dataset’s survey assessment package. The TGNC group was characterized by those youth who indicated any of the following categories: “non-binary,” “Two Spirit,” “trans female,” “trans male,” “not sure/questioning” and “other”. The individuals who selected “prefer not to answer” were left out of the analyses to respect their desire to not define their gender; these youth made up 0.005% (4/727) of the entire sample.

Dependent/Outcome Variable

The dependent variable was mental health distress, which was captured using the Kessler Psychological Distress Scale (K10). The K10 is a 10-item patient-reported outcome measure designed to capture non-specific psychological (mental health) distress. Each item has a four-point response scale, with a total score that ranges from 0-40 (or 10-50 depending on how it is scored), with 0 (or 10) indicating no mental health distress and 40 (or 50) indicating the highest mental health distress. Of note, the dataset used in this study scored the K10 from 10-50 and so all K10 scores reported in this thesis are on this scale.

Psychological or mental health distress as a construct has been shown to be common across different common mental health conditions (Kessler et al., 2002), so using the K10 for this study was a salient method of measuring general mental health distress unassociated with specific diagnostic categories. The K10 can be used as a broad screening tool for identifying potential mental health concerns, both at a clinical level and at a population level (Cornelius et al., 2013; Kessler et al., 2003; Sunderland et al., 2011). The K10 was originally developed for use in differentiating individuals who fit the diagnostic criteria for a *DSM-IV* diagnosis and specifically, those who would be considered to have a serious impairment or serious mental illness in national community health surveys (Kessler et al., 2003). It has been shown to have excellent sensitivity in the 90-99th percentile of the general population distribution of psychological distress (Kessler et al., 2003), meaning it is good at differentiating those people in the highest range of mental health distress. The K10 is also a useful tool due to its brief, self-administered format; individuals can fill it out on their own or a lay person can assist in filling it out, making it low-cost as well.

The K10 has some recognized cut-points for researchers and clinicians that aid with interpretation of scores, 10 – 15 “no or low psychological distress,” 16 – 21 “moderate distress,” 22 – 29 “high distress” and 30 – 50 “very high distress” (Australian Bureau of Statistics, 2009). An Australian study (Andrews & Slade, 2001) presenting normative data on the K10 from a national survey found a strong association between high scores on the K10 and a current diagnosis of anxiety and/or an affective disorder. While Andrews and Slade (2001) did not define a “high score” for the K10, it reported that the probability of having a current *DSM-IV* diagnosis for scores from 25-29 was

58.9% and 76.3% for scores from 30-34 (Andrews & Slade, 2001). Another study conducted in Australia found that the prevalence of DSM-IV mood, anxiety, or substance use with serious impairment was strongly associated with scores on the K10 from 30-50 (Sunderland et al., 2011). In this capacity, the K10 can be used as a tool to identify those individuals in a population who are most in need of mental health services and social supports.

The K10 has not been extensively studied in a youth population, despite its common use within the youth literature (Smout, 2019). A study by Smout (2019) set out to examine the factor structure and predictive validity of the K10 in children and adolescents and results from this indicated the K10 was “unidimensional enough” for the children and youth population. Another study by Chan & Fung (2014) looked at the reliability and validity of the K10 for screening depressive symptoms among Hong Kong students aged 12 to 19 years and found that the K10 appears to be both reliable and valid for use within this culturally specific youth population. As reliability and validity are not inherent features of the tool itself, it is important that any tool be tested within different populations to ensure that it is appropriate for that specific use.

My supervisor’s (Dr. Skye Barbic) research team recently tested the K10 in 8,000 young people (mean age: 18.5 years, $SD=3.1$) accessing integrated youth mental health services at different centers across BC (Barbic et al., under review). The as-yet-unpublished data suggests excellent targeting of the items to the sample, high internal consistency (Cronbach’s α 0.92) and minimal floor/ceiling effects. Floor/ceiling effects are seen when the majority of scores congregate at either end to the scale (i.e., at the “floor” or the “ceiling”) and such effects are indicative of the need for additional

items at the lower or higher ends of a scale (de Vet et al., 2011). Furthermore, the results from this study showed good convergent and divergent validity (i.e., produces scores similar to other measures for distress and, is different from measures of other constructs, like anxiety or depression) and a good fit to the Rasch model. This means that the K10 represents a higher order scale that show a meaningful progression from low to high distress and had no item bias for gender, age, or centre (Barbic et al., under review). However, the paper also conducted a thorough historical exercise exploring the K10 and revealed limited patient engagement in the development of the items, questioning its fit for purpose within this context of use.

Other Variables

As mentioned previously, race was selected as an additional variable for examination of the intersectional effects of gender and race on mental health. Regarding the race item in the dataset, the survey screening package asked participants “which of the following do you identify with (check all that apply)” and the options were: “South Asian,” “Black/African,” “Caribbean,” “Hispanic/Latino,” “First Nations/ Métis/Inuit,” “Middle Eastern/North African,” “White/Caucasian,” “You don’t have an option that applies to me (please specify your ethnicity).” In order to maintain adequate numbers for the TGNC category, I grouped the data into two strata: white and non-white groups. The white group was made up of individuals who responded to this item with “White/Caucasian” and the non-white category were those that responded to this item with any other option or with multiple options. I made the decision to include those participants who selected “You don’t have an option that applies to me (please specify your ethnicity),” in the non-white strata because the available options did not cover a

comprehensive range of possible racial categories. A more in-depth discussion of issues related to categorizing people by race can be found in the Discussion section (Chapter 4).

Additionally, I also opted to include age as a variable of interest because within the wider youth mental health literature, there is some support for the notion that age may be associated with mental health distress, and younger age might infer higher mental health distress (Jager, 2011; Keyes et al., 2014). No other variables were selected for inclusion for several reasons. I wanted to keep an introductory, exploratory focus in my variables of choice and subsequent data analysis and as this was not intended to provide a comprehensive model with multiple variables, I anticipate that there will be more to do in subsequent studies. Additionally, I wanted to keep my analyses rooted in a context-based, theoretical approach that attempted to honor real-life implications of belonging to multiple minority groups. Simply adding additional variables to a model (e.g., education, site location) assumes that such variables can be “held constant” and are equal distance to the relationship of interest (Bauer, 2014). I also wanted my results to be readily understandable to a clinician population (i.e., practicing mental health practitioners of various disciplines) and so taking a stratification approach was deemed to be the most straightforward to understand. Future research could consider other variables such as parental level of education or income (as an indicator of class, for example) for inclusion in a theoretically driven statistical model.

Data Quality

To begin, I explored the data for quality. Missing data was identified as those participants whose data were missing in the key variables: age, gender identity, K10 score, race, level of education and Foundry site. According to Kang (2013), there are

several types of missing data: missing completely at random (MCAR), missing at random (MAR) and missing not at random (MNAR), all of which are defined below. My strategy for dealing with this missing data was to look for any patterns to determine whether the data was missing at random and missing not at random.

MCAR is defined as “when the probability that the data are missing is not related to either the specific value which is supposed to be obtained or the set of observed responses” (Kang, 2013, p. 402). For example, this might happen when data is lost in transit or lost due to equipment malfunction. MAR is defined as “when the probability that the responses are missing depends on the set of observed responses but is not related to the specific missing values which is expected to be obtained” (Kang, 2013, p. 403). For example, this might happen if a participant is interrupted partway through a survey and does not or cannot return to complete it. MNAR is defined as data that does not fit into either the MCAR or the MAR categories (Kang, 2013). For example, this can happen with particularly stigmatizing questions, like items on substance use, salary or suicide or self-injury (Swalin, 2018).

The original dataset included 775 participants’ and after reviewing this data for quality, 727 participants were selected for inclusion in the analytic sample as they contained complete information in the 6 variables of interest. Forty-eight participants had fully or partially incomplete survey packages and were deemed missing. Twenty-four (24) of the participants were missing the K10 data. This could be related to the design of the survey package itself; the demographic information was on the first three pages, the K10 survey was on page 12 of the package and there were ten total outcome measures. The entire survey package was twenty-two pages long and time to complete may have

been a barrier for some participants. Information gleaned from the primary study (Barbic et al., 2019) indicated that some of the participants ran out of time when completing the survey assessment package, as they were interrupted when they were called in for their scheduled medical appointment; however, the exact number of these cases was not reported. Eighteen of the surveys ended following the demographic questions, for unknown reasons, but possibly related to being interrupted. As this was a secondary analysis of existing data, I was limited in my ability to infer the possible reasons for the missing data. Twenty-four participants had the age item missing and while it was not entirely clear what contributed to this value being missing, it could have been inadvertently missed due to the placement of the question in survey package (see Appendix A for the complete survey package). The age item was the first item on the survey, but it was immediately underneath a disclaimer script and there was limited white space between the disclaimer and the age item question. Participants working on a paper survey may have inadvertently missed this question, so this data was deemed to be MAR, by design. Overall, the majority of these 48 participants were deemed to be MAR for the reasons described above.

Ideally, missing data are minimized by careful planning and study execution; in this case, however, I was unable to ensure this as I was using existing data that I had no part in obtaining nor designing. This also means that I was unable to increase my sample size in order to offset the impact of missing data and increase statistical power (Cheema, 2014). The total number of participants deemed as missing data is 48, which constituted 6% of the overall sample size (48/775). No steps were taken to replace or manage these missing data because they made up such a small proportion of the overall sample. Despite

the commonplace nature of missing data in quantitative research, there is no recognized cut-off for how much is considered acceptable (Dong & Peng, 2013). Some researchers say less than 10% (Bennett, 2001) is acceptable (i.e. does not impact the generalizability of the results) and some argue that the positive effects of data imputation can be outweighed by the negative effects of measurement error that would be introduced with imputation (Cheema, 2014). In relation to the overall sample size the proportion of missing data was deemed to be small and the decision was made to remove this data rather than use data imputation methods. The resulting analytic sample size was large enough to maintain sufficient power in detecting meaningful differences between groups.

Power Calculation

The power calculations were performed in R Studio, version 1.1.456. In order to estimate the sample size needed for each group, to ensure the study was adequately powered (80%), I took a conservative approach and estimated the sample size based on a moderate difference between groups, using the pooled standard deviation found in the existing literature (Veale, Watson, et al., 2017). The result was a sample size of $n=64$ for each group. The reason for taking a conservative approach was that when I estimated the sample size based on information I found in the existing literature, i.e., difference in means and standard deviation from a 2017 Canadian study by Veale, Watson & colleagues (2017), the sample size estimate was $n=4$ for each group. This was likely related to the very large difference between TGNC and cisgender groups found in this study, which showed an effect size of greater than 2.

Data Analysis Strategy

The TGNC group was characterized by youth who responded to the gender identity item with one or more of the following: “non-binary”, “Two Spirit”, “trans female”, “trans male”, “not sure/questioning”, and “I don’t identify with any of these options/other” (see Appendix A for survey package). The cisgender group was characterized by those youth who identified as either “female” or “male” on the gender identity item.

I summarized the data descriptively by examining frequencies, proportions, means, standard deviations for the two gender identity categories (cisgender and TGNC) and I explored the data for floor and ceiling effects. I used a two-sample t-test to analyze descriptive statistical differences between the two groups. I selected a two-sided significance level of 0.05 as means of taking a conservative approach to determining differences between the groups and being open to a difference in either direction. A two-sample t-test was selected because it is an appropriate method for comparing 2 independent groups on a continuous or numeric variable (Pagano & Gauvreau, 2000), in this case, mental health distress/K10. I also examined the internal consistency of the K10 item responses in my sample using Cronbach’s alpha (Cronbach, 1951). Internal consistency is a measure of reliability of a set of scale items (i.e. each of the 10 items on the K10) and is an important way to determine if each of these scale items is measuring the same underlying concept (Goforth, 2015), in this case, psychological or mental health distress.

Next, I used a stratified linear regression analysis, in which I examined the primary association of interest (gender identity and mental health distress) stratified by

race. Stratification was deemed to be an easier method to interpret, compared to interaction models or more complex hierarchical models, for example. Simple linear regression is typically used when examining the relationship between two numerical variables (Pezzullo, 2013). However, it can also be used to examine differences between groups, for example when looking at the relationship between one categorical variable and one numerical variable (Hardy, 1993). Linear regression seeks to explain or predict the effect of the exposure variable on the outcome variable (Pezzullo, 2013). I used regression so that I could adjust for age within this stratified analysis.

Regarding the race variable, I conducted the linear regression analysis (both unadjusted and age adjusted models) within each race stratum: white and non-white. Since the dataset I used for this study was not obtained via a stratified random sampling method, I stratified the data at the time of analysis. In doing so, I needed to be cognizant of whether the stratum of the population was in proportion to the stratum in my sample. Forty-eight percent (48%) (n= 352) of the youth in this sample indicated one or more racial identities other than white, inclusive of Indigenous youth (First Nations, Métis and Inuit). This is higher than the wider provincial census numbers that show approximately 36% of British Columbians report being either a visible minority or Indigenous (First Nations, Métis and Inuit) (Government of British Columbia, 2017) but similar to proportions seen in Metro Vancouver. The majority of participating youth (77%) were from the Metro Vancouver area, where demographic reports show 51% of people in Vancouver and metro area report being a visible minority or Indigenous (First Nations, Métis and Inuit) (Statistics Canada, 2017). My sample's strata were considered proportionate to the population from which it was drawn.

With respect to adjusting for multiple tests, I recognize that methods such as the Bonferroni correction can be considered overly conservative and disagreement exists on whether to perform such adjustments at all (Glickman et al., 2014; Perneger, 1998). As my analysis plan was focused on only three, hypothesis-driven tests, I did not correct for multiple tests. Instead, I described each test performed, justified why it was performed as well as commented on what the results might mean, in the context of my research question (Perneger, 1998). In addition, I reported on the absolute magnitude of differences observed as well as the standardized mean differences using Cohen's d , and reported on the precision of my measurements using confidence intervals. This way, the readers of these results are provided with the actual data related to each test result rather than a statement by me in relation to an arbitrary set p -value. I used R Studio, version 1.1.456, to conduct all statistical analyses.

Question #3

Question #3: What are the lived experiences of TGNC young people accessing mental health services in British Columbia?

For question #3, I expanded on the quantitative data by performing a qualitative exploration of the personal experiences of TGNC young people using mental health services. These interviews focused on how the various aspects of their identity influenced their experience with mental health services.

Sampling and Recruitment Strategy:

I conducted in-depth interviews ($n=5$) with TGNC young adults using a purposeful sampling method. Purposeful sampling is when “the researcher selects the

best participants based on the quality of their insights and willingness to reflect upon the phenomenon of interest” (Hole, 2014, p. 174). In this study, the “best participants” were deemed to be TGNC youth, of any non-cisgender identity, who had a past experience using mental health services. I recruited participants from one Foundry centre in BC (Vancouver Granville), from a community organization and clinic dedicated to serving queer and trans youth in Vancouver, QMUNITY, and I also attended several trans youth groups around Metro Vancouver. I provided the staff at the two sites and participants of the youth groups with a presentation summarizing the nature of the research study and I answered any questions or concerns they had regarding the study and recruitment procedures. The recruitment posters included information on the study details as well as contact information to find out more or to sign up for the study. I also sought additional ethical approval to circulate the recruitment posters on Foundry social media pages in order to widen the exposure to the study. There was no prior relationship between me and any of the participants. All participants who volunteered to participate completed an interview and no one dropped out partway through.

Inclusion Criteria

Young adults:

- Aged 19-25 years, who have utilized a mental health service. Mental health service was defined as one or more of the following: individual counselling/therapy, group counselling/therapy, Cognitive Behavioural Therapy, psychiatry, peer support, Dialectical Behavioural Therapy and any other formally recognized mental health treatment modality sought by the individual.

- With transgender and/or gender nonconforming identities (See Glossary for a list of possible non-cisgender identities).
- Able to provide verbal or written informed consent.

Of note, for the qualitative arm of this project, I selected slightly older participants (19-25 years) than the quantitative phase (16-25 years). This decision was made considering the scope of the research project as well as this age range is more likely to include those individuals who have already experienced initial onset of a mental health symptom(s), are more likely to have attempted access of a mental health service and who have reached the provincial age of consent.

Procedures

After informed consent was obtained, each participant was asked to participate in an in-person interview, approximately 60 minutes long, conducted by me (please refer to Appendices B & C for the written and verbal consent documents). All interviews were audio recorded and transcribed later for analysis. The procedure of obtaining written consent and conducting in-person interviews was adjusted following the COVID-19 pandemic research restrictions, which were put into effect March 17, 2020. As a result of this, the procedure was altered to obtaining verbal consent and conducting telephone or virtual interviews in order to comply with health and safety protocols published by both UBC and the province of BC. Three interviews were conducted in-person and two were done virtually.

The interview guide (see Appendix D for full interview guide) included questions that focused on the intersectional nature of the participants identity and how different aspects of their identity influenced their experiences of mental health services. Some

questions asked were: *How has your experience as a transgender and/or gender nonconforming person influenced your experience of accessing mental health services, if at all? What other aspects of your identity, if any, influence your experience of mental health services? What are some challenges, if any, you face with the health system in terms of the various aspects of your identity?* These questions served as a general framework for the in-depth interviews and participants were encouraged to respond freely in order to expand on how the nature of how their identity shaped their experience.

The results of the qualitative phase of the study were reported using the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007) to ensure that I included all of the relevant components of the study's design, context, findings and interpretation and analysis. With respect to my mixed-methods approach, I also used the Good Reporting of a Mixed Methods Study (GRAMMS) (O'Cathain et al., 2008) checklist to ensure that my decision-making process for selecting and implementing a sequential explanatory design was clearly laid out. Both of these completed checklists can be found in Appendices E and F, respectively.

Qualitative Data Analysis

I utilized qualitative description, a qualitative methodology that aims to “provide a rich, straight description of an experience or an event” (Neergaard et al., 2009, sec. Discussion), one that seeks to stay as close as possible to the data and in a way that mirrors the participant's language and way of speaking. Rooted in naturalistic inquiry (Guba & Lincoln, 1982), qualitative description is a methodology that does not have a founding parent researcher or theorist associated with it, as other qualitative methodologies might (e.g., grounded theory's Glaser and Strauss). Qualitative description

is often used by researchers from a clinical health or health policy background who seek to “understand a phenomenon through description” (Chafe, 2017; Hole, 2014, p. 170) and for whom the other qualitative methods do not neatly fit the research question.

Qualitative description, in staying as close to the participants’ words as possible, involves interpretation with less inference and assumption, making it more likely that different researchers might reach consensus about the description of an experience or event (Neergaard et al., 2009; Sandelowski, 2000). However, this does not mean that qualitative description performs *no* interpretation and analysis, rather, it requires the researcher to “make something of their data,” in a way that moves beyond simply what the participants’ have said (Sandelowski, 2010, p. 79; Willis et al., 2016). This methodology was selected as the best approach for my qualitative research question because I wanted to apply the results toward an exploration of practical recommendations for changing how mental health providers deliver treatment. My initial question for the qualitative arm of this project was positioned as exploratory in nature (“what *are* the lived experiences of TGNC youth accessing mental health services?”), and it was not my intent to create a comprehensive theory but rather to sketch out an initial framework of understanding. In this way, highly abstract interpretations of participant narratives would have been unhelpful in informing health and mental health providers about specific ways to change their behavior when providing care to TGNC young people. I wanted to keep my analysis focused on a description of the experiences of TGNC young people using mental health services and on what they report could make these experiences more respectful. This is also in keeping with an intersectional framework, as I did not want to “presume – a priori – the importance of one category over another” (Hankivsky &

Christoffersen, 2008, p. 276), rather I wanted the narratives of the participants to define and situate the factors relevant to their experiences.

While qualitative description was the primary methodology used, I also incorporated overtones of constructivist grounded theory (Charmaz, 2010, 2017), which according to Sandelowski (2000), can be part of any qualitative description approach. As I wanted to focus on the level of the social experience and social relationships, adopting a constructivist grounded theory overtone was a way of adding what Sandelowski (2000, p. 337) called “hues, tones, and textures” to a qualitative description. There is some precedence for including “hues, tones, and textures” to a qualitative description approach, as can be seen in Michael et al., (2014) who paired qualitative description with grounded theory and in a study by Peacock et al., (2014, p. 3) that adopted a “phenomenological overtone” to its qualitative description approach. In this regard, I adopted memo writing and methodological reflexivity in the course of the research process, in recognition that as the researcher, I was not a neutral, distant observer.

Interviews were transcribed and reviewed by me and I managed codes manually, using Microsoft’s Word and Excel. Codes were organized into themes and compared manually, within each major theme and across transcripts. The data were rich enough to generate over twenty codes that all spoke directly to the initial research question. All codes and relevant themes can be found in Appendix G. The data from the interviews were analyzed using constructivist grounded theory coding (e.g., line-by-line coding, focused coding and constant comparison) (Charmaz, 2006) and memo writing from the onset of the data collection process. In this way, the early codes and memos were compared with emerging data in an iterative process of data analysis. I also engaged in

the practice of methodological self-consciousness throughout the entire research process in the form of a research journal and post-interview reflection exercises. Both the qualitative description approach and the overtones of constructivist grounded theory fit with my ontological position of interpretivism/constructivism in that they both view reality as “multiple, intangible, [and] divergent” (Guba & Lincoln, 1982, p. 237) and as inherently value-laden, thus necessitating processes like methodological reflexivity and researcher positionality.

