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Effects of Discrimination on Transgender Populations

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Katherine R. Moyer

A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Spring, 2019

Winona State University

College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

CAPSTONE PROJECT

Effects of Discrimination on Transgender Populations

This is to certify that the Capstone Project of

Katherine Moyer

Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

Master of Science Degree in

Counselor Education

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Abstract

Transgender individuals often face discrimination in multiple domains, such as in employment and healthcare settings, among others. This can affect their overall job satisfaction, job security, financial stability, physical and emotional wellbeing. Furthermore, past literature indicates that the prevalence of suicide, substance use/abuse, and mental illness, tend to be higher among gender-nonconforming populations. To enhance understanding of the above adverse issues and kinds of discriminatory practices that take place within these settings—and within greater society; this study integrates a social-ecological framework. Such an approach focuses on how stigma impacts individuals at various levels: structurally, interpersonally, and individually. Particularly, U.S. westernized culture has adopted a gender binary system. Present in mainstream education, the binary system perpetuates illiteracy of transgender knowledge within individuals, research, and learning environments by excluding the "other". Inevitably, effecting laws, policies, and the behaviors of others. For instance, currently there are no outright federal protections against gender identity discrimination. Instead, individual states and localities govern laws, which are not all-embracing. Considered part of the structural level, these sanctions influence policies, protections, and outreach resources within workplace and healthcare organizations. Moreover, everyday interpersonal relations between individuals and their doctors, mental health providers, employers, employees, and/or other key players, are influenced by professional knowledge/awareness and laws. Together, these layers simultaneously affect how one responds at the individual level. The goal of this project is to make sense of these interrelated parts, as well as include potential ways in which stakeholders can support and advocate for transgender persons.

Table of Contents

Introduction ……………..…………………………………………………………...…….5

Review of Literature ……………..…………………………………..……………….....….11

Effects of Stigma at Structural Level …………………………………………………….....11

Effects of Stigma at Interpersonal Level…………………………………………...……....18

Effects of Stigma at Individual Level………………………..………………...……………...24

Multi-level Stigma Interventions……………………….………………………………......31

Conclusion…………………………………..…………………………………………...37

References……………………………………………………………..……………………40

Introduction

From the instant one is born—or determined even earlier via ultrasound technology, a *sex* is assigned based on the appearance of external genitalia, internal genitalia, chromosomal makeup, and/or hormonally. These appearances typically distinguish us as either a "male" or "female", though in rare cases, some individuals are born with a combination of male and female parts that determine them as *intersex*. The term *gender identity* on the other hand, refers to one's sense of oneself, regardless of whether it coincides with their assigned sex. In other words, a person can be designated male at birth but inherently identify as female (transgender woman), be designated female at birth but inherently identify as male (transgender man), may be assigned a label at birth but does not inherently align with any gender (agender or genderless), may identify with two or more genders despite being assigned a singular gender at birth (bigender, trigender, or pangender), or may fluctuate/move between various gender identities (genderfluid). Considered an umbrella term, *transgender* or "trans" for short, is used to describe the above-mentioned gender identities (APA, 2015, pp. 1-7; GLAAD, 2017).

A marginalized group, mainstream culture has attempted to silence the transgender population throughout history, due to the threat of their existence on the *gender binary* system. Such a system presses that no other possibilities for gender or anatomy are believed to exist, solely "male and female" categories. Put another way, society oppresses anyone that does not align with the sex they were assigned at birth (i.e., cissexism), especially for those who are *nonbinary/genderqueer* and do not fit neatly into one of the two standard categories (University of Florida, 2017).

Despite inherently identifying with the sex opposite of the one assigned at birth, binary transgender people tend to face less discrimination in comparison to nonbinary transgender

persons, since their identity is generally “fixed” and conforms to the ideals of society’s “two-gender” paradigm. Moreover, a systemic level issue, while almost all research studies include binary gender categories in their demographics…genderqueer categories get frequently left out. Ultimately, reinforcing cultural incompetence across various social-ecological layers, as exclusion or “erasure” of diverse demographic gender identities and expressions, not only misrepresents the actual U.S. population, but inhibits people’s ability to think beyond the gender binary box. Thus, in view of the foregoing, when utilizing services and/or interacting with others, nonbinary individuals may be especially subject to stigma, given professionals are likely not culturally aware of/trained to recognize their inherent identity. Resultantly, help-seeking, health-seeking and participation in the workforce are reduced (Rider, McMorris, Gower, Coleman, & Eisenberg, 2018; Kcomt, 2018; Thorne et al., 2018; Lefevor, Boyd-Rogers, Sparague, & Janis, 2019; Grant et al., 2011).

Although many distinct adversities exist among LGBTQ identities—more specifically, the “TQ” (transgender and queer) in the case of this project; binary and genderqueer individuals also share in numerous struggles and concerns. For instance, *gender expression* is vital to transgender peoples’ wellbeing, given it entails how individual’s present themselves in terms of physical appearance and behaviors. For some, identity concealment is crucial (i.e., appearing more “male” or “female” in order to avoid stigma) while for others, having a visible identity is less of a concern with greater emphasis being placed on living authentically. In any case, regardless of the objective, a vast majority of trans individuals highlight that having access to trans-affirming medical/legal procedures (e.g., hormonal treatments, gender reassignment surgeries, voice therapy, changing one’s name, etc.,) is top priority, as again, not only may these procedures help reduce stigma through increased conformity, but having the freedom to explore one’s identity and live

authentically, ultimately improves health outcomes (Goldberg, Kuvalanka, Budge, Benz, & Smith, 2019; Fiani & Han, 2018; Thorne et al,, 2018).

However, accessing these procedures requires a bit of legwork, as one must get formally diagnosed with *gender dysphoria* (GD) by a qualified health professional before being able to go through with any sort of transition, which, although seemingly harmless, such a label carries with it, negative repercussions. Case in point, earlier editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) treated transgender individuals' as mentally ill; labeling them with Gender Identity Disorder (GID) up until 2012, before release of the DSM-5 and only having been seven years from today, the potential for stigma is still there (American Psychiatric Association, 1980; American Psychiatric Association, 1994; American Psychiatric Association, 2013). Moreover, even though GD is not classified as a mental disorder, but rather, a "state" which brings about great deals of stress, anxiety, and depression if one cannot live as their most inherent self…there are still symptomologies listed. In fact, "symptoms" must be present for at least six months (e.g., one must display apparent signs of disgust toward their genitals and/or have a strong desire to be rid of certain sex characteristics) before an official diagnosis can be given. Finally, getting diagnosed with GD does not guarantee coverage of trans-affirming procedures since certain areas within the U.S. enable providers to deny and/or invalidate the needs of transgender clientele (Goldberg, 2018).

For example, currently 36 states contain no LGBTQ protective laws against private insurance discrimination, nine states explicitly exclude transgender health coverage and care within the Medicaid program, 22 states contain no explicit policy regarding transgender health coverage and care within the Medicaid program, 12 states explicitly exclude transition-related healthcare in their state employment health benefits, and 21 states do not include transition-related

healthcare in their state employee health benefits. However, some relief can be found within certain cities and counties of states, which may offer their own protections against gender identity discrimination. In other words, around one fifth—or 20% of states, continue to allow employers and even the Medicaid program to withhold trans persons of their vital medical needs. Moreover, an even larger number of states, "subtly" limit opportunity by failing to elaborate on whether private insurers, employers, and/or the Medicaid program are required to cover trans-affirming medical procedures (Movement Advancement Project [MAP], 2019).

Relative to this, opportunity is restricted in areas of employment as well. Currently, there are 27 states which do not contain any explicit laws, prohibiting gender identity discrimination in private employment settings; as for public (state) employees, 19 states. Again, however, some relief can be found in localities and even within certain workplace companies, whom are granted access to set their own policies and protections. Nonetheless, this and the above data communicate a much larger issue, which is to say, that although it is clear gender identity non-discrimination laws have expanded overtime…general acceptance of the transgender community is still rather divided in this country. Such a mixed political climate reveals many layers of stigma (MAP, 2019).