Quality Considerations

It is important that any undertaking in qualitative methodology pay attention to issues related to the quality and trustworthiness of the research process and subsequent findings. The following is a discussion of the steps I took to demonstrate the quality and trustworthiness of my research process.

The practice of methodological self-consciousness and the reflexive activities employed were an opportunity for me to engage in on-going reflection on my own values, reactions to the data and analysis process, as well as my social position and standpoint throughout the research process. From an interpretive/constructivist framework, these reflexive practices acted as an additional means of gathering data from various social perspectives (e.g., my own independently as well as in the context of each participant’s narrative), in an effort to generate a richer collection of perspectives. On-going reflexivity assisted me as the researcher to understand what I might be expecting from the data, in the context of my own experience and perspective, and how this might be similar to, or different from, the standpoints of the participants.

In terms of data analysis, I used a constant comparative method, associated with constructivist grounded theory. This method, as delineated by Charmaz (2006), involves the ongoing comparison of theory, background, and data collected to emerging analyses and vice versa. As part of the iterative process of data collection and analysis, I re-read each transcript after transcribing and in advance of all interviews. From this, I was able to alter slightly my interview guide to include follow up questions on the differences between youth and adult services. In total, I read each transcript approximately 3 times throughout data collection and analysis. In this way, I was able to immerse myself in the data, throughout the collection and analysis processes. Such immersion is part of establishing trustworthiness of the research, and as outlined by Morrow (2005, p. 256) “these repeated forays into the data ultimately lead the investigator into a deep understanding.” My own immersion in the data also continued during the analysis phase, where I returned to each transcript multiple times over to compare and contrast. In this way, I was also able to demonstrate authenticity. Authenticity in qualitative research is defined by Whittemore (2001) as whether the analysis captured the voices of the participants at that particular point in time and can distinguish subtle differences in experience and narrative. My immersion in the data allowed me to become familiar with the nuances both within and across interviews.

Interview transcripts, initial themes and codes were explored with a member of my committee (Dr. W. Ben Mortenson) as a means of collecting an additional interpretation of the data. Sharing my codes and qualitative findings with another researcher was a way for me obtain another perspective on this data and to encourage more reflection on my own engagement with the data. In this way, I demonstrated

credibility, per the framework for validity put forth by Whitemore and colleagues (2001). This framework details four primary criteria: credibility, authenticity, criticality and integrity (Whitemore et al., 2001). Credibility is how the researcher makes plain the ways they ensured their interpretations were trustworthy and reflected the experiences of the participants in an authentic manner. In sharing the data and my initial impressions with another person, I was able to reflect on the why and how I had come to any conclusions and on how I was representing the participants and the analyses.

Reflexivity and Situating the Researcher

In the spirit of methodological self-consciousness, which is considered to be the act of “examining ourselves *in* the research process [and] the meanings we make” (Charmaz, 2017, p. 36), it is important to make explicit my position as a person doing research. To the extent that so-called objectivity or distance from the matter under study is both impossible and undesirable (Day, 2012), I highlight the following aspects of my personal identity that may be salient to my research process. I am a 36-year-old, Canadian citizen of white settler descent, working on a second post-graduate degree, a member of a registered mental health profession, as well as a person with both queer and gender nonconforming identities. I used the Social Identity Map tool developed by Jacobson and Mustafa (2019) to help me map out how the different aspects of my identity might position me in relation to my research (see Appendix H for my completed Social Identity Map). These facets of my identity influenced how I approached this research (both in terms of why I chose this research area and in terms of specific decisions I made regarding the research process itself) and how I perceived the data and my subsequent interpretations (Day, 2012; Jacobson & Mustafa, 2019; Shaw et al., 2019). My decision

to conduct research in the area of gender identity and mental health was directly influenced by my own personal exploration of gender and by my professional work as a mental health therapist. My professional experiences as a mental health service provider put me on the other side of the table, so to speak, from the participants and this may have influenced my focus on the nature of the interaction between provider-client as opposed to any personal or emotional impact of mental health services on the person. Several of the research participants either assumed I was queer and gender nonconforming or were oriented to this by the sharing of my pronouns with them; this may have influenced the rapport we built and the level of sharing that occurred, as it positioned me as an insider. Conversely, this might have hindered some elements of the interview process as participants' may have assumed that I knew what they meant, and I may not have followed up on what was discussed as thoroughly as I might have if I did not hold insider status. In engaging in this critical reflective process, I was able to demonstrate criticality and integrity in my research process. These criteria for validity are defined respectively as, when the research process includes "reflexivity, open inquiry, and critical analysis" (Whittemore et al., 2001, p. 531) and when a researcher situates themselves as a value-laden participant who routinely examines the research process for bias (Milne & Oberle, 2005).

Ethical Approval and Data Management

For the quantitative phase, ethical approval was obtained from the Providence Health Care Research Institute Research Ethics Board, on October 28, 2018 [certificate # H17-00127]. For the qualitative phase of the study, ethical approval from the UBC Research Ethics Board was provided on November 5, 2019 [certificate #H19-01072].

Subsequent approval was sought for the addition of virtual and telephone interviews, following the COVID-19 pandemic restrictions; this approval was obtained on May 2, 2020, under the latter certificate. The informed consent packages, initial letter of contact and recruitment poster that were provided to the qualitative phase participants can be found in Appendices B, C, I and J, respectively. Research data were kept confidential from the inception of the study. Participants' identities were coded with a unique study ID and was kept separate from any identifying data. Data entered into spreadsheets and any other electronic files were stored securely on the UBC Department of Occupational Science & Occupational Therapy password-protected server. Electronic files were accessible only to members of the research team (i.e. me, Dr. Skye Barbic and my committee members). All audio interviews were transcribed by me and the audio recordings/transcripts were stored securely on the UBC Department of Occupational Science & Occupational Therapy password-protected server and were accessible only to members of the research team.

Chapter 3: Results

This section details the results of all three research questions, starting with questions #1 & 2, the results from quantitative analyses performed, and followed by question #3, the qualitative findings.

Questions #1 & 2 Results

Question #1: To what extent is mental health distress different in TGNC young people as compared to cisgender young people?

Question #2: To what extent does race amplify the association between TGNC identity and mental health distress?

Demographics

See Table 1, Quantitative column, for the characteristics of the quantitative study sample. The overall sample had a mean age of 21 years (interquartile range/IQR=4, SD=2.2). The cisgender group comprised 86% (n=627) of the overall sample and the TGNC group made up 13% (n=96) of the sample; 0.6% (n=4) of participants reported that they would prefer not to answer the gender identity item. Forty-eight (48%) selected the non-white option(s) for the race item, which were one or more of the following: First Nations/Métis/Inuit, South Asian, Black/African, Caribbean, Hispanic/Latino, Middle Eastern/North African, and “You do not have an option that applies to me/Other”. Other race categories that were specified by participants: “Filipino,” “Vietnam,” “Asian”, “Chinese,” and “Sephardic Jewish.” Over two-thirds of the sample (69%, n= 501) had completed at least high school (some high school and completed high school) and 77% of respondents were recruited from Foundry centres in Metro Vancouver, including downtown and North Vancouver.

The overall mean K10 score was 28 (IQR= 14.5, SD=9.7), while the mean K10 for the TGNC group was 32 (IQR= 12, SD=9.1) and the cisgender mean was 28.0 (IQR=15, SD=9.8). See Figure 1 for the distribution of K10 scores. Nearly half of the sample (48%, n= 346) fell within the highest range for the K10 cut points, with scores ranging from 30 to 50 indicating “very high distress.” Only 13% (n= 91) had scores from 10 to 15, which indicate “no to low psychological distress.” These cut points are taken from the 2007 Australian National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2009). Floor and ceiling effects were classified as negligible, that is, 3.7% at the floor (score of 10) and 1.5% at the ceiling (score of 50).

Table 1 *Characteristics of study sample*

		Quantitative	Qualitative
Age		N=727	N=5
	Mean	21	21
	Median	21	20
	Age Range	16 to 25	19 to 25
	IQR**	19, 23	19.5, 24.5
Gender Identity		<i>n (%)</i>	<i>n (%)</i>
	Cisgender	627 (86)	--
	TGNC*	96 (13)	5 (100)
	Prefer not to answer	4 (0.6)	--
Race			
	White	374 (51)	2 (40)
	Non-White	352 (48)	3 (60)
	NA	1 (0.1)	0
Non-white Subgroups		<i>n (%)</i>	<i>n (%)</i>
	Indigenous/First Nations/ Métis	116 (16)	--
	Mixed Ethnicity	108 (15)	3 (60)
	South Asian	32 (4)	--
	Black/African	21 (3)	--
	Hispanic/Latinx	18 (3)	--
	Middle Eastern/North African	22 (3)	--
	Other	23 (3)	--
	Caribbean	12 (2)	--
Level of Education			
	At least high school	501 (69)	3 (60)
	More than high school	222 (31)	2 (40)
	NA	4 (0.6)	0
Foundry Center			
	Vancouver Granville	448 (62)	3 (60)
	Vancouver North Shore	108 (15)	--
	Kelowna	64 (9)	--
	Prince George	52 (7)	--
	Victoria	55 (7)	--
	Campbell River	NA	1 (20)
	Never accessed Foundry	0	1 (20)
K10 Entire sample		<i>mean (n)</i>	<i>mean (n)</i>
		28.3 (727)	--
	IQR**	21.0, 35.5	--
	median	29.0	--

		<i>mean (n)</i>	<i>mean (n)</i>
TGNC*		31.3 (96)	32.6 (5)
	IQR**	26.0, 38.0	30.5, 36
	median	32.5	31
Cisgender		27.8 (627)	--
	IQR**	20.0, 35.0	--
	median	28.0	
Sample in terms of K10 cut points		<i>n (%)</i>	<i>n (%)</i>
10 to 15 none to low psychological distress		91 (13)	--
16 to 21 moderate psychological distress		103 (14)	--
22 to 29 high psychological distress		187 (26)	--
30 to 50 very high psychological distress		346 (48)	5 (100)
K10 scores by Foundry Center		<i>mean (sd)</i>	
	Vancouver Granville	28 (10.3)	
	Kelowna	31 (9.2)	
	Vancouver North Shore	27 (8.8)	
	Prince George	28 (8.4)	
	Victoria	30 (7.7)	

*TGNC= transgender and/or gender nonconforming

**IQR= interquartile range

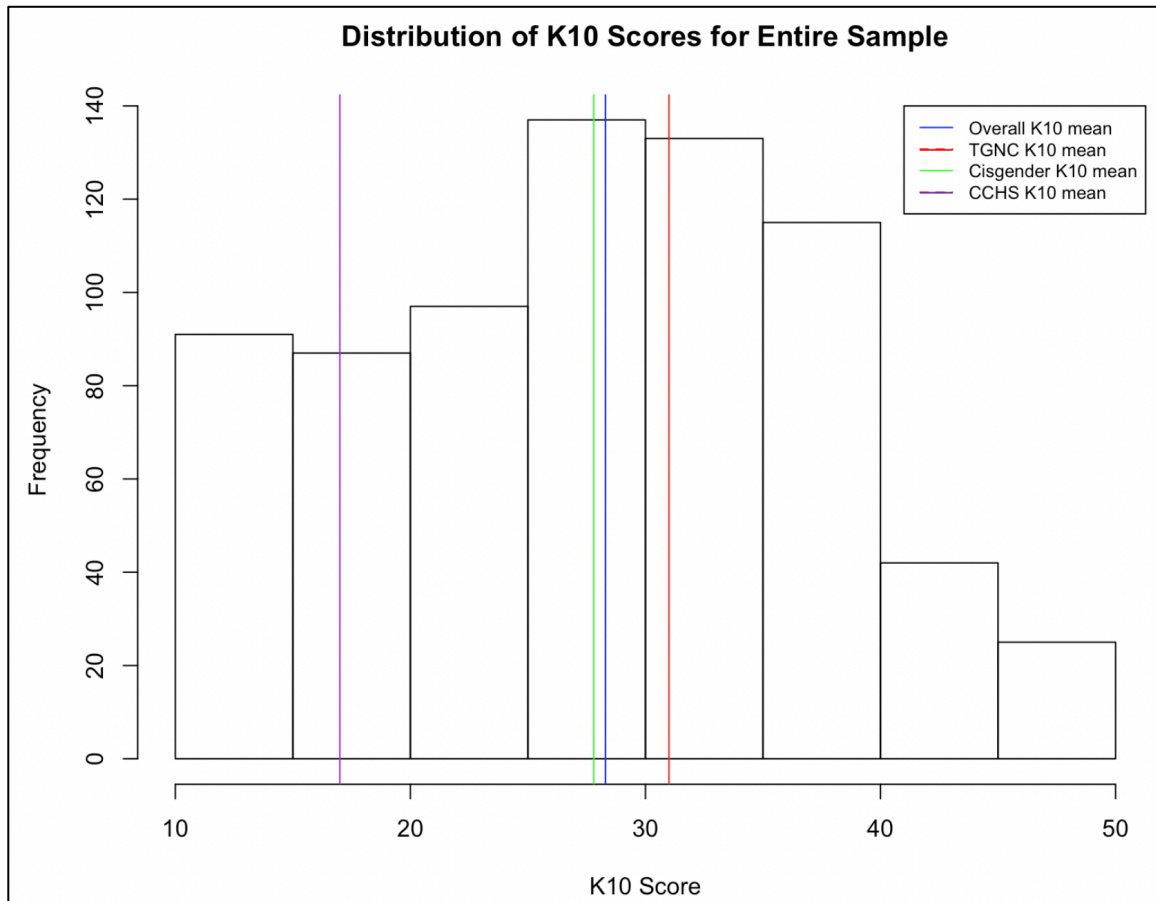


Figure 1: *Distribution of K10 Scores in the sample (n=727)*

**Note: the K10, or Kessler Psychological Distress Scale, is a standardized scale measuring psychological or mental health distress that was developed by Kessler (2002 & 2003).*

***For reference, K10 scores 10 to 15 “none to low physiological distress,” 16 to 21 “moderate psychological distress,” 21 to 29 “high psychological distress” and >30 “very high psychological distress.”*

****CCHS: 2012 Canadian Community Health Survey-Mental Health data*

****TGNC: transgender and/or gender nonconforming*

Results of Statistical Analyses

Results from the independent 2-sample t-test and age adjusted and unadjusted stratified linear regression models are explained here and presented in Tables 2 & 3. The Cronbach's alpha for this sample was high, $\alpha = 0.93$ (CI=0.93, 0.94), demonstrating high item covariance, indicating that each item probably measures the same underlying concept. This alpha is the same or very similar to those found in the wider literature for the K10 (Barbic et al., under review; Kessler et al., 2002, 2003).

The results of the t-test indicated that, when compared with cisgender youth, TGNC youth showed significantly higher average scores on the K10 (difference in means = 3.44, $t=3.24$, CI: 1.35, 5.52, $p = 0.001$). Effect sizes for the overall difference between groups was medium (Cohen's $d = 0.4$). The differences between groups in both the white and the non-white strata also showed a medium effect size (white strata, Cohen's $d = 0.4$ and non-white strata, Cohen's $d = 0.4$).

Both age adjusted (see Table 3) and unadjusted (see Table 2) models were trialed to explore the relationship between gender identity and mental health and the results from both models were nearly identical. Compared with cisgender youth, TGNC youth had significantly higher average K10 scores across both race strata (white strata: $\beta = 3.64$, CI: 0.88, 6.40, $p = 0.01$ & non-white strata: $\beta = 3.42$, CI: 0.02, 6.62, $p = 0.04$). Given the unadjusted and age adjusted models were almost identical, this suggested that age did not seem to substantially change the association between gender and mental health distress. This suggests that very little, if any, of the observed differences in mental health distress (as measured by the K10) between gender groups can be attributed to potential differences in age. Within the wider youth mental health literature, there is some support

for the notion that age is associated with mental health distress, in that younger age might infer higher mental health distress but the results from my study suggested that age was not associated with the relationship of interest. Possible reasons for this are explored further in the Discussion section (Chapter 4).

Table 2 *Univariable analysis of gender identity and mental health distress, stratified by race*

	Non-White Strata		White Strata	
	Beta (95% CI***)	p-value	Beta (95% CI***)	p-value
Cisgender	REF**	--	REF**	--
TGNC*	3.42 (0.02, 6.63)	0.04	3.64 (0.88, 6.40)	0.01

*TGNC= transgender and/or gender nonconforming

**REF= referent group

***CI=confidence interval

Table 3 *Multivariable analysis of gender identity, mental health distress and age, stratified by race*

	Non-White Strata		White Strata	
	Beta (95% CI***)	p-value	Beta (95% CI***)	p-value
Cisgender	REF**	--	REF**	--
TGNC*	3.41 (0.20, 6.62)	0.04	3.60 (0.84, 6.37)	0.01
Age	-0.21 (-0.7, 0.3)	0.40	-0.06 (-0.5, 0.4)	0.80

*TGNC= transgender and/or gender nonconforming

**REF= referent group

***CI=confidence interval

Question #3 Results

Question #3: What are the lived experiences of TGNC young people accessing mental health services in BC?

Demographics of Qualitative Sample

A total of five individuals volunteered to participate in a 1:1 interview, lasting from 30-75 minutes. The mean age of these youth was 21 years (IQR: 5). All five individuals were TGNC, reporting labels ranging from trans/nonbinary, Two Spirit/nonbinary, transfeminine, and nonbinary. Three out of five (60%) were non-white and sixty percent (60%, 3/5) had completed at least high school. Three out of five

accessed services at Foundry Vancouver Granville, one person from Foundry Campbell River and one had never accessed Foundry services. The mean K10 score for these youth was 33 (IQR: 5.5). See Table 1, Qualitative column, for a comparison of the demographics of the quantitative and qualitative samples.

Qualitative Findings

This section reports on the findings from the analysis of the five qualitative interviews. My analysis identified three themes that described the experiences of TGNC young people accessing mental health services: 1) *“these microaggressions will build up,”* experiencing upsetting interactions with health providers, 2) *“oh yea, I remember why I don’t wanna go there,”* encountering barriers and facilitators to services, and 3) *“I feel completely invisible to society,”* managing the tyranny of the gender binary. These findings describe the lived experiences of TGNC young people accessing mental health services.

Theme 1: “These microaggressions will build up,” experiencing upsetting interactions with health providers

All of the young people interviewed described recurring interactions with health and/or mental health providers that were upsetting, disrespectful and/or invalidating in relation to their TGNC identity. These provider interactions ranged from attending the emergency room in crisis, utilizing primary care and/or specialist physicians, getting lab work done and accessing mental health therapists and psychiatrists. This theme is divided into 3 categories, 1) how providers perceived the youths’ gender identity (or not), 2) how providers attempted to “treat” the youths’ gender identity and 3) the manner in which the youths needed to stand up for themselves in the face of these upsetting interactions.

How providers perceive my gender identity (or not).

All of the participants described various experiences where health and mental health providers would make assumptions about their gender identity in such a way that was disrespectful, upsetting and invalidating. One significant thread was related to the pain of being misgendered by a provider. Being misgendered is when someone (in this case a health provider) incorrectly assumes another person is a particular gender, either by referring to them using the incorrect pronouns (e.g., he/him, she/her, they/them, ze/zir), or by using someone's legal name despite being informed that they use a different name. The participants described several different ways that misgendering occurred, one such way is described here by a Two Spirit, nonbinary person who said,

thinking about when I have to go to the ER or I have to go to get blood tests or whatever and I still haven't changed my legal name and I have to hear that and be referred to as that. And have them ask "well there is a blank or an x or whatever for [the gender item], do you want us to change it to [female]?" and I'm like {shakes head}I don't know what to say?? I kinda forgot that that happens cuz I was so used to having everyone know me as [my chosen name] and um even on my prescriptions and stuff, crossing out my legal name and writing [my chosen name].

Another way that providers can misgender clients is described by a nonbinary participant,

I went to a psychiatrist in [a small BC town] and I told him that I use they/them pronouns and stuff like that and his response was to write an entire report about me using she/her pronouns instead and he literally wrote the sentence "she wants

to be referred to as they/them” and I lost my mind a little bit because of that {laughed} because the level of disrespect was significant.

These examples suggest that misgendering may occur as a result of a provider’s assumptions about how a person looks and/or the assumed gender of their legal name, despite, in some cases, being explicitly informed otherwise by the client. Another nonbinary participant described being misgendered by the manager of a queer and trans organization, *“I mean I worked for a queer program and the director of the program was always calling me she...{laughs} ugh, cuz I use they.”*

The participants also described their reactions to being misgendered as characterized by discomfort, upset and hopelessness. One transfeminine participant described it as such,

it really sucks when you go into a psychiatrist that you don’t know, thinking that you are gonna talk stuff out and just get deadnamed {smacks fist into open palm}, and get fucking.... incorrectly gendered and stuff. It’s just like, it sucks, it sucks. Um and it really throws you off, you know.

A nonbinary participant described feeling hopeless as a result and not even wanting to correct providers anymore, *“like at a certain point I just feel complacent about it, like I am tired of this, so I don’t fight anymore sometimes.”*

The participants also described the experience of being “deadnamed,” which happens when someone calls them by the name given to them at birth (i.e., their legal name if they have not yet sought an official name change) instead of their chosen name. TGNC people often choose names for themselves that are more aligned with their sense of who they are and their gender identity and ask to be referred to as such in social

settings. Many people also take steps to undergo a legal name change, if they have the necessary financial means. Within a healthcare setting and with the presence of health records and identification that contain a person's birth name, rather than their chosen name, many health providers often default to the name on a chart when meeting new clients. Many clinics have intake forms and personal health records that do not have space for a patient's chosen name and pronoun and the result of this is that clinic staff only see incorrect or incomplete personal information for a client. The participants described being met with confusion or resistance when explaining that they go by a different name and as one Two Spirit person stated, *"it's like, no, just basic human decency and respect, if someone asks you to call them by a different name than what their records say, then just do that!"*

Being deadnamed also tied into the way in which someone was perceived (i.e., what gender they are thought to be) based on their name and their gender presentation. The participants described the disconnect or tension between how they were perceived based on their birth name and their gender presentation. One participant relayed this story:

I had one friend who was in the hospital after a suicide attempt and was gonna see a psychiatrist but their legal name was like a feminine name and they were presenting as male, and the doctor like looked around, I think it was all men in the room and just walked away cuz they thought the patient had left. And didn't verify to like even check in. um and that can be really frustrating cuz it's like, you're...like it takes a long time even, like I've had to wait like 8 hours to see a

psychiatrist. So, when the psychiatrist finally gets there, if they walk away you have to wait another 8 hours? It's just really hard on your mental health, yeah.

How providers "treat" my gender

Among the myriad of upsetting interactions that the participants reported was the tendency of some mental health providers to equate the individual's mental health symptoms to their gender identity. The majority of youth described experiences with psychiatrists, a profession they specifically named here, who would attribute the person's mental health symptoms to their non-cisgender identity, as in their gender identity was the *cause* of their mental health concerns.

I was talking to a psychiatrist and he kept asking me questions about me being trans and about my gender dysphoria. And I remember trying to say like, oh its manageable, it's really like I am doing fine with that and I kept on trying to talk about like the other things that I was experiencing.....And like he just kept bringing it back to me being trans. Like I would talk about other symptoms and he would always just bring it back to me being trans. Um yeah, I just felt really invalidated (a queer, nonbinary person).

The participants described experiences where the provider would over-focus on attributing their mental health concerns to their TGNC identity, despite their own awareness that their mental health issues predated coming out as TGNC or were completely unrelated. The participants described this tendency to "treat their gender identity" as primarily invalidating and as negating their own expertise on their lived experience. This intersection of gender identity and mental health was described as apparently difficult for providers to navigate and so many providers appeared to resort to

erroneous assumptions that a non-cisgender identity was the *cause* of a mental health concern. One participant reported being unsure whether they had ever experienced a provider attribute their mental health concerns to their nonbinary identity but did state they had seen a therapist who was not able to fully comprehend the anxiety they experienced as a trans person.

Standing up for myself.

As a result of the upset caused by the experience of being misgendered and/or deadnamed, all of the participants endorsed the on-going need to stand up for themselves and self-advocate every time they saw a new health provider. As all of the participants had been accessing services from a young age, they all stated that self-advocacy was *always* required, both in terms of their gender identity and their mental health needs. Several participants described the need to stand up for themselves even in times of mental health crisis or after harming themselves; it appeared as though all health settings and levels of care often required this of the youth. Many participants described being accustomed to self-advocacy, as they had been accessing services since they were as young as 13 years old.

I'm just used to it, I guess, I've been doing this since I've been 14, I've been advocating for myself like trying to get my own therapists, talking to social workers all by myself at like 15, 14 years old. So, I am very used to just walking into a clinic and saying, "hey is there, do you guys have therapy here, do you guys have psychiatrists for me" and signing up for that (nonbinary, agender person).

Despite being accustomed to self-advocacy, the participants described it as frequently ineffectual and as having little impact on how providers treated them during interactions. Many participants shared experiences when they corrected a provider and the provider continued to make the same mistake throughout the session. A Two Spirit, nonbinary participant stated,

I am kind of at this place where I'm like....it's not worth my time and energy to try to like correct them over and over and over and over again if they're not gonna listen, cuz it's like, do I want to out myself 5 different times with different people around each time, in the span of an hour just trying to get through this??

Another nonbinary person indicated that standing up for themselves, in terms of their nonbinary identity, was exhausting and stated that *"I find that the practitioners don't really understand, and it turns into more of like a trying-to-justify-my-identity session."*

Participants described being caught between the proverbial "rock and a hard place," where many providers needed to be educated on TGNC concepts but then did not listen to, or abide by, the youths' requests. As a Two Spirit person described, this meant that they often needed mental health support just to help them deal with the impact of this situation; *"after the second or third time, do I just like drop it? Yea it's come to just...drop it and it'll be over with and then I can go to therapy and talk about it or process it later."*

Theme 2: "Oh yea, I remember why I don't wanna go there," barriers and facilitators to care

All of the participants described various barriers to accessing care, both from a gender perspective and from a mental health perspective, as well as identified some things that facilitated their access to gender and mental health care. This theme is divided

into 3 categories: 1) experiencing the physical clinic environment as a salient aspect to care, 2) experiencing specific barriers to care, and 3) noticing the difference between youth care and adult care.

The Environment Matters!

Many of the participants described the effects of the physical clinic or service setting as signifying the potential for either safety and comfort or discomfort. They described things in the environment like rainbow Pride flags, trans-positive posters, pamphlets on queer and trans health and the presence of gender-neutral bathrooms as signifying a potentially safe place that recognized gender diversity. The presence of such items was described as helping them to feel seen and recognized within a world where they are typically made invisible.

And yea, having that respected and seeing, even just seeing little stickers and stuff with pride flags or trans flags, it's like yay, it's me! I feel like recognized and welcome here and its obviously not just that stuff and it's shown through people's actions and stuff. Or even like having bathrooms changed from gendered to gender neutral bathrooms and seeing that and being like, oh they really do care! And that's made me more comfortable with going to the doctor (Two Spirit, nonbinary person).

One participant also pointed out that despite having these physical indicators of recognition, that a service still needed to prove that they were safe through their actions, *“that's something that means a lot to me, cuz I've gone to places that say they are queer friendly, trans friendly, and they are the furthest thing from it. Like why bother saying that you are??”*

The participants also described other features of a clinic or service setting that made them feel uncomfortable or that presented challenges for them. They pointed to the highly gendered nature of the healthcare system as a whole and the way this gendering was reinforced in the physical office setting. They spoke about needing to access services at “women’s health” or “men’s health” clinics and the discomfort involved in attending a service that was heavily advertised as being for a binary gender. One participant described some physical aspects of a clinic’s environment that reinforced the gender binary in its design,

I’ve had to go to the gynecologist a lot and that’s a lot different because it’s, its own separate office and so like...just being there that’s in a place that specifically for like female reproductive system health, it’s like, I don’t want to be here, I don’t want to.....see all the stuff around that’s for pregnancy and birth control stuff and even the office has the little female symbol things...they’re like part of the bars that are going over the windows....I don’t know how to describe it... but anyway it’s a permanent feature of this establishment and there is no way to avoid it

In these ways, they had to constantly evaluate and re-evaluate the potential for safety and harm even before they interacted with a provider.

Access Barriers

One common access barrier the participants described had to do with service differences between small or rural towns and larger cities. The majority of them had experience accessing care in both urban and rural settings and predominantly characterized small towns as having nearly non-existent mental health services. They

discussed the difficulties obtaining mental health support in small BC towns as well as significant challenges in finding providers who were affirming of gender diversity. One participant described the following story:

I actually ended up attempting suicide when I was living there and like they didn't know what to do with me, really, they were like "we want to send you up to [a large BC city]" and my mom was like, no we can't go. So that was really difficult and having to decide, what do we do? Like do we actually try to make the trek up to [the city] and deal with work and school and all that stuff later? Or is it just something that's gonna have to wait? And it ended up being something that just had to wait, which...not ideal!

Others described difficulties in finding providers in their small towns who had knowledge of TGNC health and related concepts and often reported that they felt invisible and overlooked as a gender diverse person. All of the participants (with the exception of one person who had never lived rurally) reported that they had to travel to nearby towns to access care or else they ended up moving permanently as a means to access better care in larger municipalities.

Even within the larger municipalities, however, they described services as being at times, overburdened and hard to access. One participant described trying to access a specific mental health program, related to his mental health diagnosis and stated he "call[ed] 300 times in one hour" because entrance to the program was based on a lottery system; he was unsuccessful in securing a spot in this program. Several participants indicated it seemed like they could only access care after serious self-harm or suicide attempts and felt that the system only cared for them at the point of crisis. Specific

barriers to care mentioned were the lack of low or no cost therapy options, long wait times, high staff turnover and needing to see a different provider every time and specific to small towns, a lack of mental health service in general.

Another barrier described by participants was the frustration of needing to educate or teach health and mental health providers about TGNC concepts in the midst of seeking care for themselves. Many participants described seeking care for their mental health and facing a provider ignorant of TGNC concepts and concerns and needing to explain things like pronoun usage and gender identity terms. This was described as both mentally taxing and monopolizing valuable time with the provider. A nonbinary participant described a story where he was being taken to hospital in an ambulance after harming himself and a police officer riding in the back with him had never heard of a trans person before and peppered him with questions about why he was prescribed hormones. He described this as: *“frustrating if I have to be put in a position where I am teaching someone where I am the one needing help?”* Another participant, a nonbinary person, related the following story,

Like I had my doctor when I was saying I was having a flare-up of body image issues, was like “I get the whole like girls wanting to look like women in magazine, but what do you mean when you say you have body image issues, as a nonbinary person?” and so then I had to like explain that in the rest of our 15 minute session.

All of the participants described an obvious lack of knowledge or understanding on the part of many providers who had either never heard of gender identity beyond the binary and/or who expected the patient to educate them during the health session. This lack of

awareness and professionalism around TGNC identities was taxing to the youth, who expected their providers to have at least baseline knowledge in the area, as health professionals. As one transfeminine participant stated,

I find it really annoying to have to deal with those people who like don't want to be transphobic, that are trying to learn, but they don't know that they can just use the internet to learn this shit and so they dump everything on you.

Many participants described this as the standard for most provider interactions and reported that finding providers who *were* educated on TGNC concepts and/or who did not ask to be educated was so rare, one participant described it as “*mind-blowing.*” All of the participants had had at least one positive experience with a particular clinic or specific provider who either were knowledgeable about TGNC concepts from the start or appeared to be learning on their own, concurrent to their work with the person. Such experiences were described as atypical and often surprising, but always welcome in terms of making the youths feel respected and affirmed.

All of the participants had a straightforward recommendation for health providers on how to manage names and pronouns: ask for them when meeting a new person and then do your best to use them correctly and consistently. The participants acknowledged that there can be a transition period for someone switching to using a new name and/or pronoun for a person and normalized that making mistakes was part of this transition. A transfeminine participant described one affirming experience,

[my therapist] was trying to readjust to that, it literally took him like, you know...he messed up once, he was talking to somebody else about me and he said “he, I mean, sorry, she” and then just left it at that, which was so nice.

They did not expect perfection and a total absence of mistakes, just a demonstration of *effort* to incorporate the new information. They all described the experience of being preemptively asked for their pronouns and/or chosen name as affirming and demonstrating respect. They also described the importance of having their entire health team know and use their name and pronouns and recommended that a clinic have dedicated space on clinic charts and records for this information. As one participant described their experience at an affirming clinic,

when I am at [a local youth clinic], where there are trans-positive posters on the wall and my doctor uses the correct pronouns for me in the notes she writes about me that I am not even going to see, but the entire clinic is up-to-date constantly on everybody's gender, everybody's pronouns, where we are going with our gender. She checks up on me monthly about what direction I am going with my gender (nonbinary, agender person).

This way, all clinic or service staff can access correct, up-to-date information at all times.

Anticipating challenges figured prominently in the ways that the participants experienced barriers to accessing health and mental health services. The participants described being warned by their TGNC friends and network about the potential difficulties associated with accessing health care and consequently avoided seeking care. They also described being constantly leery of new services due to their past negative experiences. They even described avoiding services to the detriment of their own mental health, just to avoid anticipated unaffirming providers.

I convinced myself that I am fine, I don't need to deal with any of this and a part of it was because I didn't want to have to go through that process of having to

meet with someone and not know how they're gonna react. I think if I didn't have those worries, that I would've gone a lot sooner and it wouldn't have taken me to this point where I had like a mental breakdown and you know, my mom had to like convince me, after months and months that ok, please go! (Two Spirit, nonbinary participant)

This anticipation of difficulties was a uniform experience across all of the participants, and some described obtaining information about affirming and unaffirming providers either from their network of TGNC friends or from a trusted health provider.

[My nurse practitioner] was able to refer me to one of her colleagues who works at endocrinology at [the hospital] so I've been seeing, like that's how I've got through that process and once again it was all people that [the nurse practitioner] worked with so once again I knew I could trust them and that they're not gonna be like just asking weird questions and all that.

This participant spoke about the importance of obtaining referrals within their trusted network of health providers and how they knew that if one of their trusted providers referred them to another service, it was likely to be a safe provider.

Youth vs Adult Care

Many of the individuals interviewed described differences in accessing mental health care as a youth vs as an adult. The majority of them had accessed services from the time they were in their early teens and could describe differences after they transitioned to adult services. The participants reported that many youth-specific services seemed to have more awareness of TGNC health and related concepts and made more obvious attempts to make their clinics welcoming and safe. Typically, youth clinics did this by

posting physical cues like Pride symbols and pamphlets on queer and trans topics or by offering queer and trans group programming and/or peer support. Those participants who had accessed Foundry services (only one person interviewed had never used Foundry services) reported feeling generally safe and welcome as a TGNC person and that Foundry staff seemed to actively practice things like asking for (and then using appropriately) pronouns and chosen names.

Several individuals described feeling as though they were cared for more but not taken seriously as an under 18 person and then cared for less but taken more seriously as an adult. As one queer, nonbinary participant described,

I think when I was a youth, I think people were more concerned about me. Um, I think...actually it's kind of like pros and cons. Like when I was a youth, people were more concerned about my safety, um so I was given all these different free services, I was being monitored kind of. Like I was being very well taken care of, but also with that I wasn't necessarily being listened to.

He goes on later to describe that as an adult, he'd had several suicide attempts but was sent home from the ER rather than be admitted, "*I think another part of it is because I am an adult...there is not as much, well I felt like there wasn't as much concern as there was like when I was a teenager.*" Another participant described it as:

Definitely within aspects of how I am treated as an adult, which is really nice, until I really turned 19, I was really treated like more of a child, which I fucking hated. You know, I've been on my own since 13, so to be treated as a child up until that point was like, "really what's the point?" it's like why, magically, when I become 19 I become an adult that can handle all this shit?

The participants all emphasized the importance of being taken seriously as a young person or adolescent, both in terms of their mental health and in terms of their TGNC identity. They faced multiple barriers to accessing appropriate services, from limited treatment and therapy options to long wait times, and then when they finally got into a service, they described feeling as though their needs and identity were not always taken seriously. As one participant stated,

like especially when you are young and accessing mental health services, they don't entirely listen to you. You're just kind of like humored, in terms of like any diagnoses you think you have. You're just kind of considered to be a stupid teenager that doesn't know what they're doing and is just like picking a random diagnosis to seem cool or something.

The youths described both negative and positive experiences with health and mental health providers. As mentioned earlier, it seemed as though youth-oriented services appeared to have a better understanding of TGNC concepts and health-related concerns and providers at such clinics were more likely to be experienced by the participants as affirming and respectful. The people interviewed indicated that a positive experience with a provider was a dynamic and changing interaction, rather than static; which is to say that provider-client interactions must be constantly negotiated and feeling affirmed does not end at asking for a person's name and pronouns. One positive experience was detailed as follows,

all he'd said was asked me what pronouns I use and I told him, I use he/him pronouns...and I would mention...but he like didn't ask me about being trans. Um I think maybe once he asked me if that was something I wanted to talk about with

him and I told him I don't think I need to, and he just didn't bring it up again. Um but also when I would talk about maybe an experience when I was misgendered and it made me feel anxious, it was the fact that I wanted to deal with the anxiety, he would, he was really good at acknowledging that it was painful for me, he wouldn't make me explain why it was painful for me. And he would just help me deal with the anxiety of it, so it seemed like he was doing his own research, so I didn't have to explain anything to him (underlining added for emphasis)

The consistent theme detailed in the positive interactions are highlighted in the underlined sections of the previous quote. Behaviors that facilitate positive interactions with TGNC youth are asking for and using name and pronouns, believing the person when they say that their gender identity is not the reason for them seeking care, and self-educating on TGNC concepts as needed while working with a client. Another highlight of a positive interaction was the practice self-correcting after a mistake, as described here,

we have it so ingrained in us to think about things in the binary that even people who use they/them pronouns are gonna mess up sometimes and you know, but it's like, ok we don't do anything else perfectly in our lives so we are allowed to make a mistake as long as we correct ourselves with grace

This point was made consistently, that the youth did not expect perfection from providers but rather simply that they graciously acknowledge an error made, self-correct, and move on.

Theme 3: "Oh, I feel completely invisible to society," the tyranny of the gender binary.

All of the participants described the oppressive effects of the gender binary on different aspects of their lives, in addition to their experience accessing health and mental

health care. They also highlighted other aspects of their identities that were often intertwined with their TGNC identities and influenced their lived experiences. This theme is divided into 3 categories: 1) exploring personal intersections, 2) tyranny in action in different parts of society, and 3) recommending solutions to respond to the effects of the binary.

Exploring Intersections

All of the participants brought up unique intersections within their identities that they described as influencing the experiences they had with mental health services. The question posed to each participant was “what other aspects of your identity, if any, influence your experience of mental health services” and from this, they identified a range of intersections that were grouped into 3 categories, health related, social identity related, and personal experience related intersections. Specific examples from different participants were as follows: being a survivor of abuse and/or trauma, being queer, having certain mental health and/or neurological diagnoses, being of a particular race and/or culture and their experience of gender dysphoria all impacted how they experienced care. As one nonbinary participant described an experience with a mental health counsellor,

she was great and very open to LGBTQ type stuff but not very equipped to be sensitive about body image and eating disorder type stuff so I ended up being triggered at a certain point from some of the advice and so I decided not to go back.

This individual also described how they experienced challenges as a “multi-ethnic” person when accessing care, specifically around not seeing racial and/or ethnic diversity

in their providers. In this way, their nonbinary and multi-ethnic identity presented them with overlapping challenges within each health interaction. Another participant, who described themselves as Two Spirit, stated that despite this term being the best-suited label to capture their identity, that other people were frequently confused as to its significance,

I've been slowly becoming more comfortable with identifying myself [to others] as Two Spirit because to me that's what fits best. But I hate having to explain what it is every time cuz its still something new to a lot of people, like not just in the LGBT community but in the Indigenous community, let alone everybody else!

Another participant, who reported having a particularly stigmatizing mental health diagnosis, stated that he had not been informed of being given the diagnosis until a few years *after* it had been applied to his health record. He explained that when he asked a psychiatrist why, the response was: “*he basically explained that they probably just didn't want to tell [me] because they were afraid that [I]’d freak out.*” He subsequently described mental health providers refusing to work with him due to this diagnosis and experienced significant challenges in accessing effective treatment.

The participants did not characterize the effect of these intersections and the challenges they posed as being primarily negative, however. Rather, they often described them as contributing to their resilience and ability to meet life’s challenges. The individual who had his mental health diagnosis kept from him stated that this experience emboldened him to be more assertive when seeking treatment and often asked providers directly if they had the necessary knowledge and training to work with him. Another participant stated that their experience as a trauma survivor contributed to their ability to advocate for themselves in a health care setting,

I've always been told that, oh I am so mature and so well spoken for my age and all that, and like I know my view on that has changed, after realizing, oh yea, that's because of all this trauma and stuff and being expected to be, you know, in control of these things. And learning about it myself and through experience, so like I think yeah, I learned a lot of that stuff at a really young age and that was expected of me.

These examples highlight the challenges that TGNC young people face when seeking care as they must not only navigate issues related to their TGNC identity and presentation, but also those posed by other aspects of their identity. These intersections also reveal how the participants developed resilience and new skills that helped them navigate the social environment.