According to the ideals laid out by numerous social-ecological models—the primary framework which will be utilized in this paper, these layers of stigma occur at various "levels": structurally, interpersonally, and individually. More specifically, structural and interpersonal discrimination puts stressors upon marginalized persons, who, in turn, experience negative outcomes at the individual level. In the case of the above section, much of the content described, happens to revolve around structural level issues; (i.e., laws, societal norms, and educational insufficiencies) the outermost circle labeled on most diagrams of the socio-ecological model. Overall, findings demonstrate that gender binary norms, academic limitations and "erasure" caused

by structural level stigma, reinforces limited knowledge of transgender persons in the field both in areas of healthcare and employment (Kcomt, 2018). Moreover, because U.S. laws/policies derive from the voices of the American people, whom are of course, influenced by the overarching culture, current non-discrimination laws are not all-embracing…resultantly, limiting healthcare and employment access; especially among those living in more conservative areas (White-Hughto, Murchison, & Reisner, 2016).

Precisely, states and localities with few anti-discrimination laws in place, permit more transphobic organizations the ability to fire, not hire, or otherwise, deny individuals promotional opportunities. Additionally, in areas of healthcare, regions with few non-discrimination protections allow providers greater opportunity to deny patients access to trans-affirming medical procedures, often claiming they are "medically unnecessary." Particularly, this is prevalent among providers that do not receive government funding, as they cannot be held accountable as independent entities. Subsequently, forcing many individuals to either travel great distances in order to receive inclusive and quality care or otherwise, they may be burdened with paying high out of pocket costs (White-Hughto et al., 2016; "The Equality Act: What Transgender People Need to Know", 2019; Tebbe, Allan, and Bell, 2019; Hughto, Reisner, & Pachankis, 2015).

Similarly, the literature found that knowledge limitations and transphobia influence the development of and content within workplace/healthcare policies. Among the most commonly cited problems, findings show that many organizations not only lack a means of enforcing their policies but fail to elaborate on them. Specifically, there often tends to be discrepancies between values, visions, mission statements, and anti-discrimination procedures, since many remain broadly defined and fail to give specific examples of discriminatory behavior—notably, more subtle forms of stigma which persons may use as a loophole to restrict transgender persons

(Quereshi et al., 2017; Seelman, Colon-Diaz, LeCroix, Xavier-Brier, & Kattari, 2016; Galupo & Resnick, 2016). Furthermore, forms which request the demographic information of individuals and procedures that require the presentation of personal ID (i.e., a driver's license or birth certificate in order to be considered for a job or for healthcare) often fail to consider other gender identities beyond the binary. Thus, both excluding/dehumanizing their existence and outing their identity; consequently, limiting employability, treatment on the job even if hired, and the healthcare experience once in contact with medical staff (Shelton, 2015; Dietert & Dentice, 2009; Winter et al., 2016).

Predictably, information and norms (or lack thereof) then, effect practice at the interpersonal level. As noted within a majority of studies, cultural incompetence impacts trans individuals by delimiting their ability to make fairer connections with their providers, colleagues, employers, medical staff, and so on. In particular, explicit discrimination from others, drives transgender persons from their jobs (both voluntarily/involuntarily), from seeking healthcare for fear of getting stigmatized, and even goes so far as to deny them the right to a safe restroom. Moreover, due to situational instabilities, financial status is more likely to fluctuate, given there is no guarantee of a solid provider or work (Paine, 2018; Kattari, Walls, Speer, & Kattari, 2016; Kcomt, 2019; Grant et al., 2011; Lerner and Robles, 2017).