Tyranny in Action

The tyranny of the binary was emphasized through the ways that language structured and re-enforced the gender binary and the manner in which the binary structure of the health system served to render the youth either invisible to, or segregated from, the rest of the health system. The way in which language re-enforced the gender binary was emphasized within the participants' descriptions of how they perceived their own gender identity and the words they used to describe it. All of the participants referred to their gender using a combination of terms (rather than a single term) and all emphasized the complexity of articulating the inner, felt sense of their own gender. The participants used combinations of words, from nonbinary, queer, male aligned, masculine, trans, Two Spirit, feminine-leaning, femme and androgynous.

Mostly I guess where I'd say I am is nonbinary but masculine leaning and I'd rather be identified, or pass I guess, as male than female so...I know that's like a lot, but {laughs} it's hard to put it into just one word! (Two Spirit, nonbinary participant)

This points to the over-simplification of labeling gender as male/female and even the existence of other gender terms, like nonbinary or gender nonconforming, continue to conceptualize gender in relation to the binary. Expressing who they are and their sense of their own gender, especially as people who do not fit within society's binary notions, called for an on-going examination of their inner sense of who they were and how they were (and wanted to be) perceived by the world.

Many of the participants described their TGNC identity as more of a journey than a destination and expressed how they had to learn to differentiate their own identity from the external, social forces that constantly imposed gender as a binary. As one nonbinary participant put it, *"transphobia makes feeling like nonbinary is fake, and all that, so like a lot of the time it makes it hard to really exist as yourself and tell people that."* Another nonbinary person stated,

I kind of feel sometimes...{laughs} like this doesn't sound great but sometimes like, "ugh maybe it's just too tough to be nonbinary" like in an ideal world where you could just be whatever without consequence, like I probably would choose that.

They highlight the potential for consequences to living according to your true self in a world that asks for (and enforces) conformity to pre-set conditions, as in male/female, man/woman, masculine/feminine.

Some of these consequences were described by the participants as: being treated as “weird” or “perverted” and facing intrusive questions, receiving “weird looks” and generally being treated as different. As one participant described:

It's hard existing in a body, in a world where everyone is perceived as male or female and if you don't have a body that perfectly aligns with what a woman looks like or what a man looks like, you get stared at. Or glared at, or whatever, like people straight-up ask you, like I've been asked by drunk men on the bus, "are you a girl" before, because they were hitting on me, and because I have a flat chest but the rest of me is very feminine looking and so it's like a big Frankenstein, hodgepodge thing of masculine and feminine traits that makes me like a walking gender-fuck.

The participants described the weight of such experiences as cumulative rather than isolated and emphasized that the impact of ignorance was not benign in nature. All of the people interviewed reported that acts of outright discrimination or hatred were rare but acts of ignorance and oversight were an on-going and not insignificant burden to carry. Instances of being misgendered and/or deadnamed were no less negatively impactful when the perpetrator was unaware or simply ignorant of TGNC concepts and TGNC people. While health providers were often ignorant but well-meaning, the impact of the ignorance far outweighed the intent behind the oversight or mistake.

What seems like a minor, like a small thing to a cis person, is like a big thing to a trans person. And especially if you are someone who is struggling with their mental health, your like, your threshold for pain is a lot lower than you would be if you were at your best, and that maybe it wouldn't affect you if you were feeling

really good, like when you are in a vulnerable place, accessing these services, it could like completely destroy you (queer, nonbinary participant).

The participants also described feeling invisible, both to health services and to the rest of the world, as one participant put it, *“oh, I feel completely invisible to the rest of society.”*

They highlighted the structure and nature of the health system itself as contributing to feeling invisible, especially for those nonbinary people who often felt imprisoned by the emphasis on “men’s” and “women’s” health. Additionally, the absence of options on health forms for gender identity beyond male/female indicate how the health system fails to recognize and acknowledge their existence as nonbinary people. As one person stated,

trans people actually aren’t a whole new species, that are completely different and require all these super specific high needs....it’s like no, just basic human decency and respect

Another participant described her desire to just be treated like a “regular person,”

Cuz I am just a person, I am trying to live my fucking life, I am not here to do all this shit that they say I am doing, I am not here to infiltrate women’s bathrooms, or infiltrate women’s spaces....I just wish that trans people could be treated as humans, equal, just like everybody else.

Recommending Potential Solutions

The participants recommended a range of potential solutions. The overwhelming consensus was that health providers, regardless of discipline, should receive specific training on TGNC concepts and health-related topics. The people interviewed recommended training programs that included discussions on what the gender binary is

and how it is re-enforced in society, issues related to names and pronouns, different TGNC terms and concepts (for example, like the terms presented in the Glossary), and on the way in which “trans health” is integrated into health services. Both explicitly, and implicitly through their stories and experiences, all of the participants emphasised the importance of health providers asking for a client’s name *and* pronouns at the start of every interaction and the positive impact doing so would have on service provision, client-centeredness and rapport-building. Related to this, they called for all health records and written documentation to explicitly include sections for pronouns and chosen name. The presence of this information on written documentation would ameliorate the expectation that client’s come out during every provider interaction because a provider would see on the chart how the client is to be addressed. One participant described an experience at a youth clinic that did not require patients to show their legal identification each time they accessed the service. Instead, this clinic had a form that included the person’s chosen name and pronouns, along with their personal health number, that was shared with any staff working with that patient.

Not having to either explain it to the receptionist and... rely on them, to pass on the info, but not have it there to begin with. And then the doctor sees it anyway and, in my experience, totally just has respected that and been like, cool, this is you.

In this way, the clinic or service can assist in disseminating and displaying the correct information about a client for all staff to access, rather than putting the onus back on the patient to explain it at every interaction.

Beyond providing education on why names and pronouns are relevant, education on TGNC concepts and terms more broadly could alleviate the burden of clients/patients being asked to teach their providers. The participants described being disappointed that health professionals, most of whom have years of specialized training, appeared to be inconsistently aware of either the existence of TGNC people or of related health topics. Whether this was due to an actual lack of training and knowledge or simply a lack of putting knowledge and training into action was not clear, at least from the perspective of the participants. Based on the various experiences they shared, it seemed as though it was a bit of both, as it is likely that some providers have received training and did not utilize it while others have no training or knowledge with which to put into practice.

Another recommendation was related to how health services are structured around the gender binary. Some of the youths described feeling as though they were segregated from the rest of the health system because they often were required to access “trans health” clinics or so-called, “gender clinics.” This experience was described as “self-limiting” and disempowering, as it set up gendered assumptions from the start, and someone accessing a service deemed as “men’s” or “women’s” is automatically assumed to be a man or a woman.

Chapter 4: Discussion

Synthesis of Findings from All Three Research Questions

The following section reports on the integrated findings from the quantitative and qualitative results and discusses the implications of these results. The research questions that guided this mixed-methods research are listed in the box below.

Question #1: To what extent is mental health distress different in TGNC young people as compared to cisgender young people?

Question #2: To what extent does race amplify the association between TGNC identity and mental health distress?

Question #3: What are the lived experiences of TGNC young people accessing mental health services in British Columbia?

Question #1: To what extent is mental health distress different in TGNC young people as compared to cisgender young people?

The findings from the first part of this study show that TGNC youth scored significantly higher on a measure of mental health distress than their cisgender peers. This supports the original hypothesis that TGNC youth are more distressed than cisgender youth. Additionally, the results revealed the high mental health distress scores of the *entire* sample, as both TGNC *and* cisgender groups had scores in the high and very high categories on the K10 (overall mean=28, SD=9.7, TGNC mean=31, SD=9.1, cisgender mean=28, SD=9.8, see *Table 1 Characteristics of study sample*). This pattern was also seen across both race strata. The results of this study are notable when compared to data collected at the population level, in the 2012 Canadian Community Health

Survey-Mental Health component (CCHS-MH). First, the distress scores from this study, as measured by the K10, were considerably higher than population estimates for similarly aged youth, regardless of gender identity. Data from the 2012 CCHS-MH captured only binary options, male/female, and included K10 scores for respondents aged 15-24 years ($n=4013$), with a mean K10 score of 17 ($SD=8.9$, median=15). In comparing this estimate to the cisgender group in my study (i.e., comparing the two cisgender groups), the cisgender group in this study had higher average K10 scores (K10 mean=28, $SD=9.8$) than did the population group (K10 mean=17, $SD=8.9$), with an effect size of 1.2 (Cohen's $d=1.2$).

High distress scores were expected in this sample given that it included young people who were accessing integrated health services at Foundry. The differences found in this thesis represent a conservative estimate of the actual difference in mental health distress between TGNC and cisgender youth, as it is possible that the medium effect size seen between the cisgender and TGNC groups was obscured by the high rates of mental health distress among the cisgender group. If youth seeking services are overall more distressed than youth in the general population, and if TGNC youth are significantly more distressed than cisgender youth, it is important to examine the challenges and barriers TGNC youth might face in accessing effective and affirming care.

At this time, I am unaware of an equivalent probability-based estimate for trans and/or TGNC Canadian young people that uses the K10 measure for mental health distress. In 2015, the Canadian Trans Youth Health Survey (Veale, Saewyc, et al., 2015), recruited a nonprobability sample of 923 TGNC youth from across Canada that examined various demographic and health outcomes, including the K10 for 19-25-year-olds. This

Canadian study (Veale, Saewyc, et al., 2015) used purposive sampling and recruited participants from youth advisory committees, social media sites, through LGBTQ organizations and from clinical/health care service providers who served trans youth specifically. Youth who completed this survey had an average K10 score of 30.5 (note, this score has been adjusted to reflect the 10-50 scoring format for the K10) (Veale, Saewyc, et al., 2015) which is comparable to the average K10 scores for the TGNC group in the current study, outlined in this thesis. Both the Veale study and my findings report considerably higher K10 scores than seen in the youth sampled with the 2012 CCHS-MH data.

It is relevant to note that not all TGNC youth experience such high levels of mental health distress and it is likely that there are differences between TGNC population numbers and estimates gleaned from convenience samples. For example, findings from a US study revealed that TGNC young people accessing services from providers with some training in TGNC concepts and care, reported overall positive experiences with primary care (Guss et al., 2019). Results from a Canadian study of 839 TGNC youth (Veale, Watson, et al., 2017) reported that approximately 25% of the youth surveyed indicated their mental health was either good or excellent. However, in the absence of a large, population-based sample of TGNC youth in Canada, at this time it is not possible to comment on the extent of the differences between TGNC youth in population vs those seeking care. This points toward the need for a more comprehensive picture of the needs and wellbeing of TGNC young people in Canada, as these findings present only a small glimpse into one aspect of their mental health outcomes. What might also be useful, alongside an appropriately sampled, population-level estimate of mental health distress, is

insight into those TGNC youth who are *not* distressed and who are flourishing; what elements of their lives and experiences might inform future policy action on integrated youth mental health services?

While these numbers illuminate the extent of between group differences, they do not explain *why* such differences might exist. What is important to emphasize is, it is *not* something inherent to TGNC identities that produce higher levels of mental health distress but rather, it is likely factors associated with social determinants (Garofalo et al., 2006; Parra & Hastings, 2018; Singh, 2012). From the qualitative part of the study, the voices of the participants interviewed brought to life a wider social context and illuminated the numbers beyond simply two dimensions. The qualitative data showed that the participants often faced negative interactions with health providers, many barriers to care and had to contend with the deleterious effects of the wider social conceptualization of gender as strictly binary. The participants characterized negative and upsetting experiences with health and mental health providers as the norm, while positive or affirming experiences were the exception. The qualitative findings from this study echo findings from existing qualitative literature that documents a myriad of TGNC youth voices citing disrespectful, unaffirming and/or ignorant health care interactions (C. Brown et al., 2020; Corliss et al., 2007; Poteat et al., 2013; Snyder et al., 2017; Wagaman, 2014). When examined within the context of the imposed gender binary and how this was represented as a tyrannical force in their lives, one can begin to see the layer on layer of challenge and frustration faced while navigating health services.

Research in the area of health outcomes for TGNC people has used the minority stress model (Meyer, 1995, 2003) to attempt to explain the health and mental health

inequities seen in TGNC populations. Minority stress is defined as the process through which individuals belonging to multiple minority social groups experience stigma, prejudice and discrimination, resulting in an upsetting and stressful social experience (Meyer, 2003). This model theorizes that the experience of discrimination and stigma from the social environment leads to health and mental health inequities for minority groups. Minority stress has been used to explain suicide risk in transgender adults in Canada (Bauer et al., 2015), peer victimization, school belonging and drug use in trans youth and trans youth of color (Hatchel & Marx, 2018), depression and anxiety in TGNC youth (Chodzen et al., 2019), as well as used extensively to explain differences among sexual minority populations. Therefore, the high rates of mental health distress among TGNC youth in the quantitative phase of this study could be associated with the social experiences described in the qualitative narratives of TGNC youth. These descriptions of their experiences with stigma and discrimination in the health care setting contribute evidence for the existence of systemic barriers that can result in a stressful and upsetting social environment, in-line with the minority stress model.

Question #2: To what extent does race amplify the association between TGNC identity and mental health distress?

Regarding the second research question, the findings demonstrated that TGNC youth scored significantly higher than their cisgender peers, across both race strata. This suggests that support for the original hypothesis was not found and TGNC youth from this sample, at the intersection of TGNC identity and a non-white racial identity, do not appear to be significantly more distressed than white TGNC youth.

There is limited research in this area, especially that takes an intersectional approach to mental health outcomes for TGNC youth and that examine race specifically. A study by Goldenberg et al., (2019) looked at the potentially mediating effects of gender affirmation by health providers on the relationship between stigma and healthcare use in specifically black TGNC young people. The results here pointed to the importance of not only gender affirming health care practices and spaces but also of the need for cultural humility training in reducing the impact of both gender and racial discrimination for TGNC youth of color. Another study examined transgender youth and peer victimization (i.e. emotional, physical or verbal abuse) and looked specifically at the effect of the intersection of race and other social factors. Hatchel & Marx (2018, p. 2) adopted an intersectional approach to look at the moderating effects of “socioeconomic status and [youth of color] status on the relationships among peer victimization, school belonging and drug use” for transgender students. This study (n= 4721) found that although transgender youth of color did experience higher rates of victimization than white transgender students, this did not lead to higher rates of drug use among transgender youth of color (despite victimization experiences leading to higher rates of drug use among white transgender students). This implies that assuming that membership in *additional* minority groups infers poorer health outcomes is not necessarily supported by research, as can be seen in Hatchel & Marx’s (2018) study and potentially in the results of this study. It invites an examination of the potential for protective effects from membership to different racial identities, something that could be explored in future research.

Collectively, my research and that of others emphasizes the importance of adopting an intersectional approach to explicating health inequities for various populations, as traditional linear or additive methods may not fully “capture the intricate transactions between multiple social identities that shape the lived experiences” (Parra & Hastings, 2018, p. 93) of people as they navigate the social world. Assuming an intersectional approach may be beneficial to the design of the health system in general and integrated youth mental health services specifically, because the interactions with health providers are considered sites of social engagement wherein stigma and discrimination are enacted (or vice versa, where respect and affirmation can occur). This thesis contributes knowledge to the importance of person-centred care in health system design, taking into consideration the various needs of TGNC young people accessing integrated health services.

As described by Fusar-Poli (2019, p. 9) “addressing inequities (including sex disparities)” is a fundamental aspect of developing youth-friendly health services. The WHO’s 2012 framework for the development of youth-friendly services includes specific mention of the responsibilities and behaviors of health providers (and associated support staff) to be free from stigma and to be “non-judgemental and considerate” (WHO, 2012, p. 6) when interacting with young people. This would reasonably include considerations for both gender identity and race, in an attempt to recognize the intersecting social forces, present in the lives of young people. In Canada, this is particularly relevant as provinces move towards system redesign and the implementation of integrated service models such as Foundry (BC), Youth Wellness Hubs Ontario (Ontario), and Access Open Minds (pan-Canadian). Without consideration for social determinants of health and how they

intersect, different groups of people will continue to experience disproportionately poorer health outcomes.

The concept of intersectionality was also portrayed in the narratives of the participants in this study. Several of them identified race or culture as a salient feature of their identity that impacted their experience of mental health services. Similar to issues related to their gender identity, the participants described their concerns over the lack of representation of racially diverse mental health practitioners and of a perceived deficit in understanding (on the part of providers) how racial or cultural influences might impact their lives. Other intersections that the participants described as relevant, that were not covered by the quantitative analysis, were around queer identity, as in sexual orientation and attraction, and mental health identity, as in having a particular label or diagnosis. As this data was not captured within the traditional quantitative metrics, it raises the importance of ensuring that young people are listened to and not classified into pre-defined categories in data capture systems like electronic medical records and survey research.

To highlight the insights that can be revealed from an intersectional approach to a health research question, take an example from a 2014 study by Bostwick et al. (2014). This study, while not in the area of TGNC identities, adopted an intersectional approach to examine how suicide and self-injury factors among sexual minority youth (i.e. non-heterosexual identities and practices) differed according to sex and race/ethnicity (Bostwick et al., 2014). The results showed complex nuance within patterns of suicide and self-harm behaviors among sexual minority youth when stratified by race/ethnicity and then further, by sex. For example, Asian and Black sexual minority youth had better

outcomes compared to white youth but when this was stratified further by sex, only Asian and Black female youth appeared to benefit from this protective factor (Bostwick et al., 2014). In terms of the results found for my study's second objective, it may be important for future research to consider the wide variety of experiences *within* a social category like non-white race, for example, looking at different subgroups like membership to a specific racial identity (e.g., Chinese) or a mixed racial identity. Data collection systems need to offer meaningful choices to young people accessing care and subsequent data analysis of such data needs to recognize the complex interplay of membership within and across multiple, social groups.

Another area of note in my research is that forty-eight percent (48%) (n= 352) of the participants in my study's (quantitative) sample indicated one or more racial identities other than white, inclusive of Indigenous youth (First Nations, Métis and Inuit). The sample of people who participated in this study were more racially diverse than those who typically access Foundry. The most recent estimates of youth accessing Foundry suggest that 28% select a non-white option(s) on demographic forms (Mathias et al., under review). Foundry's overall proportion is similar to the wider provincial census that show approximately 36% of British Columbians report being either a visible minority or Indigenous (First Nations, Métis and Inuit) (Government of British Columbia, 2017). The higher proportion seen in the study's sample could be attributed to the majority of participating youth (77%) residing in the Metro Vancouver area, where demographic reports show 51% of people in Vancouver and Metro area report being a visible minority or Indigenous (First Nations, Métis and Inuit) (Statistics Canada, 2017). With such diversity seen among youth accessing integrated youth mental health services, like

Foundry, it is vital that we do not stop at simply describing the differences *between* groups across BC, but also explore differences *within* the groups and interrogate the location of the boundaries themselves.

There is some precedence to utilizing groupings like “white” and “non-white,” as the 2012 CCHS-MH edition used these same categories on the item for “culture/race flag” (Statistics Canada, 2014). Some studies in the area of gender identity and youth mental health also dichotomize the “race/ethnicity” variable, with “white” & “racial/ethnic minority” in one (Reisner, Veters, et al., 2015) and “white”, “other race/ethnicity” & “multiracial” in another (Veale, Peter, et al., 2017), so there is some precedence to this particular grouping for the race variable. However, the dichotomization of people into “white” and “non-white” categories is potentially problematic for a number of reasons.

Categorizing people as such can reinforce the belief that the assigned racial or ethnic categories are fundamentally different and can also fail to consider how the individuals themselves conceptualize the influence of this categorization in their lives (Moscou, 2008). My study highlighted that it is important to be critical about the apparent boundaries that define any social category one uses in research and to interrogate the assumptions underlying the presence and location of these boundaries. Not to mention that broad categorization of any kind can make invisible the unique contextual factors that are associated with different countries, cultures, and communities, as these can reveal various racial and/or ethnic definitions (Moscou, 2008). According to McCall’s (2005, p. 1783) intra-categorical approach to intersectionality, “the point is not to deny the importance...of categories but to focus on the process by which they are produced,

experienced, reproduced and resisted.” It is in the spirit of McCall’s intra-categorical approach that I critique the boundaries of race used in my study. As this was a secondary analysis of existing data, I did not participate in creating the race item nor its associated options, which do not fully align with what is seen in larger surveys like the Canadian census, for example. Some caution might be warranted in interpreting the numbers related to race in this study, as the survey question could be considered ambiguously worded, with no mention of the words “race”, “ethnicity” or “racial background” in the item question and the item response options did not include a comprehensive list of racial and/or ethnic categories. For example, the available options did not include a Chinese option, despite 19% of people in the metro Vancouver area reporting Chinese on census surveys (Statistics Canada, 2017) (See Appendix A for a listing of the demographic survey item options).