Finally, the aforementioned societal standards and negative relational experiences have adverse consequences on the health and wellbeing of transgender populations at the individual level. Precisely, thus far research shows that stigmatization has been known to lead to higher rates of psychological disorders and distress, internalized transphobia, anxiety/nervousness, suicide, healthcare avoidance, hypervigilance, substance use/abuse, internal unrest, stigma concealment, and suchlike proximal afflictions (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Mizock

& Mueser, 2014; Levitt & Ippolito, 2013; Martinez, Sawyer, Thoroughgood, Ruggs, & Smith, 2017; Ozturk & Tatli, 2015; Reisner et al., 2015; Rudin et al., 2015; Hatzenbuehler & Pachankis, 2016). In order to counteract these problems, it is suggested coping interventions be implemented. Moreover, increased educational awareness and change to structural norms, laws, and policies is necessary to give individuals equal opportunities to access and wellbeing. Finally, by exposing others to education and transgender populations through intergroup contact means understanding, empathy, and comfort levels should naturally increase, thus, transphobia be reduced (O'Hara, Dispenza, Brack, & Blood, 2013; Walch et al., 2012; Acker, 2017; Mizock & Hopwood, 2017; Barbir, Vandevender, and Cohn, 2017).

Review of Literature

Access to a steady job and healthcare is crucial to the wellbeing of trans individuals, as many long for gender-affirming medical procedures that allow them to live as their most inherent selves. Unfortunately, however, this need cannot be so easily fulfilled, as stigma against this population continues to persist at various levels: structurally, interpersonally, and individually. Rather than working in a top-down or bottom-up fashion, research points toward the above components as interacting simultaneously. For example, laws at the structural level impact one's ability to find transgender-inclusive providers in their community; while in a more indirect sense, protective laws serve as a model, influencing employers/employees' discriminatory behaviors within organizations. Likewise, without dialogue and learning at interpersonal and individual levels, structural change could not occur.

On the other hand, some of the literature has chosen to focus solely on how one level or levels influences another (e.g., how does interpersonal level stigma impact the individual; how can persons at the individual level advocate to create change at the structural level). Whichever

the case may be, this literature review includes findings from both approaches in order to improve learning outcomes. Furthermore, this section has been divided into numerous subpoints to demonstrate what stigma looks like at each of the socio-ecological levels. Finally, findings on advocacy and best practice have been included utilizing a multi-level approach.

Structural Level Discrimination

From the instant one is born, based on biological sex characteristics, they are assigned one of two genders, “male” or “female” on their birth certificate—even for individuals born “intersex” most guardians choose to label their infants in the above manner; basing their decision on whichever sex characteristics appear most visibly congruous to one of the two binary categories. This process of labeling has become normalized by the majority culture over time and naturally, because infants cannot give consent, guardians are forced to select a sex for them, which may or may not match their inherent sense of self. Regardless, any thoughts that one may not fit with either of the assigned categories or otherwise reject certain biological characteristics later in life, historically, has been highly discouraged. As a matter of fact, until release of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), if one misaligned with their assigned sex at birth, they were thought to be mentally ill; the disorder was referred to as, Gender Identity Disorder (GID). Moreover, other structural level norms eventuated as a result of the binary system, further marginalizing those that do not align with the sex they were assigned at birth.

For example, the binary system is difficult to reframe because gender roles, expectations, and expressions have been created around “male” and “female” cisgender orientations and reinforced over a large period of time. Simply put, transgender and nonbinary identifying individuals are considered a “threat” to these norms as they not only misalign with their

designated sex, but frequently take on roles or express their gender in ways that don't appear "typical" of a man or woman. Granted, some cisgender individuals choose to express themselves or take on roles outside what is considered typical of their gender as well, however, the difference is, society places greater emphasis on cisnormativity than it does other forms of gender deviance.

The above social and cultural norms are particularly deep-rooted within U.S. westernized educational institutions, which, continue to both overtly and covertly exclude information on the needs and experiences of transgender individuals. For instance, Kcomt (2018) describes a systemic problem known as "informational erasure," its rationale elucidates that, a lack of knowledge produced about transgender populations in the curriculum, perpetuates erroneous assumptions that all research participants are cisgender. Thus, topics which are important to gender-nonconforming people are never brought into focus (e.g., trans-specific health issues, pronouns beyond male/female or man/woman categories, the need for unisex and gender-neutral bathrooms, etc.,). What is more, discussion of transgender subject matter generally gets lumped into lesbian, gay, bisexual, transgender, and queer (LGBTQ) studies, thereby neglecting to establish important distinctions between gender identity and sexual orientation (i.e., sexual orientation entails having sexual, romantic, and/or an emotional attraction toward others, while gender identity involves how one inherently self-identifies and pursues themselves).