Another important factor to consider is how the race variable is often selected and defined by members of the dominant social group (i.e. white researchers), rather than by TGNC people at the intersection of various social groups themselves. As Bowleg (2012) asserts, this is where the power of an intersectional framework comes into play, to emphasize the socially constructed nature of variables like race and gender identity and expose the way in which dominant social groups (e.g., cisgender, white) define the inclusion and exclusion criteria for the categories themselves. Future research might consider beginning with a qualitative exploration of what TGNC youth consider to be the salient social conditions that inform and influence their health experiences and use these constructs to then select relevant quantitative variables for analysis. A review by Parra & Hastings (2018) further explicated the need for taking an intersectional approach to

studying health outcomes and highlighted how it is not simply *membership to* multiple social groups (e.g., TGNC and a particular racial identity) but also *how* an individual perceives and understands their membership to these groups and consequently, how they navigate the social terrain. This emphasis on understanding the perspectives of individuals themselves fits into the WHO framework for the development of youth-friendly health services, which states that a core aspect of integrated youth health services is listening to the perspectives of youths themselves in order to develop “youth-friendly” services (Fusar-Poli, 2019; Tylee et al., 2007; WHO, 2012). Any initiatives or research in the area of TGNC youth mental health need to be structured around the consultation and recommendations of these youth, as the key stakeholders, for integrated youth health service provision.

Age

This research also lent some evidence towards a developmentally appropriate understanding of how young people, aged 16-25 years, access services. There is some support for the notion that age is associated with mental health distress, in that younger age might infer higher mental health distress but the results in this study indicated that age was not associated with the relationship between mental health distress and TGNC identity. One study in 2014 compared the age effects of mental health distress and found that psychological distress was “highest in late adolescence and early adulthood, [peaking] at age 20-24 years” (Keyes et al., 2014, p. 1218). Another study found a lack of consensus on whether depressive affect increases, stays the same or decreases from adolescence to early adulthood, however it did find evidence that depressive affect for youth starts declining in their early 20s (Jager, 2011). Therefore, age may in part explain

the high rates of mental health distress in the entire sample, but not the large differences between TGNC youth seeking care vs youth in the population, as can be seen in my sample and existing literature.

In the qualitative narratives, age did come up as a factor that influenced the participants' experiences of mental health services, with some of them describing "ageist" experiences in the health system. The theme of "not being taken seriously" as a young person, both with regards to their mental health symptoms and/or diagnoses and regarding their TGNC identity, was conceptualized as a barrier to services and characterized as frustrating. It is possible that observed differences in mental health distress between adolescents, young adults and adults could be attributed, in part, to social factors such as not being taken seriously by health care providers or by adults in general.

The results also highlighted the barriers that can result when health systems are designed and led exclusively by adults. A qualitative study by Singh (2012) examined resilience among transgender youth of color and these youth identified experiences with "adultism - the system where adults hold privilege and power in the youths lives" (Singh, 2012, p. 697). They described similar experiences to not being taken seriously and reported that adults often sent them the message "wait until [you] grow up" (p.697) before deciding on a TGNC identity. This speaks to the importance of providing non-judgemental and respectful services, as is proposed by the integrated youth mental health services framework. Indeed, a common theme that transcends the diversity among youth, is that they all "want to be treated with respect" (WHO, 2012, p. 8), which the participants in this study emphasized as something that could be achieved by taking them

seriously, no matter their age, gender identity, or mental health symptoms. Currently, the retention rate for mental health treatment in youth is considered to be very poor (Fusar-Poli, 2019) and the qualitative findings detailed in this thesis highlight the tendency of youth to avoid services they anticipate being unhelpful and/or disrespectful. If Canada is to strive toward leadership in integrated youth mental health services, meaningful engagement of diverse young people in all aspects of research, system design, evaluation, and policy are necessary (Fusar-Poli, 2019; Tylee et al., 2007; WHO, 2012). Such an approach could help ameliorate the impact of “adulthood” experiences of TGNC youth seeking care and, in the end, lead to improved health outcomes and experiences for this population.

Beyond race and age as potentially impacting the relationship between gender identity and mental health distress, variables related to socioeconomic status (SES) and class could be considered in future research in this area. Variables of interest here could include parental level of education and level of income, personal level of education and subjective socioeconomic status. There is some research that suggests that youths’ level of education and youths’ subjective SES may be associated with mental health outcomes in youth in general (Weinberg et al., 2019), however there is limited research among TGNC young people. A study by Hatchel & Marx (2018) demonstrated that trans youth with low SES were more at risk for both peer victimization and subsequent increased substance use. Another study by Ryan et al., (2010) noted that there exists a protective influence for LGBT youth who have an accepting family but found that families from a low SES background were less likely to be accepting of LGBT youth. This represents an

area of future research to consider, those factors related to TGNC young people's SES and class position, that might impact their mental health.

Question #3: What are the lived experiences of TGNC young people accessing mental health services in British Columbia?

Regarding the third research question, the findings revealed that TGNC young people often experience upsetting interactions with health providers, that they frequently experience barriers and facilitators to care and that they must navigate and challenge the norms laid out by the gender binary, in many aspects of their lives. These findings echo existing research, as mentioned earlier regarding disrespectful interactions, and as it relates to the barriers and facilitators TGNC people face in accessing care. Several studies have identified the importance of using correct labels for TGNC individuals, like names and pronouns, as a means of supporting their identities (C. Brown et al., 2020; Katz-Wise et al., 2017; Olson et al., 2016). A qualitative study out of Canada, on the use of pronouns for LGBTQ young people, conducted by C. Brown et al., (2020, p. 77), found youth overwhelmingly reported that “appropriate pronoun use [is] an important marker for what makes a space feel safe for them in their communities.” This is in line with the findings from this thesis, that detailed the importance of both appropriate pronoun usage and the importance of seeing a clinic, service and/or provider as safe and welcoming. A review paper by Donald & Ehrenfeld (2015, p. 178) described the relevance of collecting correct name and pronouns for health service users as a means to increase service utilization by TGNC people *and* to signal to TGNC service users that they are in an “inclusive and affirming clinical environment.” This is in keeping with the voices of the participants in this study, who discussed how they often avoided services that were potentially

unaffirming or not inclusive and returned to (and recommended to their network) those services that proved to them they were affirming.

The portrayal of the tyranny of the gender binary in the lives of the participants was also in line with what other studies have found. Trans youth have described experiences of generalized societal oppression and stigma and discrimination in the form of gender policing in various settings, including health care (Singh, 2012; Singh et al., 2014). With regards to the language of gender and the way in which TGNC young people navigate labels and expressions of their TGNC identity, many of the participants in this study tended to reject one single term. Trans youths in other studies have echoed this process of understanding and affirming their own gender identity, in such a way that this “self-theorizing of gender” (Singh et al., 2014, p. 215) can even lead to increased resilience. Allowing individuals to define and express themselves in an authentic manner is a process that can either be supported or constrained by social systems, like health and mental health care. The health system in general, and providers specifically, must reflect on the ways the system enacts the gender binary and consider the opportunity to reconstruct policy, programs and behaviors in a way that reduces the harm done by strict adherence to this binary. The findings from this study highlight that the lived experiences of TGNC young people accessing mental health services cover a wide range of concerns and challenges, that all echo previous research, and while pockets of positive action are occurring in some health centers, there is still work yet to do. While future research is needed to help expand our understanding of the lived experiences of TGNC youth accessing care, what is also needed is research into how specific changes to health policy

and programming can attempt to address the structural barriers, across many sectors, identified by TGNC youth.

Study Strengths and Limitations

One major strength was using a mixed-methods study design. The merging of the quantitative findings with the qualitative was a way to achieve integration and a means to “bring the two databases together for analysis and comparison” (Fetters et al., 2013, p. 2140). The quantitative part of the study revealed information on the “what,” as in what is the relationship between TGNC identity and mental health distress while the qualitative study revealed information on the “why,” as in what potentially contributed to mental health distress among TGNC young people. As outlined by Creswell et al., (2011, p. 6), “problems most suitable for mixed methods are those in which the quantitative approach or the qualitative approach, by itself [would be] inadequate.” Without the stories of the TGNC young people to bring to life their experiences in the health system, the quantitative results alone might have resulted in a one-sided picture of the impact of TGNC identity on mental health distress.

Despite the critiques I provided of the race variable, this study and its findings are one of the few Canadian studies that use a mixed-method and intersectional approach to conceptualize mental health distress among TGNC young people. The intersectional framework allowed for a more critical examination of the inclusion of particular variables of interest, as well as incorporated the voices of those people who are potentially made vulnerable by our health system. Encouraging the qualitative participants to identify salient aspects of their identity, beyond their TGNC identity, that impacted their

experience of mental health services, opened up additional intersectional possibilities in how I conceptualized the relationship between mental health distress and TGNC identity. Had I only focused on race, I would have missed the nuances reported by the participants in terms of their queer and mental health identities, for example. Considering that I am an early career clinician-scientist, it was important for me to engage in ongoing critique of my work so as to excavate a better path forward for future studies; using the intersectional framework encouraged this process.

Another strength was the way in which gender identity was measured in both the quantitative and qualitative parts of the study. The survey item included options beyond male/female, as well as Two Spirit, nonbinary/gender nonconforming options for the youth to self-identify. While there is no standard process for reporting gender options beyond male/female, there is growing recognition for the value of including both transgender and nonbinary/gender nonconforming identities on demographic surveys of all kinds (Deutsch et al., 2013; Reisner, Deutsch, et al., 2016; Veale, Watson, et al., 2017). The way this study measured gender identity is a step in the right direction for adequately capturing TGNC individuals in health research. While it did not align with the two-step question process recommended by WPATH, as detailed earlier, the mere presence of options beyond the gender binary was identified by the study's participants as refreshing and affirming.

Another strength was the wide geographic range of participating young people; the quantitative data included participants from five BC Foundry centers, covering a range of urban and rural settings. This allowed for a range of perspectives and experiences to be represented in the data. Additionally, the primary study from which I

drew the dataset utilized the Strategy for Patient Oriented Research (SPOR) framework, which includes a strong emphasis on patient engagement in decision-making (CIHR, 2014), which coincides with the intersectional approach that emphasizes including the voices of the research participants themselves.

This study is not without limitations. The WPATH recommendation for a two-step process includes questions about sex-assigned at birth and current gender identity would allow for the possibility of a more nuanced understanding of a sample's gender identity that could include different combinations of sex and gender (Coleman et al., 2012; Reisner, Deutsch, et al., 2016). The survey used for this study did not follow this 2-part gender and sex item method and so this sample did not differentiate those individuals who reported male or female on the survey item and who also have a different birth-assigned sex, making the TGNC group potentially underrepresented.

Another limitation is the relatively small sample size for some of the subgroups in the quantitative study and for the qualitative portion of the study. As a result, caution is warranted in interpreting the frequencies and associations seen in this data, especially for the stratified analysis of race; it was not possible to examine subgroups within the non-white category and so no inferences can be made regarding within group differences. However, despite the small sample size, the qualitative data were able to contextualize and bring to life the associations seen in the quantitative results and provided an adequate initial exploration of the experiences of TGNC young people. In light of the small sample size for the qualitative interviews (n=5), some questions might arise as to the notion of data saturation. Saturation is thought to be a marker of quality in qualitative research and as defined by Bowen (2008, p. 140), "saturation is reached when the researcher gathers

data to the point of diminishing returns, when nothing new is being added.” I recognize that due to the small number of interviews conducted and despite the richness of the data gathered, that saturation was not reached. Additional perspectives are needed, such as experiences of binary trans youth who transitioned around puberty and whose gender expression aligns with stereotypical notions of masculinity or femininity, or TGNC youth who had either neutral or positive experiences with mental health services. Such perspectives would help to create a more nuanced picture that might be more generalizable to the TGNC population as a whole.

Additionally, for the qualitative phase, recruitment of TGNC young people proved to be a slow and difficult process, contributing to the small number of youths interviewed. This difficulty was heightened by the COVID-19 pandemic. The difficulties in recruitment for the qualitative study may have been attributed to the reticence of TGNC youth to engage with health services in general and engaging in research may have presented them with the same reservations. I acknowledge that as a researcher, I was an unknown adult, in a position of power, who the youths had not yet vetted as a safe or affirming person and this may have led to the low uptake in recruitment. Additionally, my position as an adult (rather than someone closer to their age cohort) may have also contributed to slow recruitment. Despite attending several youth groups in-person as part of the recruitment process, these youth may not have seen me as relatable, either due to my age or other reasons. Future research should consider including youth research associates in designing and implementing recruitment and data collection protocols.

Another limitation of this study is the cross-sectional nature of the quantitative and the retrospective nature qualitative data. This study represents a cross-sectional

snapshot of mental health distress among TGNC youth and so no causation can be inferred. However, the narratives of the TGNC youths interviewed point toward some potential contributors to the differences seen between TGNC and cisgender youth accessing mental health services. Future research in this area might consider a longitudinal approach to examining mental health distress and TGNC identity over time, especially if it includes qualitative narratives of how TGNC youth navigate service experiences as they move from adolescence to young adulthood and beyond.

Finally, a notable limitation of the study was the tool selected to measure distress in the quantitative part of the study. The Kessler Distress (K10) scale was originally designed as a population measure to capture non-specific psychological distress (i.e., common across the common mental health disorders) in an American adult population. Few studies have validated the K10 as a measure that is fit for purpose for the context of integrated youth health services. A recent, as yet unpublished, Canadian study that examined the validity of the K10 in the context of integrated youth health services (Barbic et al., under review), found that despite the K10's established statistical measurement performance, it lacks underlying conceptual validity within this context. This study points toward the need for future work to develop a conceptualization of mental health distress from the perspective of young people themselves, from which future measures can be validated and developed.

Recommendations for Future Research

This research project provided some insights into the relationship between TGNC identity and mental health distress, as well as into the experiences of TGNC young

people accessing mental health care. A collective summary of recommendations for research is found below.

Future research could consider adopting the WPATH recommendation of using the two-step sex and gender process for capturing trans and nonbinary gender identities on demographic surveys, so as to encourage a comprehensive picture of all binary and nonbinary trans identities. Statistics Canada, after consultations with various stakeholders across Canada, has made the important decision to include sex *and* gender questions in the upcoming 2021 census, that recognize not only trans identities but also nonbinary identities (Statistics Canada, 2019b). This might open up an interesting and important glimpse into prevalence of TGNC people in Canada and hopefully inspire future researchers to include multiple gender identity options on their demographic surveys.

As well, using a larger sample size that ensures diverse and inclusive recruitment practices might also allow for the possibility of subgroup analyses within the TGNC group. This could support the growing body of literature that recognizes the differences in health outcomes between trans people who identify within the gender binary and those individuals who identify outside of this binary (B. A. Clark, Veale, Townsend, et al., 2018; Reisner, Poteat, et al., 2016). The numbers in my study sample's TGNC group were not sufficient to disaggregate binary trans youth from nonbinary youth, so future research that includes larger sample sizes and appropriate capture of TGNC identity could allow such a subgroup analysis to happen.

As the qualitative interviews focused only on youths aged 19-25 years, an area of future research would be to include the voices of youths from 12-18 years. Participants in this study identified changes in how they experienced mental health services as they

progressed from adolescence to young adulthood. Recognizing both the developmental trajectory and the unique perspective of youths themselves would be in keeping with the WHO framework for the development of youth-friendly health services (WHO, 2012). Understanding the diverse needs of younger youths and adolescents may help inform future research to support the creation of upstream interventions that promote health and wellbeing. Another area of research may also be engaging those young people who are not distressed, as this research captured youth mostly at the high end of the distress spectrum. Listening to the narratives of those TGNC youth who are *not* distressed (or are less distressed) and/or not seeking services may provide valuable insight into their experiences using health and mental health care and in how they maintain their mental health and resilience.

Future research in any area of TGNC youth mental health should include the voices, experiences and recommendations of TGNC participants in all aspects of research design, analysis, and knowledge translation. Centering the voices of TGNC youth would work to ensure proposed research is relevant to their lives and needs, that the manner in which it is carried out is affirming and respectful, and that any results or recommendations are implemented appropriately. As well, creating ways to engage youth from rural and remote communities may support a less urbanized view of how young people engage in integrated health service models such as Foundry. Such future research might also examine how rural or remote TGNC youth conceptualize and express non-cisgender identities. Understanding such needs over time, using longitudinal research designs, will be critical to understand the changes in mental health distress from early adolescence to young adulthood for TGNC youth. Doing so might highlight not only how

youth traverse their evolving gender identity, but also how this aspect of their identity (and other relevant social identities) influence their use of mental health services as they age.

Implications for Policy and Programs

The young people who participated in the qualitative interviews for this study all expressed their desire to participate *so that* their voices could effect change for mental health service delivery for TGNC people. The findings that emerged in this thesis indicate that intervention and education on TGNC concepts are not only required for health professions and the health system, but also for other social systems, such as the justice system, health research, education and media. The results reported in this thesis also highlight the need for future public health research and initiatives to look beyond rates and frequencies within mental health distress, toward a more social determinant-based understanding of health inequities for TGNC young people. The integrated discussion brought up some areas of potential interest for policy makers and researchers.

This study suggests the need for health professionals providing integrated health services to engage in an educational training program on TGNC concepts and related health topics. Based on the data in this study, it is recommended that future training curriculums are co-developed with TGNC youth and utilize the diverse experiences of TGNC youth to inform training objectives, content, and outcomes. As well, providing training support for TGNC youth to deliver this future training to current health staff, regardless of role or profession, may enhance province wide understanding and awareness of TGNC concepts and issues. Such strategic professional education could also

be delivered to future health providers from all health disciplines and decision makers within healthcare and government. This is why it may be important for policy and decision-makers to consider funding allocation in the area of education and training. Such an approach could potentially address how the structure of our health system and subsequent health programs reinforce the gender binary and contribute to the disengagement of TGNC youth with health services.

Given the context of this study, it is recommended that existing provincial investment such as Foundry are leveraged to support accessible, affirming and youth-friendly mental health care. With ten centers currently operating and nine more in development, Foundry is positioned as a potential medium for improving mental health service delivery for both TGNC and cisgender youth in BC. The findings detailed in this thesis could have direct impact on how health and mental health services (at Foundry and elsewhere) are conceptualized, structured, and delivered to young people in BC. Service providers could consider, for example, changing the way they gather and record patient information, so that information like pronouns and preferred name are included on medical records and documentation. In light of the BC Government's strategic plan for mental health and addiction ['A Pathway to Hope' (Government of British Columbia, 2019)], now is an ideal time to implement integrated youth health services that recognize and affirm the diverse array of TGNC youth specifically, and youth more broadly

Finally, the intersectional framework used in this study highlighted the importance of not only changes to health service delivery, but to the cooperation and partnership of other social institutions in improving the mental health outcomes and service experiences of TGNC youth. The participants in the qualitative study brought up

similarly negative experiences with the justice system, postsecondary education system and medical laboratory services, pointing to the importance of partnership and concurrent system-level changes to multiple social service structures. While there currently exists barriers to timely and appropriate provision of evidence-based service provision, the health system does not exist in a vacuum and is itself influenced by wider social views like TGNC stigma, mental health stigma, ageism and racism. Intentional, considered partnership and cooperation between both health and social service structures are needed to dismantle forces of stigma and discrimination that disproportionately impact young people in general and TGNC youth specifically.

Implications for Clinical Practice

Impacting clinical practice was one of the aims of this research project and the qualitative findings highlighted several practical items that clinicians and health-related staff could implement to enact immediate change. A comment made repeatedly by the participants was the importance of normalizing the request for, and sharing of, personal names and pronouns at the beginning of every clinical interaction. When a health provider either explicitly requested this information from the patient or the patient had the opportunity to share this information on health intake forms, the participants described this as immediately affirming. Doing so signalled to them the possibility that this provider or clinic was knowledgeable and safe. Health providers could consider implementing such behavior into their daily interactions, with both new and existing patients. Additionally, space for legal name *and* preferred name, pronouns and current gender identity (with multiple options beyond male/female) could be added to health

intake forms, patient history templates, and other documentation pertaining to a patient. If a clinician's clinic or organization does not currently have space for this information, they could consider advocating for its inclusion and/or adding it to their personal clinical templates until such a change is made.

Participants also advocated for health providers to “do their own research” if they served a TGNC client for the first time and had no prior knowledge or training in the area. Rather than relying on a specific patient for education, health providers can gain much from a simple Google search on either a specific term or more broadly on gender identity terms and concepts. Please see Appendix K for a list of websites for self-study in this area. This could help ameliorate the tendency of TGNC young people being expected to educate their providers on relevant terms and topics. The participants emphasized perfection was not expected, rather, only an honest demonstration of effort, humility and compassion on the part of a health provider.

Knowledge Translation

As outlined by the CIHR, “[Knowledge translation]/KT is of critical importance to health research” (CIHR, 2012, p. 1) because it helps to get new knowledge on health-related topics into the hands of those individuals and organizations that can use and apply it. As research in the area of TGNC young people and mental health is in its beginning stages, end-of-grant KT was selected as a means of contributing to the small, but growing, body of evidence in this area.

Some KT activities that I engaged with are detailed as follows. I presented my research project and its quantitative findings at the national Canadian Association of

Occupational Therapists (CAOT) virtual conference on May 8th, 2020. This conference was (virtually) attended by practicing occupational therapists (OT) and OT students from across Canada, as well as by researchers and various health policy decision-makers. I plan on submitting my completed thesis and results for inclusion in the 2021 CAOT conference so that I may disseminate the narratives of the TGNC participants more fully.

In this research process, I was able to draw attention to the WPATH recommendations for a two-step process for capturing gender identity to the Foundry management team and this system has since been implemented in relevant Foundry demographic survey items. Additionally, I will create a virtual presentation on my research results and recommendations for clinical practice, to be disseminated to Foundry staff. Finally, my plan is to publish my results in open access journals, such as PLOS One, Journal of Pediatrics or BMC Medicine.

Conclusion

In conclusion, this research project found that TGNC young people are significantly more distressed than their cisgender peers and that in general, youth seeking care are significantly more distressed than youth in the population. It also found that while TGNC youth were more distressed than cisgender youth in both non-white and white race strata, there did not appear to be a specific, additional negative impact of a non-white racial identity on the mental health distress of TGNC young people. This project also heard from TGNC young people and their voices echoed narratives of upsetting interactions with health providers, various challenges to accessing mental health services, and a general barrage of binary gender norms in their lives in general.

The barriers detailed by the youths brought to life the intersections of different aspects of their identities, beyond simply their TGNC identity, and how these both frustrated them and inspired them to cultivate personal resilience. The application of intersectionality to this research contributed to a new conceptualisation of health inequalities among TGNC young people and a recognition of the role multiple and intersecting pathways of oppression play in reproducing health inequalities. Further research and policies are needed that adopt this intersectional approach to better understanding both the particular health outcomes and lived experiences of TGNC young people accessing health services, in a way that centers their concerns and supports those factors they define as contributing to their wellbeing. Application of this project's findings focus on promoting increased education and understanding of TGNC concepts and health concerns as well as on promoting intersectoral collaboration of social services organizations beyond simply health care.

References

- Adbul Rehman, A., & Alharthi, K. (2016). An Introduction to Research Paradigms. *International Journal of Educational Investigations*, 3(8), 51–59.
- Andrews, G., & Slade, T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health*, 25(6), 494–497. <https://doi.org/10.1111/j.1467-842X.2001.tb00310.x>
- 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>
- Asher, M., Asnaani, A., & Aderka, I. M. (2017). Gender differences in social anxiety disorder: A review. *Clinical Psychology Review*, 56(Journal Article), 1–12. <https://doi.org/10.1016/j.cpr.2017.05.004>
- Australian Bureau of Statistics. (2009). 4327.0—*National Survey of Mental Health and Wellbeing: Users' Guide*, 2007. <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4327.0Main%20Features72007?opendocument&tabname=Summary&prodno=4327.0&issue=2007&num=&view=>
- Barbic, S., Leon, A., Manion, I., Irving, S., Zivanovic, R., Jenkins, E., Ben-David, S., Azar, P., Salmon, A., Helps, C., Gillingham, S., Beaulieu, T., Pattison, R., Talon, C., Oyedele, O., Tee, K., & Mathias, S. (2019). Understanding the mental health and recovery needs of Canadian youth with mental health disorders: A Strategy for Patient-Oriented Research (SPOR) collaboration protocol. *International*

Journal of Mental Health Systems, 13(1), 6–8. <https://doi.org/10.1186/s13033-019-0264-0>

Barbic, S., Pattison, R., Tee, K., Helfrich, W., Chan, G., Henderson, J., & Mathias, S. (under review). Rasch analysis of the Kessler Distress Scale (K10) for young adults receiving integrated youth health services in British Columbia, Canada. *Lancet Psychiatry*.

Bauer, G. R. (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Social Science & Medicine* (1982), 110(Journal Article), 10–17. <https://doi.org/10.1016/j.socscimed.2014.03.022>

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15(1), 525. <https://doi.org/10.1186/s12889-015-1867-2>

Bennett, D. A. (2001). How can I deal with missing data in my study? *Australian and New Zealand Journal of Public Health*, 25(5), 464–469. <https://doi.org/10.1111/j.1467-842X.2001.tb00294.x>

Bostwick, W. B., Meyer, I., Aranda, F., Russell, S., Hughes, T., Birkett, M., & Mustanski, B. (2014). Mental Health and Suicidality Among Racially/Ethnically Diverse Sexual Minority Youths. *American Journal of Public Health* (1971), 104(6), 1129–1136. <https://doi.org/10.2105/ajph.2013.301749>

- Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research: QR*, 8(1), 137–152.
<https://doi.org/10.1177/1468794107085301>
- Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality- an important theoretical framework for public health. *American Journal of Public Health*, 102(7), 1267. <https://doi.org/10.2105/AJPH.2012.300750>
- Brown, A., Rice, S. M., Rickwood, D. J., & Parker, A. G. (2016). Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. *Asia-Pacific Psychiatry: Official Journal of the Pacific Rim College of Psychiatrists*, 8(1), 3–22.
- Brown, C., Frohard-Dourlent, H., Wood, B. A., Saewyc, E., Eisenberg, M. E., & Porta, C. M. (2020). “It makes such a difference”: An examination of how LGBTQ youth talk about personal gender pronouns. *Journal of the American Association of Nurse Practitioners*, 32(1), 70–80. <https://dx-doi-org.ezproxy.library.ubc.ca/10.1097/JXX.0000000000000217>
- Chafe, R. (2017). The Value of Qualitative Description in Health Services and Policy Research. *Healthcare Policy/Politiques de Santé*, 12(3), 12–18.
<https://doi.org/10.12927/hcpol.2017.25030>
- Chan, S. M., & Fung, T. C. T. (2014). Reliability and validity of K10 and K6 in screening depressive symptoms in Hong Kong adolescents. *Vulnerable Children and Youth Studies*, 9(1), 75–85. <https://doi.org/10.1080/17450128.2013.861620>
- Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis*. SAGE Publications Ltd.

- Charmaz, K. (2010). Premises, Principles, and Practices in Qualitative Research: Revisiting the Foundations. In *SAGE Qualitative Research Methods* (Vol. 14, pp. 976–993). SAGE Publications, Inc. <https://doi.org/10.1177/1049732304266795>
- Charmaz, K. (2017). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry*, 23(1), 34–45. <https://doi.org/10.1177/1077800416657105>
- Cheema, J. R. (2014). Some General Guidelines for Choosing Missing Data Handling Methods in Educational Research. *Journal of Modern Applied Statistical Methods*, 13(2), 53–75. <https://doi.org/10.22237/jmasm/1414814520>
- Chodzen, G., Hidalgo, M. A., Chen, D., & Garofalo, R. (2019). Minority Stress Factors Associated with Depression and Anxiety Among Transgender and Gender-Nonconforming Youth. *Journal of Adolescent Health*, 64(4), 467–471. <https://doi.org/10.1016/j.jadohealth.2018.07.006>
- CIHR. (2012). *Guide to Knowledge Translation Planning at CIHR: Integrated and End-of-Grant Approaches*. Government of Canada. <https://cihr-irsc.gc.ca/e/45321.html#a2>
- CIHR. (2014). *Strategy for Patient Oriented Research (SPOR): Patient engagement framework*. <https://cihr-irsc.gc.ca/e/48413.html#a7>
- CIHR. (2018, May 1). *Sex, Gender and Health Research*. <http://www.cihr-irsc.gc.ca/e/50833.html>
- Clark, B. A., Veale, J. F., Greyson, D., & Saewyc, E. (2018). Primary care access and foregone care: A survey of transgender adolescents and young adults. *Family Practice*, 35(3), 302–306. <https://doi.org/10.1093/fampra/cmz112>

- Clark, B. A., Veale, J. F., Townsend, M., Frohard-Dourlent, H., & Saewyc, E. (2018). Non-binary youth: Access to gender-affirming primary health care. *International Journal of Transgenderism*, 19(2), 158–169.
<https://doi.org/10.1080/15532739.2017.1394954>
- Clark, T., Lucassen, M., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The Health and Well-Being of Transgender High School Students: Results from the New Zealand Adolescent Health Survey (Youth'12). *Journal of Adolescent Health*, 55(1), 93–99.
<https://doi.org/10.1016/j.jadohealth.2013.11.008>
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., ... Zucker, K. (2012). *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People*. World Professional Association for Transgender Health.
- Corliss, H. L., Belzer, M., Forbes, C., & Wilson, E. C. (2007). An evaluation of service utilization among male to female transgender youth: Qualitative study of a clinic-based sample. *Journal of LGBT Health Research*, 3(2), 49–61.
- Cornelius, B. L. R., Groothoff, J. W., van der Klink, J. J. L., & Brouwer, S. (2013). The performance of the K10, K6 and GHQ-12 to screen for present state DSM-IV disorders among disability claimants. *BMC Public Health*, 13(1), 128.
<https://doi.org/10.1186/1471-2458-13-128>

- Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), 1241–1299.
<https://doi.org/10.2307/1229039>
- Creswell, J. W., Klassen, A. C., Plano-Clark, V. L., & Clegg Smith, K. (2011). *for the Office of Behavioral and Social Sciences Research: Best practices for mixed methods research in the health sciences*. National Institutes of Health.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). SAGE Publications.
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297–334. <https://doi.org/10.1007/BF02310555>
- CSDH. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission of the Social Determinants of Health*. World Health Organization.
- Davis, K. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory*, 9(1), 67–85.
<https://doi.org/10.1177/1464700108086364>
- Day, S. (2012). A Reflexive Lens: Exploring Dilemmas of Qualitative Methodology Through the Concept of Reflexivity. *Qualitative Sociology Review*, 8(1).
- de Vet, H. C. W., Terwee, C. B., Mokkink, L. B., & Knol, D. L. (2011). *Measurement in medicine: A practical guide*. Cambridge University Press.
- Deutsch, M. B., Green, J., Keatley, J., Mayer, G., Hastings, J., Hall, A. M., & World Professional Association for Transgender Health EMR Working Group. (2013). Electronic medical records and the transgender patient: Recommendations from

- the World Professional Association for Transgender Health EMR Working Group. *Journal of the American Medical Informatics Association: JAMIA*, 20(4), 700–703. <https://doi.org/10.1136/amiajnl-2012-001472>
- Donald, C., & Ehrenfeld, J. M. (2015). The Opportunity for Medical Systems to Reduce Health Disparities Among Lesbian, Gay, Bisexual, Transgender and Intersex Patients. *Journal of Medical Systems*, 39(11), 1–7. <https://doi.org/10.1007/s10916-015-0355-7>
- Dong, Y., & Peng, C.-Y. J. (2013). Principled missing data methods for researchers. *SpringerPlus*, 2(1), 222–222. PubMed. <https://doi.org/10.1186/2193-1801-2-222>
- Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving Integration in Mixed Methods Designs—Principles and Practices. *Health Services Research*, 48(6pt2), 2134–2156. <https://doi.org/10.1111/1475-6773.12117>
- Fetters, M. D., & Molina-Azorin, J. F. (2017). The Journal of Mixed Methods Research Starts a New Decade: The Mixed Methods Research Integration Trilogy and Its Dimensions. *Journal of Mixed Methods Research*, 11(3), 291–307. <https://doi.org/10.1177/1558689817714066>
- Fusar-Poli, P. (2019). Integrated Mental Health Services for the Developmental Period (0 to 25 Years): A Critical Review of the Evidence. *Frontiers in Psychiatry*, 10(Journal Article), 355–355. <https://doi.org/10.3389/fpsy.2019.00355>
- Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, 38(3), 230–236. <https://doi.org/10.1016/j.jadohealth.2005.03.023>

- Georgakakou-Koutsonikou, N., & Williams, J. M. (2017). Children and young people's conceptualizations of depression: A systematic review and narrative meta-synthesis. *Child: Care, Health and Development*, 43(2), 161–181.
<https://doi.org/10.1111/cch.12439>
- Glickman, M. E., Rao, S. R., & Schultz, M. R. (2014). False discovery rate control is a recommended alternative to Bonferroni-type adjustments in health studies. *Journal of Clinical Epidemiology*, 67(8), 850–857.
<https://doi.org/10.1016/j.jclinepi.2014.03.012>
- Goforth, C. (2015, November 16). Using and Interpreting Cronbach's Alpha. *University of Virginia Library: Research Data Services & Sciences*.
<https://data.library.virginia.edu/using-and-interpreting-cronbachs-alpha/>
- Goldenberg, T., Jadwin-Cakmak, L., Popoff, E., Reisner, S. L., Campbell, B. A., & Harper, G. W. (2019). Stigma, Gender Affirmation, and Primary Healthcare Use Among Black Transgender Youth. *Journal of Adolescent Health*, 65(4), 483–490.
<https://doi.org/10.1016/j.jadohealth.2019.04.029>
- Government of British Columbia. (2017, October 26). *Issue 17-138: 2016 Census: Highlights from the Indigenous People in Canada Release*.
<https://www2.gov.bc.ca/gov/content/data/statistics/infoline/infoline-2017/17-138-2016-census-indigenous-people-canada?keyword=indigenous&keyword=census>
- Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and Methodological Bases of Naturalistic Inquiry. *Educational Communication and Technology*, 30(4), 233–252.

- Guetterman, T. C., Babchuk, W. A., Howell Smith, M. C., & Stevens, J. (2017). Contemporary Approaches to Mixed Methods–Grounded Theory Research: A Field-Based Analysis. *Journal of Mixed Methods Research, Journal Article*, 155868981771087. <https://doi.org/10.1177/1558689817710877>
- Guss, C. E., Woolverton, G. A., Borus, J., Austin, S. B., Reisner, S. L., & Katz-Wise, S. L. (2019). Transgender Adolescents’ Experiences in Primary Care: A Qualitative Study. *Journal of Adolescent Health*, 65(3), 344–349. <https://doi.org/10.1016/j.jadohealth.2019.03.009>
- Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271–283. <https://doi.org/10.1080/09581590802294296>
- Hardy, M. A. (1993). *Regression with dummy variables: Vol. no. 07-093*. Sage Publications.
- Harris, M. G., Diminic, S., Reavley, N., Baxter, A., Pirkis, J., & Whiteford, H. A. (2015). Males’ mental health disadvantage: An estimation of gender-specific changes in service utilisation for mental and substance use disorders in Australia. *Australian & New Zealand Journal of Psychiatry*, 49(9), 821–832. <https://doi.org/10.1177/0004867415577434>
- Hatchel, T., & Marx, R. (2018). Understanding Intersectionality and Resiliency among Transgender Adolescents: Exploring Pathways among Peer Victimization, School Belonging, and Drug Use. *International Journal of Environmental Research and Public Health*, 15(6), 1289. <https://doi.org/10.3390/ijerph15061289>

- Heffernan, D. (2012, December 3). *The APA Removes 'Gender Identity Disorder' From Updated Mental Health Guide*. Glaad. <https://www.glaad.org/blog/apa-removes-gender-identity-disorder-updated-mental-health-guide>
- Hole, R. (2014). *Qualitative Health Research*. In Bassil K. Editor & Zabkiewicz, D. Editor (Eds.), *Health Research Methods: A Canadian Perspective* (First, p. 25). Oxford University Press.
- Human Rights Campaign Foundation. (2019). *A National Epidemic: Fatal anti-transgender violence in the United States in 2019*. Human Rights Campaign Foundation.
- Jacobson, D., & Mustafa, N. (2019). Social Identity Map: A Reflexivity Tool for Practicing Explicit Positionality in Critical Qualitative Research. *International Journal of Qualitative Methods*, 18(Journal Article), 160940691987007. <https://doi.org/10.1177/1609406919870075>
- Jager, J. (2011). A developmental shift in Black-White differences in depressive affect across adolescence and early adulthood: The influence of early adult social roles and socio-economic status. *International Journal of Behavioral Development*, 35(5), 457–469. <https://doi.org/10.1177/0165025411417504>
- Johns, E. A., Jin, H., Auerswald, C. L., & Wilson, E. C. (2017). Sociodemographic Factors Associated with Trans*female Youth's Access to Health Care in the San Francisco Bay Area. *Journal of Adolescent Health*, 61(2), 259–261.
- Kang, H. (2013). The prevention and handling of the missing data. *Korean Journal of Anesthesiology*, 64(5), 402–406. PubMed. <https://doi.org/10.4097/kjae.2013.64.5.402>

- Katz-Wise, S. L., Budge, S. L., Fugate, E., Flanagan, K., Touloumtzis, C., Rood, B., Perez-Brumer, A., & Leibowitz, S. (2017). Transactional pathways of transgender identity development in transgender and gender-nonconforming youth and caregiver perspectives from the Trans Youth Family Study. *The International Journal of Transgenderism*, 18(3), 243–263.
<https://doi.org/10.1080/15532739.2017.1304312>
- Kessler, R., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S.-L. T., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32(6), 959–976.
<https://doi.org/10.1017/S0033291702006074>
- Kessler, R., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M. J., Normand, S.-L. T., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for Serious Mental Illness in the General Population. *Archives of General Psychiatry*, 60(2), 184–189.
<https://doi.org/10.1001/archpsyc.60.2.184>
- Keyes, K. M., Nicholson, R., Kinley, J., Raposo, S., Stein, M. B., Goldner, E. M., & Sareen, J. (2014). Age, Period, and Cohort Effects in Psychological Distress in the United States and Canada. *American Journal of Epidemiology*, 179(10), 1216–1227. <https://doi.org/10.1093/aje/kwu029>
- Longman Marcellin, R., R. Bauer, G., & I. Scheim, A. (2013). Intersecting impacts of transphobia and racism on HIV risk among trans persons of colour in Ontario,

- Canada. *Ethnicity and Inequalities in Health and Social Care*, 6(4), 97–107.
<https://doi.org/10.1108/EIHSC-09-2013-0017>
- Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, 96(9), 644–653. <https://doi.org/10.2471/blt.18.211607>
- Marmot, M. G., & Bell, R. (2012). Fair society, healthy lives. *Public Health*, 126(Journal Article), S4–S10. <https://doi.org/10.1016/j.puhe.2012.05.014>
- Marmot, M. G., Rose, G., Shipley, M., & Hamilton, P. J. (1978). Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology and Community Health*, 32(4), 244–249. <https://doi.org/10.1136/jech.32.4.244>
- Mathias, S., Tee, K., Helfrich, W., Gerty, K., Chan, G., & Barbic, S. (under review). Foundry: Early Learnings from the Implementation of an Integrated Youth Service Network. *Early Intervention in Psychiatry*.
- McCall, L. (2005). The Complexity of Intersectionality. *Signs*, 30(3), 1771–1800.
<https://doi.org/10.1086/426800>
- Meyer, I. H. (1995). Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behavior*, 36(1), 38–56. <https://doi.org/10.2307/2137286>
- Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, 129(5), 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- Michael, N., O’Callaghan, C., Baird, A., Hiscock, N., & Clayton, J. (2014). Cancer Caregivers Advocate a Patient- and Family-Centered Approach to Advance Care

- Planning. *Journal of Pain and Symptom Management*, 47(6), 1064–1077.
<https://doi.org/10.1016/j.jpainsymman.2013.07.009>
- Milne, J., & Oberle, K. (2005). Enhancing rigor in qualitative description: A case study. *Journal of Wound, Ostomy, and Continence Nursing: Official Publication of The Wound, Ostomy and Continence Nurses Society*, 32(6), 413.
- Morgan, R., George, A., Ssali, S., Hawkins, K., Molyneux, S., & Theobald, S. (2016). How to do (or not to do)...gender analysis in health systems research. *Health Policy and Planning*, 31(8), 1069–1078. <https://doi.org/10.1093/heapol/czw037>
- Morrow, S. L. (2005). Quality and Trustworthiness in Qualitative Research in Counseling Psychology. *Journal of Counseling Psychology*, 52(2), 250–260.
<https://doi.org/10.1037/0022-0167.52.2.250>
- Moscou, S. (2008). The conceptualization and operationalization of race and ethnicity by health services researchers. *Nursing Inquiry*, 15(2), 94–105.
<https://doi.org/10.1111/j.1440-1800.2008.00413.x>
- Mughal, F., & England, E. (2016). The mental health of young people: The view from primary care. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners*, 66(651), 502–503.
<https://doi.org/10.3399/bjgp16X687133>
- Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description—The poor cousin of health research? *BMC Medical Research Methodology*, 9(1), 52–52. <https://doi.org/10.1186/1471-2288-9-52>

- O’Cathain, A., Murphy, E., & Nicholl, J. (2008). The Quality of Mixed Methods Studies in Health Services Research. *Journal of Health Services Research & Policy*, 13(2), 92–98. <https://doi.org/10.1258/jhsrp.2007.007074>
- O’Cathain, A., Murphy, E., & Nicholl, J. (2010). Three techniques for integrating data in mixed methods studies. *BMJ*, 341(7783), 1147–1150. <https://doi.org/10.1136/bmj.c4587>
- Office of the Premier. (2019, June 26). *B.C. launches ‘A Pathway to Hope’ for better mental health and addictions care*. BC Gov News. <https://news.gov.bc.ca/releases/2019PREM0078-001333>
- Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics (Evanston)*, 137(3), e20153223. <https://doi.org/10.1542/peds.2015-3223>
- Pagano, M., & Gauvreau, K. (2000). *Principles of biostatistics* (2nd ed.). Duxbury.
- Papenfuss, M. (2019, May 31). World Health Organization Removes Gender Nonconformity from List of Mental Disorders. *HuffPost US*.
- Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PloS One*, 10(9), e0138511. <https://doi.org/10.1371/journal.pone.0138511>
- Parra, L. A., & Hastings, P. D. (2018). Integrating the Neurobiology of Minority Stress with an Intersectionality Framework for LGBTQ-Latinx Populations. *New Directions for Child and Adolescent Development*, 2018(161), 91–108. <https://doi.org/10.1002/cad.20244>

- Patton, G. C., MD, Sawyer, S. M., MD, Santelli, J. S., MD, Ross, D. A., PhD, Afifi, R., PhD, Allen, N. B., PhD, Arora, M., PhD, Azzopardi, P., MEpi, Baldwin, W., PhD, Bonell, C., PhD, Kakuma, R., PhD, Kennedy, E., MPH, Mahon, J., PhD, McGovern, T., JD, Mokdad, A. H., PhD, Patel, V., PhD, Petroni, S., PhD, Reavley, N., PhD, Taiwo, K., ... Viner, R. M., PhD. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *Lancet, The*, 387(10036), 2423–2478. [https://doi.org/10.1016/S0140-6736\(16\)00579-1](https://doi.org/10.1016/S0140-6736(16)00579-1)
- Payne, S. (2009). *Policy Brief 12: How can Gender Equity be Addressed Through Health Systems?* World Health Organization.
- Peacock, S. C., Hammond-Collins, K., & Forbes, D. A. (2014). The journey with dementia from the perspective of bereaved family caregivers: A qualitative descriptive study. *BMC Nursing*, 13(1), 42–42. <https://doi.org/10.1186/s12912-014-0042-x>
- Perneger, T. V. (1998). What's wrong with Bonferroni adjustments. *BMJ (Clinical Research Ed.)*, 316(7139), 1236–1238. PubMed. <https://doi.org/10.1136/bmj.316.7139.1236>
- Pezzullo, J. C. (2013). *Biostatistics for dummies* (1st ed.). For Dummies.
- Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine*, 84, 22–29.
- Priest, N., Perry, R., Ferdinand, A., Paradies, Y., & Kelaheer, M. (2014). Experiences of Racism, Racial/Ethnic Attitudes, Motivated Fairness and Mental Health

- Outcomes Among Primary and Secondary School Students. *Journal of Youth and Adolescence*, 43(10), 1672–1687. <https://doi.org/10.1007/s10964-014-0140-9>
- Reisner, S., Deutsch, M. B., Bhasin, S., Bockting, W., Brown, G. R., Feldman, J., Garofalo, R., Kreukels, B., Radix, A., Safer, J. D., Tangpricha, V., T’Sjoen, G., & Goodman, M. (2016). Advancing methods for US transgender health research. *Current Opinion in Endocrinology & Diabetes and Obesity*, 23(2), 198–207. <https://doi.org/10.1097/MED.0000000000000229>
- Reisner, S., Poteat, T., PhD, Keatley, J., MSW, Cabral, M., Mothopeng, T., Dunham, E., MPP, Holland, C. E., MSPH, Max, R., MSPH, & Baral, S. D., MD. (2016). Global health burden and needs of transgender populations: A review. *Lancet, The*, 388(10042), 412–436. [https://doi.org/10.1016/S0140-6736\(16\)00684-X](https://doi.org/10.1016/S0140-6736(16)00684-X)
- Reisner, S., Veters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study. *Journal of Adolescent Health*, 56(3), 274–279. <https://doi.org/10.1016/j.jadohealth.2014.10.264>
- Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study. *Pediatrics*, 141(3), 1–8. <https://doi.org/10.1542/peds.2017-1683>
- Rose, G. (2001). Sick individuals and sick populations. *International Journal of Epidemiology*, 30(3), 427–432. <https://doi.org/10.1093/ije/30.3.427>

- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family Acceptance in Adolescence and the Health of LGBT Young Adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205–213. <https://doi.org/10.1111/j.1744-6171.2010.00246.x>
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340. [https://doi.org/10.1002/1098-240X\(200008\)23:4<334::AID-NUR9>3.0.CO;2-G](https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G)
- Sandelowski, M. (2010). What’s in a name? Qualitative description revisited. *Research in Nursing & Health*, 33(1), 77–84. <https://doi.org/10.1002/nur.20362>
- Shaw, R. M., Howe, J., Beazer, J., & Carr, T. (2019). Ethics and positionality in qualitative research with vulnerable and marginal groups. *Qualitative Research, Journal Article*, 146879411984183. <https://doi.org/10.1177/1468794119841839>
- Singh, A. A. (2012). Transgender Youth of Color and Resilience: Negotiating Oppression and Finding Support. *Sex Roles*, 68(11–12), 690–702. <https://doi.org/10.1007/s11199-012-0149-z>
- Singh, A. A., Meng, S. E., & Hansen, A. W. (2014). “I Am My Own Gender”: Resilience Strategies of Trans Youth. *Journal of Counseling & Development*, 92(2), 208–218. <https://doi.org/10.1002/j.1556-6676.2014.00150.x>
- Smout, M. F. (2019). The factor structure and predictive validity of the Kessler Psychological Distress Scale (K10) in children and adolescents. *Australian Psychologist*, 54(2), 102–113. <https://doi.org/10.1111/ap.12376>
- Snyder, B. K., Burack, G. D., & Petrova, A. (2017). LGBTQ Youth’s Perceptions of Primary Care. *Clinical Pediatrics*, 56(5), 443–450.

- Standing, H. (1997). Gender and equity in health sector reform programmes: A review. *Health Policy and Planning*, 12(1), 1.
- Statistics Canada. (2014). *Canadian Community Health Survey (CCHS), Mental Health—Public Use Microdata file, Derived Variables Specs*. Statistics Canada.
- Statistics Canada. (2017). *Greater Vancouver, RD [Census division], British Columbia and Saskatchewan [Province] (table). Census Profile 2016 Census* (Statistics Canada Catalogue no. 98-316-X2016001). <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E>
- Statistics Canada. (2019a). *Table 13-10-0465-01 Mental health Indicators*. Statistics Canada. <https://www150.statcan.gc.ca/t1/tb11/en/tv.action?pid=1310046501>
- Statistics Canada. (2019b). *Sex and gender* (Census Program: The Road to the 2021 Census). Statistics Canada. <https://www12.statcan.gc.ca/census-recensement/2021/road2021-chemin2021/fs-fi/sex-and-gender.cfm>
- Sunderland, M., Slade, T., Stewart, G., & Andrews, G. (2011). Estimating the prevalence of DSM-IV mental illness in the Australian general population using the Kessler Psychological Distress Scale. *Australian and New Zealand Journal of Psychiatry*, 45(10), 880–889. <https://doi.org/10.3109/00048674.2011.606785>
- Swalin, A. (2018, January 30). How to Handle Missing Data. *Towards Data Science*. <https://towardsdatascience.com/how-to-handle-missing-data-8646b18db0d4>
- Syme, S. L. (1994). The Social Environment and Health. *Daedalus (Cambridge, Mass.)*, 123(4), 79–86.
- Tashakkori, A., Teddlie, C., & SAGE Research Methods Core. (2010). *Sage handbook of mixed methods in social & behavioral research* (2nd ed.). SAGE Publications.

- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357.
<https://doi.org/10.1093/intqhc/mzm042>
- Tylee, A., Haller, D. M., Graham, T., Churchill, R., & Sanci, L. A. (2007). Youth-friendly primary-care services: How are we doing and what more needs to be done? *The Lancet (British Edition)*, 369(9572), 1565–1573.
[https://doi.org/10.1016/S0140-6736\(07\)60371-7](https://doi.org/10.1016/S0140-6736(07)60371-7)
- Van de Velde, S., Bracke, P., & Levecque, K. (2010). Gender differences in depression in 23 European countries. Cross-national variation in the gender gap in depression. *Social Science & Medicine*, 71(2), 305–313.
<https://doi.org/10.1016/j.socscimed.2010.03.035>
- Van Donge, N., Schvey, N. A., Roberts, T. A., & Klein, D. A. (2018). Transgender Dependent Adolescents in the U.S. Military Health Care System: Demographics, Treatments Sought, and Health Care Service Utilization. *Military Medicine*.
- Veale, J., Peter, T., Travers, R., & Saewyc, E. M. (2017). Enacted Stigma, Mental Health, and Protective Factors Among Transgender Youth in Canada. *Transgender Health*, 3(1), 27–216. <https://doi.org/10.1089/trgh.2017.0031>
- Veale, J., Saewyc, E., Dobson, S., Clark, B., & the Canadian Trans Youth Health Survey Research Group (2015). (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.

- Veale, J., 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>
- Wagaman, M. A. (2014). Understanding service experiences of LGBTQ young people through an intersectional lens. *Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice*, 26(1), 111–145. <https://doi.org/10.1080/10538720.2013.866867>
- Weinberg, D., Stevens, G. W. J. M., Duinhof, E. L., & Finkenauer, C. (2019). Adolescent Socioeconomic Status and Mental Health Inequalities in the Netherlands, 2001–2017. *International Journal of Environmental Research and Public Health*, 16(19), 3605. <https://doi.org/10.3390/ijerph16193605>
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in Qualitative Research. *Qualitative Health Research*, 11(4), 522–537. <https://doi.org/10.1177/104973201129119299>
- WHO. (2000). *Women's Mental Health: An evidence-based review* (p. 122). Mental Health Determinants and Populations Department of Mental Health and Substance Dependence. https://www.who.int/mental_health/resources/gender/en/
- WHO. (2011). *Glossary of Terms*. Gender, Equity and Human Rights. <https://www.who.int/gender-equity-rights/knowledge/glossary/en/>
- WHO. (2012). *Making Health Services Adolescent Friendly: Developing national quality standards for adolescent-friendly health services*. Department of Maternal, Newborn, Child and Adolescent Health.

https://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/

WHO, & Calouste Gulbenkian Foundation. (2014). *Social Determinants of Mental Health*. World Health Organization.

Willis, D. G., Sullivan-Bolyai, S., Knafl, K., & Cohen, M. Z. (2016). Distinguishing Features and Similarities Between Descriptive Phenomenological and Qualitative Description Research. *Western Journal of Nursing Research*, 38(9), 1185–1204.
<https://doi.org/10.1177/0193945916645499>

Appendices

Appendix A: Study Demographic and Mental Health Outcome Survey

Examining mental health disparities among transgender and gender nonconforming young people.

Participation I.D.: _____ Today's Date ____/____/____(mm/dd/yyyy)

Here are some basic questions about YOU. Please do not attach your name to this sheet. Remember, all of your answers are confidential, and you cannot be identified by any of the pieces of information you provide.

1. Age (in years) _____

2. How would you describe your gender? (check all that apply)

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Two-spirit
- ☐ Trans female
- ☐ Trans male
- ☐ Not sure/ questioning
- ☐ Prefer not to answer
- ☐ I don't identify with any of these options (please specify): _____

3. Which of the following do you identify with? (check all that apply):

- ☐ South Asian
- ☐ Black/African
- ☐ Caribbean
- ☐ Hispanic/Latinx
- ☐ First Nations/ /Inuit
- ☐ Middle Eastern/North African
- ☐ White
- ☐ You don't have an option that applies to me (please specify your ethnicity):

4. Please indicate your highest education level:

- ☐ Some high school
- ☐ High school diploma
- ☐ Some college or technical school education
- ☐ Some university education
- ☐ College or technical degree
- ☐ Bachelor's degree

- ☐ Master's degree or higher

5. Are you employed or in school?

- ☐ YES- If Yes, please specify→→→ **Work** OR **School** OR **both**
☐ NO

6. If NO, are you looking for employment?

- ☐ YES
☐ NO

7. Where do you currently live?

- ☐ I am homeless
☐ I am couch surfing
☐ I live in a single room occupancy (SRO) hotel
☐ I live with someone else (i.e., parents or guardian)
☐ I live in an apartment (independently or with roommates)
☐ Other: _____

8. Please indicate what Foundry services you are receiving:

- ☐ Counselling
☐ Cognitive Behavioural Therapy
☐ Psychiatry
☐ Occupational Therapy
☐ Peer Support
☐ Case Management
☐ Dialectical Behavioural Therapy
☐ Addictions support
☐ Other: please specify: _____

9. Please indicate the Foundry center where you have received mental health services:

- ☐ Foundry Vancouver Granville
☐ Foundry North Shore
☐ Foundry Abbotsford
☐ Foundry Kelowna
☐ Foundry Campbell River
☐ Foundry Penticton
☐ Foundry Prince George
☐ Foundry Victoria

- ☐ None of these locations/other, please specify:
- ☐ I have never accessed services at a Foundry location

K10

These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

1. During the last 30 days, about how often did you feel tired out for no good reason?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

2. During the last 30 days, about how often did you feel nervous?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

4. During the last 30 days, about how often did you feel hopeless?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

5. During the last 30 days, about how often did you feel restless or fidgety?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

6. During the last 30 days, about how often did you feel so restless you could not sit still?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

7. During the last 30 days, about how often did you feel depressed?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

8. During the last 30 days, about how often did you feel that everything was an effort?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

10. During the last 30 days, about how often did you feel worthless?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

Appendix B: Written Consent Form

Examining mental health disparities among transgender and/or gender nonconforming young people

INTERVIEW INFORMED CONSENT

Research Team/Primary Contact

Rachal Pattison, MSc.OT

MSc student

Faculty of Medicine, Department of Occupational Science and Occupational Therapy

The University of British Columbia

[contact information]

Principal Investigator

Skye Barbic, PhD, OT

Assistant Professor

Faculty of Medicine, Department of Occupational Science and Occupational Therapy

The University of British Columbia

[contact information]

I. INTRODUCTION:

You are being invited to participate in a study being conducted by Rachal Pattison, MSc.OT at the University of British Columbia and Foundry Vancouver Granville. This study is supervised by Dr. Skye Barbic, PhD, OT. Before agreeing to participate, please read through the following consent form in detail. If any part of the form is unclear, please ask for clarification.

II. PURPOSE AND INVITATION:

Why are we doing this study? The purpose of this study is to understand the experiences of transgender and/or gender nonconforming (TGNC) young people in accessing mental health services. We hope to conduct 10-15 interviews, on a one-to-one basis, with different individuals.

What might be the benefits of participating in this study? We hope to learn about your experiences with accessing and/or participating in mental health services. You will have the opportunity to contribute much needed knowledge about the lived experience of being TGNC in accessing mental health services, which may one day help to improve mental health service delivery in British Columbia.

III. WHAT WILL HAPPEN IN THIS STUDY?

*Due to the current COVID 19 pandemic situation, all interviews for this research project will be conducted via telephone or a secure video conference platform. You will be given

time to review this document in advance of the interview, at which time you will be asked to give your verbal consent after all of this consent information is reviewed with you again.

If you agree to be a part of the study, you will be invited to complete:

1. a **demographic survey**: asking your social characteristics, like who you are, how you identify and questions about education and employment, e.g., *“Please indicate your highest level of education,”* and *“Where do you currently live?”* We will also ask you a question about your ethnicity. Studies involving humans now routinely collect information on race and ethnic origin as well as other characteristics of individuals because these characteristics may influence how people respond to different questions. Providing information on your race or ethnic origin is completely voluntary.
2. a **mental health outcome survey**: asking you about your mood and anxiety levels, e.g., *“During the last 30 days, how often did you feel restless or fidgety?”* and *“During the last 30 days, how often did you feel depressed?”*
3. an **individual interview**: this will last approximately 60-90 minutes and will take place between you and only one interviewer, in a private, confidential room at the Foundry Vancouver Granville location. If you are not comfortable meeting at Foundry Vancouver Granville, another location can be arranged by a study team member.
4. a **follow-up interview**: this will take place 2 weeks following the initial interview and will last for 15-30 minutes. It can take place either over the phone or in-person, at Foundry Vancouver Granville.

You will be asked questions about your experiences accessing mental health services and how your gender identity has impacted these experiences. Please note, in order to hear from a wide range of young people, you may only be asked to participate in the first two activities (demographic survey and mental health outcome survey). A member of the research team will let you know if you are invited to participate in the individual interview once you complete the demographic and mental health outcome surveys.

Examples of questions you may be asked during the interview include:

1. *Tell me about how you describe yourself and who you are.*
2. *How has your experience as transgender and/or gender nonconforming influenced your experience of accessing mental health services, if at all?*
3. *What other aspects of your identity (for example, your age, race/ethnicity, age, level of education etc) influence your experience of mental health services, if any?*
4. *What are some challenges you face with the mental health system as a transgender and/or gender nonconforming person, if any?*

The individual interview and the follow-up interview will be tape-recorded and transcribed (typed out word-for-word into a written transcript) by one researcher for analysis. Only the information gathered in the interview will be collected. What you say outside the time of the official interview will not be recorded.

IV. WHAT WILL HAPPEN WITH STUDY RESULTS?

The main results of this study will be published in academic journal articles. Results will also be made available to staff at the Foundry Vancouver Granville location. There is a chance that excerpts from your interview will be quoted in published articles, but anything published *will not* identify any individual study participant. If you would like a copy of the final report, you may have one.

V. HOW DO I KNOW IF I CAN TAKE PART IN THIS STUDY?

To participate in this study, you must be between the ages of 19 and 25, identify as transgender, gender nonconforming or outside the gender binary (e.g., masculine/feminine, man/woman) in any way, and have experience accessing some type of mental health service. We define “mental health service” as any of the following: individual counselling/therapy, group counselling/therapy, Cognitive Behavioural Therapy, psychiatry, peer support, Dialectical Behavioural Therapy and any other recognized mental health treatment modality. If you have any questions about what else might be considered a mental health service, please ask a study team member.

VI. WHAT ARE THE POTENTIAL RISKS OF THIS STUDY?

What are the risks of participating in this study?

The questions in this interview will ask you to describe your experiences with mental health services, which may be upsetting for some people. The discussion may also touch upon aspects related to your gender identity, which may also be upsetting for some people. You do not have to answer any questions if you do not want to. Please let one of the study staff know if you have any concerns. A member of the research team will also give you an information sheet about resources and contacts in the Vancouver area that you can reach for additional assistance if you require this.

You will also be asked questions in the mental health outcome survey regarding your emotional state; however, you will not be offered any additional services based on your responses. If you are having difficulties with your emotions (e.g., feeling depressed or anxious) and would like help managing those difficulties, please talk with your family doctor about treatment and/or access one of the resources that will be provided to you

Your decision to participate *will not affect* your access to mental health services at Foundry or Qmunity locations or the care you receive anywhere else at Providence Health Care. In addition, your participation will be kept strictly confidential.

VII. WHAT ARE THE POTENTIAL BENEFITS OF THIS STUDY?

There are no direct benefits to participating in this study. However, in the future, others may benefit from what we learn in this study. Should you require additional assistance after this study, you will be given a list of contacts in your community to support you. You may also

request a copy of the final report, should you want one; please let the interviewer know if you would like to be provided a final report.

VIII. WHO WILL KNOW I AM IN THE STUDY?

How will your identity be protected?

Your identity will be respected and only be known by those running the study. The consent form with your name on it will be kept in a locked filing cabinet separate from the questions you complete. A code number (not your name) will be on the forms you complete with any personal information to help protect your identity. Information that has your identity will not be released without your consent unless required by law. The interview transcript will remove all references to names and places to help protect your identity. You may also specify if you would like your preferred pronouns used alongside your code number in the transcript, or not. If you would prefer that your pronouns not be used alongside your code number, only your code number will be used instead. All demographic questionnaires and transcripts will be kept in a locked filing cabinet. All data and audio files will be stored on a password-protected server or an encrypted data key stored in a locked office in the Department of Occupational Science and Occupational Therapy at UBC.

Neither your name nor any other data that can identify you will be used in any reports or publications arising from this study.

Research data will be kept confidential/private from the start of the study. Your name and identifying information will be replaced with a unique study ID (e.g., a random combination of numbers and letters). Recordings of the interviews will not be stored with your name or anything that could identify you. R. Pattison will hold the ID codes separate so that they cannot be linked with the recording of your interview. Audio recordings/transcripts will be stored securely on the UBC Department of Occupational Science & Occupational Therapy password-protected server for 5 years following the completion of the study. After this time period, they will be destroyed.

Consent forms will be kept separate from the audio recordings to protect your anonymity; and will be stored in a separately locked cabinet, by Dr. Skye Barbic in a UBC office, Room T325, 2211 Wesbrook Mall on the Point Grey campus. Five years after study completion the consent forms will be destroyed.

All paper data (e.g., consent forms, questionnaires, etc) will be kept in a locked cabinet in the Faculty of Medicine, Department of Psychiatry or Department of Occupational Science & Occupational Therapy for five years after study completion, then shredded using the unit's confidential shredding service. The electronic files with unidentifiable, aggregate (all participants pooled together) data may be kept indefinitely (e.g., to pool for analysis with future studies), and deleted from the secure server file at the discretion of the Dr. S Barbic.

No future use of the data is planned.

IX. COMPENSATION:

Will I be paid to participate in this study?

You will be paid for those parts of the study you are able to complete. There are 3 possible parts to this study: 1) filling out Consent and Demographic Forms, 2) the Individual Interview, and 3) the Follow-Up Interview. If you finish Part 1 and are **not** selected to do the Interview, you will be paid \$25. If you are selected to do the Interview, then you will be paid \$40 (this amount is **not in addition to** the \$25 for Part 1).

If you also complete Part 3, the Follow-Up Interview, you will be paid \$25 for this. This means, if you complete all three parts, you will be paid a total of \$65.

If you withdraw at any point during any of these parts, you will be paid for whatever part you were participating in. For example: withdrawal from individual interview = \$40, withdrawal from follow-up interview = \$25

Time Commitment:

- Individual interview (includes consent, demographic and mental health outcome survey completion) lasting approximately 90 minutes.
- Consent and demographic survey completion (if not selected for individual interview) lasting 15 minutes.
- Follow-up interview lasting approximately 30 minutes.

Will my choice to stop being in the study affect the care I receive?

If you decide not to participate or decide to withdraw, your decision *will not affect* your access to care at Foundry or Qmunity locations or to local youth groups, now or in the future.

X. CONTACT FOR INFORMATION ABOUT THIS STUDY:

If you have any questions or concerns about what we are asking of you, please contact the primary researcher, Rachal Pattison, via email at [email] or phone at [phone number]. This contact information will also be listed on the first page of this form.

XI. CONTACT FOR COMPLAINTS

Who can you contact if you have complaints or concerns about the study?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598. Please reference the study number [study number] when calling so the Complaint Line staff can better assist you.

Please go to the next page to provide your consent

**Examining mental health disparities among transgender and gender
nonconforming young people**

INTERVIEW INFORMED CONSENT

XII: PARTICIPANT CONSENT AND SIGNATURE PAGE

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your mental health care or any other health and social service you receive.

- Signing this page means that you have received a copy of this consent form for your own keeping.
- Signing this page means that you understand all parts of this consent form and know what to expect in the research study.
- Signing this page means you understand that taking part in the study is voluntary, and you do not have to participate if you do not want to.
- Signing this page means you understand that the interview will be audio recorded.
- Signing this page indicates that you agree to participate in this study.

Participant Signature

Date

Printed Name of the Participant signing above

Appendix C: Verbal Consent Summary

Examining mental health disparities among transgender and/or gender nonconforming young people

VERBAL CONSENT SUMMARY

Dear Participant:

Hello! My name is Rachal Pattison, MSc.OT, and I am a student at the University of British Columbia (UBC). As a requirement for my Master of Science degree, I am conducting a research study under the supervision of Dr. Skye Barbic, PhD, OT, from the UBC Department of Occupational Science and Occupational Therapy (OSOT). The purpose of this study is to understand the experiences of transgender and/or gender nonconforming (TGNC) young people using mental health services. You will have the opportunity to contribute much needed knowledge about the lived experience of being TGNC in accessing mental health services. I hope this research will one day help to improve mental health service delivery in British Columbia.

To participate, I am looking to speak to people who are:

- between the ages of 19 and 25,
- identify as transgender, gender nonconforming or outside the gender binary (e.g., non-binary, genderfluid, agender, genderqueer etc) in any way, and
- have experience accessing some type of mental health service. I define “mental health service” as any of the following: individual counselling/therapy, group counselling/therapy, Cognitive Behavioural Therapy, psychiatry, peer support, Dialectical Behavioural Therapy and any other recognized mental health treatment modality. If you have any questions about what else might be considered a mental health service, please ask me and I can clarify.

This study will use one-on-one interviews to gather information. By participating you will be asked to take part in one interview, with the *option* of also doing a second follow up interview later. The first interview will last approximately between 1-1.5 hours. In it, you’ll be asked some survey questions about who you are, how you identify and questions about schooling and jobs. You will also be asked survey questions about your current mood and anxiety levels. Then, the interview questions will focus on your personal experiences using mental health services as a trans and/or gender nonconforming person. This interview will be tape-recorded and transcribed (typed out word-for-word into a written transcript). You will receive an honorarium of \$40 for your participation in the first interview. This honorarium will be electronically transferred to you, via email transfer.

You will be asked questions in the mental health survey regarding your emotional state; however, you will not be offered any services based on your responses. If you are having difficulties with your emotions (e.g., feeling depressed or anxious) and would like help managing those difficulties, please talk with your family doctor about treatment and/or access one of the resources that will be provided to you (via email).

The optional follow up interview will take place within 4-8 weeks after the first interview. It will last 15-30 minutes and will involve me sharing ideas that came out of the first interview and asking about your thoughts on them. I may also ask clarifying questions from the first interview. This interview will also be recorded and you will be paid \$25 for this optional second interview. This means you could be paid a total of \$65 if you participate in both interviews. Everything you share in the interviews will be kept confidential, and no names, places, or other identifying information will be used.

Your participation is voluntary! Results from the research may be published in journal articles or shared in presentations to the public. Fake names will be used for quotes from interviews, to protect your identity. Data (e.g., audio recordings, participant files) will be kept secure at UBC and/or on a UBC protected server, and only me and Dr. Skye Barbic will be able to access it.

If you do not wish to participate, you may stop at any time. Data that has already been collected up to the point of withdrawal will be used for the study. If, for whatever reason, you wish that your data not be used in the study, please let me know and I will accommodate you. Neither participating nor withdrawing from the study will affect your care at any of the services you use.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598. Please reference the study number **[study number]** when calling so the Complaint Line staff can better assist you.

Thank you for your help in this study. Please keep the e-copy of this script that was emailed to you, in case you have any questions that come up. I can be reached at [phone number] or [email]. Dr. Skye Barbic can be reached at [phone number] or [email].

Do you have any questions about what I have just said?

Do you give me your permission to interview you? YES / NO

Name of person obtaining verbal consent:_____

Date verbal consent obtained:_____

Appendix D: Project Interview Script

Introductory Remarks Script

Introduction:

Thank you for agreeing to speak with me as part of this study. Our conversation should take approximately 1.5 hours in total.

I will be asking you some questions about your experiences with mental health services as a transgender and/or gender nonconforming person.

If you feel uncomfortable with a question, you do not need to answer it! You can tell me to move on to the next one. If any of the questions do not make sense to you, please ask me to explain or to reframe the question. Anything that you share is kept confidential and will not impact your services at Foundry, QMUNITY, or with Providence Health Care.

This interview is audio recorded (i.e. taped) and will be transcribed for analysis at the end of the study. I will not use your name or any other identifying characteristics in the transcribed documents. Audio recordings are kept only by me (Rachal Pattison) and will be stored on a UBC password protected server.

Before we begin our conversation, do you have any questions?

Individual Interview Topics:

1. *Please tell me your name or how you would like to be addressed, as well as your preferred pronouns.*
2. *Tell me about how you describe yourself and who you are, in terms of your gender identity..*
3. *How, if at all, has your experience as transgender and/or gender nonconforming influenced your experience of accessing mental health services?*
4. *What other aspects of your identity, if any, (for example, your age, race/ethnicity, level of education etc) influence your experience of mental health services?*
5. *What are some challenges, if any, you face with the mental health system as a transgender and/or gender nonconforming young person?*
6. *What differences do you notice interacting with the health system vs the rest of your life?*
7. *What has helped your experience in accessing mental health services, if anything?*
8. *What have you noticed about these experiences as you've gotten older?*

9. *If you could change the way that mental health services are delivered, how would you change them?*
 - a. *If you could create curriculum for mental or health professionals, what would you put into it?*
10. *What advice would you give to another person who is in a similar situation to yours?*
11. *Is there anything else you would like me to know?*

Appendix E: COREQ Checklist

No	Item	Guide questions/description	pg. #
Domain 1: Research team and reflexivity: Personal Characteristics			
1.	Interviewer/facilitator	Rachal Pattison	i
2.	Credentials	BS, MSc. OT	i
3.	Occupation	occupational therapist and graduate student	i, 39
4.	Gender	nonbinary, gender nonconforming	44, 150
5.	Experience and training	Graduate level coursework in biostatistics, epidemiology, study design for quantitative research, qualitative methods, social determinants of health Worked clinically, as OT in mental health, for 6 years	was not included in the thesis
Relationship with participants			
6.	Relationship established	No, no prior relationship existed with study participants	38
7.	Participant knowledge of the interviewer	Participants knew my reasons for doing this research, they knew about what participation entailed, how to obtain support following participation.	134
8.	Interviewer characteristics	See Appendix H: Social Identity Map tool	149
Domain 2: study design: Theoretical framework			
9.	Methodological orientation and Theory	qualitative description with overtones of constructivist grounded theory Intersectionality framework	39 16
Participant selection			
10.	Sampling	Quantitative: Purposive sampling Qualitative: Purposive sampling	25 36
11.	Method of approach	Quantitative: flyers, posters at Foundry clinics, in-person study promotion by a peer researcher located in Foundry clinic Qualitative: posters posted on clinic wall, word of mouth from peers and clinic staff, social media	not stated in this thesis, but described elsewhere (Barbic et al., 2019) 33
12.	Sample size	Quantitative: n=727 Qualitative: n=5	47 53

No	Item	Guide questions/description	pg. #
13.	Non-participation	Quantitative: drop-outs not tracked Qualitative: no drop-outs	not stated 36
14.	Setting of data collection	Quantitative: clinic environment Qualitative: 3 in a clinic environment, 2 virtual	22, 38
15.	Presence of non-participants	Quantitative: a peer researcher was present while participants filled out the demographic survey Qualitative: no one other than R. Pattison and participant being interviewed	22 38
16.	Description of sample	See Table 1 for quantitative and qualitative samples	49
Data collection			
17.	Interview guide	See Appendix D	141
18.	Repeat interviews	No	none completed
19.	Audio/visual recording	audio recordings of interviews were made	34
20.	Field notes	R. Pattison maintained reflexive journal and wrote entries following interviews as well as during the analysis process	42, 44
21.	Duration	30 – 75 minutes	38
22.	Data saturation	See Strengths and Limitations	95
23.	Transcripts returned	No	n/a
Domain 3: analysis and findings: Data analysis			
24.	Number of data coders	R. Pattison with consultation from D. Ben Mortenson	39
25.	Description of the coding tree	See Appendix G: Qualitative Codes	148
26.	Derivation of themes	themes were derived from the data	54
27.	Software	Microsoft Word and Excel R Studio	39 34
28.	Participant checking	No. Initial codes and later themes were reviewed by Dr. Ben Mortenson	n/a
Reporting			
29.	Quotations presented	yes, throughout Qualitative Findings section	54

No	Item	Guide questions/description	pg. #
30.	Data and findings consistent	yes	
31.	Clarity of major themes	Findings & Discussion	54 & 79
32.	Clarity of minor themes	each theme was described in terms of relevant sub-categories. And some negative cases were discussed	54

Appendix F: GRAMMS checklist

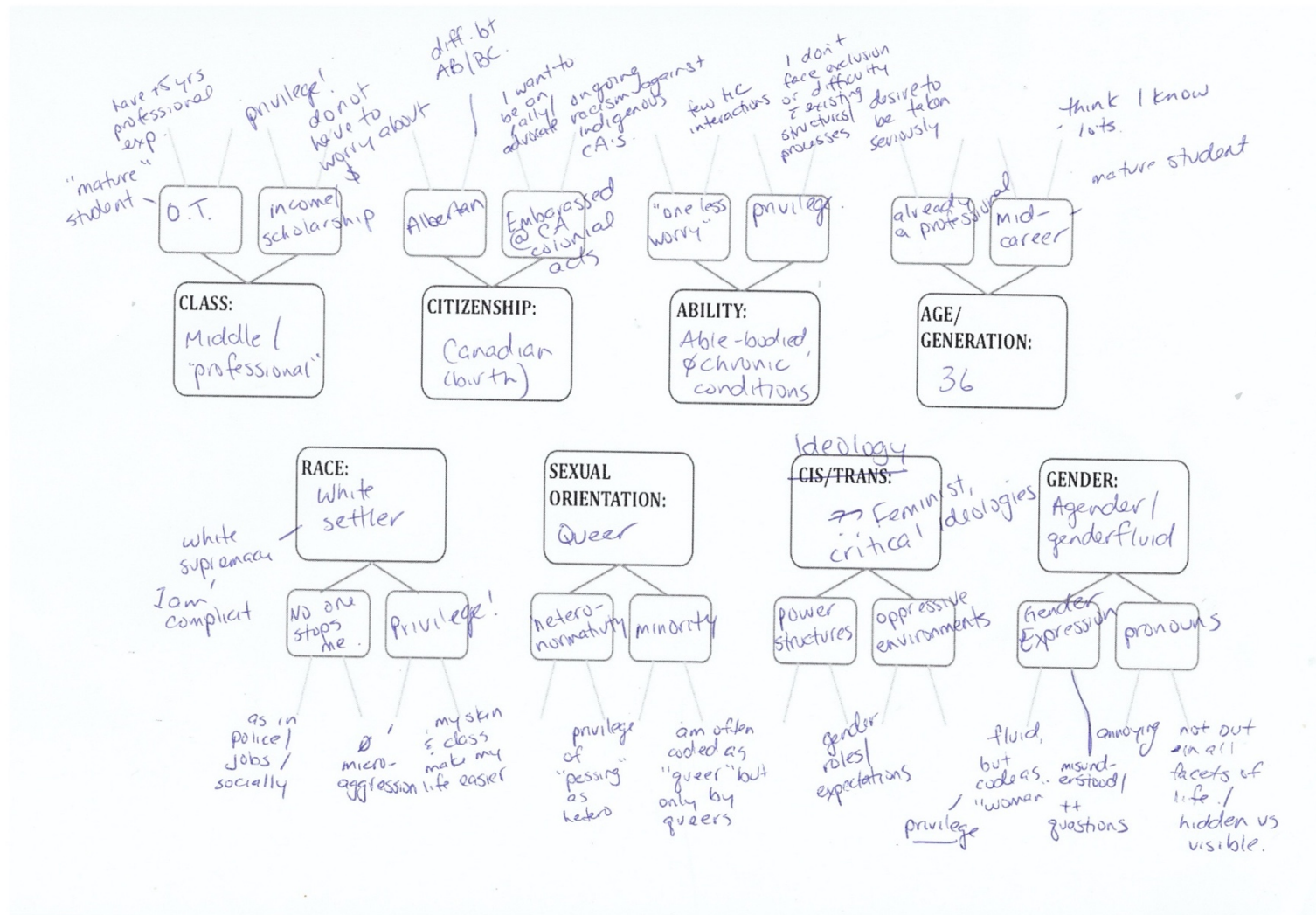
Guideline	Section: page
Describe the justification of using a mixed methods approach to the research questions	Chapter 2 Methods
Described the design in terms of the purpose, priority and sequence of the methods	Chapter 2 Methods
Described each method in terms of sampling, data collection and analysis	Chapter 2 Methods
Describe where integration has occurred, how it has occurred and who has participated in it	Integration occurred in the Discussion section, pg.79. The findings from both quantitative and qualitative results were integrated into a discussion of significance and as a means to highlight the strengths and weaknesses of each approach (and the strength of their synthesis). R. Pattison constructed the integration of findings, with support from Dr. Skye Barbic
Describe any limitation of one method associated with the present of the other method	See Strengths and Limitations, pg. 95
Described any insights gained from mixing or integrating methods	<ul style="list-style-type: none"> - insights around the different intersections relevant in the lives of the youths, from their own experience. - A more nuanced picture of the “why” of the increased rates of mental health distress - How TGNC youth carve out their own existence and maintain their mental

	<p>health within (and in opposition to) the gender binary</p> <ul style="list-style-type: none"> - Specific recommendations for how to support TGNC youth better
--	---

Appendix G: Qualitative Codes

Theme	Categories		Codes
Theme 1: Experiencing upsetting interactions with providers	Standing up for myself to providers	1	Standing up for myself
		2	Being treated as fragile
	How providers perceive my gender	3	The pain of being misgendered
		4	Advice on how to manage names and pronouns
		5	Needing to teach providers about TGNC concepts
		6	Being deadnamed
	How providers “treat” gender	7	Providers who “treat” my gender
Theme 2: Experiencing barriers and facilitators to services	Access barriers and facilitators	8	Anticipating difficulties with services
		9	City Vs small town
		10	The problem with mental health services
		11	Names from a systems perspective
	Youth vs Adult care	12	How providers treat me when I’m a minor
		13	How providers treat me when I’m an adult
	The environment matters!	14	Environment cues of (potential) 2SLGBTQ+ safety
		15	Provider specific cues of (potential) 2SLGBTQ+ safety
		16	Problems with hospital and clinic settings
		17	Online services
Theme 3: The tyranny of the binary	Tyranny in action	18	Language as a barrier
		19	Being made invisible
		20	Ways the binary is re-enforced
		21	Being segregated
	Recommending solutions	22	Calling for more training of providers
	Intersections explored	23	Health related
		24	Social identity related
		25	Personal experience related

Appendix H: Social Identity Map tool



Appendix I: Initial Contact Letter

Hello,

You have received this letter because you have expressed interest in participating in a study looking at the experiences of transgender and/or gender nonconforming young people with mental health services. The official title of this study is “**Examining mental health disparities among transgender and/or gender nonconforming young people**”. The purpose of this study is to understand how transgender and/or gender nonconforming young people access and experience mental health services, like therapy/counselling, peer support, psychiatry, or therapy groups, for example. We hope to speak with 10-15 transgender and/or gender nonconforming young people as part of this study.

*Due to the current COVID 19 pandemic situation, all interviews for this research project will be conducted via telephone or a secure video conference platform. You will be asked to give your verbal consent after all of the consent information is explained to you. Before the telephone interview starts, you will also be given two surveys, that cover demographic and mental health information. Your responses to the surveys and your consent will be kept on your secure participant file.

Our team at the University of British Columbia, led by Dr. Skye Barbic and Rachal Pattison, MSc.OT, from the Department of Occupational Science & Occupational Therapy, welcomes you! Your participation involves an individual interview and a follow-up interview to share your experiences with mental health services as a transgender and/or gender nonconforming. **Your participation is absolutely voluntary and you may withdraw at any time.**

You will be paid for those parts of the study you are able to complete. There are 2 possible parts to this study: 1) filling out Consent and Demographic Forms and the Individual Interview, and 2) the *optional* Follow-Up Interview. If you complete the Interview, then you will be paid \$40.

If you also complete Part 2, the Follow-Up Interview, you will be paid \$25 for this. This means, if you complete all three parts, you will be paid a total of \$65. Payments will be provided via email transfer, where possible.

If you withdraw at any point during any of these parts, you will be paid for whatever part you were participating in. For example: withdrawal from individual interview = \$40, withdrawal from follow-up interview = \$25

Time Commitment:

- Individual interview (includes consent, demographic and mental health outcome survey completion) lasting approximately 90 minutes.
- Follow-up interview lasting approximately 30 minutes.

The interview will take place over the telephone or on a secure video conference platform on a date and time convenient to you.

If you want to learn more about the study or if you have any questions about it, please feel free to contact Rachal Pattison, by email or by phone/text.

Warm regards,

Rachal Pattison (*they/them*)

Phone: XXX-XXX-XXXX or email@alumni.ubc.ca

Appendix J: Recruitment Poster

**What has been your
experience using
mental health services
as a trans or gender
nonconforming
person?**

Are you trans* and/or gender nonconforming?
Have you ever accessed mental health services?
Are you 19 – 25 years old?

You may be eligible for a 1:1, tape-recorded
interview that pays a \$40 honorarium.

Find out more:


***“Examining Mental Health Disparities Among
Transgender and/or Gender Nonconforming Young
People.”***

EMAIL: email@alumni.ubc.ca

CALL or TEXT: xxx-xxx-xxxx (Ask for Rachal)

Primary Investigator: Dr. Skye Barbic, UBC Department of Occupational
Science and Occupational Therapy.

· F O U N D R Y ·
WHERE WELLNESS TAKES SHAPE



Providence
HEALTH CARE

Appendix K: Online Learning Resources for Health Providers

<http://www.phsa.ca/transcarebc/child-youth/exploring-gender/gender-basics>

<https://www.wpath.org/education/upcoming-conferences>

<https://www.wpath.org/resources/recommended-reading>

<https://www.heretohelp.bc.ca/transgender-health-program>

<https://www.healthlinkbc.ca/health-topics/abj9667>

<https://www.centreforsexuality.ca/sexual-health-info/gender-identity/>

*Note: this is not a comprehensive list and there are many other good resources to be found online. Many municipalities and health authorities will have queer and trans service organizations to which you may refer.