There is overwhelming evidence in both areas of business and healthcare, that few curricular hours and/or training is being dedicated to transgender content. For instance, several findings relate that in a 2011 study of deans of medical education in North America, the median number of hours dedicated to LGBTQ-related curricular content was five (Hughto et al., 2015; Obedin-Maliver et al., 2011; Sawning et al., 2017). Moreover, Moll et al., (2014) found that in

areas of nursing and emergency medicine, the median number of hours spent learning about transgender education was around two—though a minority of responses were higher. Even in areas of counselor education students frequently report that there is an absence of transgender material in the curriculum, thought to be attributed to negligence on the part of counselor education programs, accreditation agencies, professional organizations, and practicing counselors that are supervising clinical trainees. For example, in one such study, several individuals verbalized that they had to take it upon themselves in order to learn about transgender subject matter; furthermore, participants voiced there were few experiential opportunities to interact with members of this population, despite numerous findings validating intergroup contact approaches (O'Hara et al., 2013).

Resultantly, a lack of cultural competence on the part of various individuals and organizations, perpetuates a field of untrained professionals, whom are ill-equipped to work with and/or serve transgender people (Makadon, 2008; Obedin-Maliver et al., 2011; Solursh et al., 2003; Lurie, 2005; & Poteat et al., 2013). Particularly in the healthcare domain, professional inadequacies constrain clientele, as a lack of trained providers forces many health-seekers to travel long distance just to receive quality care—or otherwise, they may feel compelled to pay out of pocket; a costly investment that is done in such cases, where one happens to live in a location with a qualified doctor(s), but does not carry the right kind of insurance. Moreover, due to the above variables, many health-seekers decide to postpone care altogether. Ultimately, marginalizing transgender populations no matter the path taken: traveling long distance, paying out of pocket, and/or postponing necessary care, creates financial, emotional, and psychological constraints (Hughto et al., 2015).

By the same token, employers and workplace staffs' educational inadequacies constrain trans people in multiple areas. To illustrate, Rudin et al., (2015) compared levels of transphobia between two cohorts of students—the Fall 2012 cohort was presented with a simulated bathroom dilemma and discussion; the Fall 2013 cohort on the other hand, was presented with both the simulation and had a separate reading and discussion on transgender issues. Results indicated that in the Fall 2012 cohort, 34% of students responded with "hostility", 38.7% with "compliance", and 27.3% with "inclusion"; while in the Fall 2013 cohort, 16.3% of students responded with hostility, 21.7% with compliance, and 62% with inclusion. In a nutshell, the more educational opportunities available, the greater transphobia appears to decline. In the case of this study, the 2013 cohort reported a stronger desire to install gender-neutral and unisex bathrooms, which, as will be discussed in the other subsections of this literature review, access to transgender friendly bathrooms is necessary to the wellbeing and safety of transgender individuals.

Coinciding with issues in healthcare more directly, several findings point out that a lack of education/training on the part of employers, decreases the likelihood that employer-sponsored health plans will cover trans-affirming medical procedures, as professionals may not grasp the pertinence of its inclusion. Furthermore, wages, the unemployment rate, and job security tend to be worse off for transgender populations, since untrained professionals are more likely to implement discriminatory practices, which both overtly and covertly exclude sufferers. Hence, affording care and accessing insurance coverage becomes difficult, given there is no promise of a steady job. As a matter of fact, several publications report that the unemployment rate for trans persons is double that of the general population, while four times the amount for trans people of color (Davidson & Halsall, 2016; Kattari, Whitfield, Walls, Langenderfer-Magruder, & Ramos,

2016; Brammer & Ginicola, 2017). Moreover, a national report of 27,715 transgender adults revealed that during the year of 2015, 30% of workers reported being fired, denied a promotion, or experienced some other form of employment-based maltreatment related to their gender identity or expression.

Along with educational insufficiencies found in the above realms, health insurance companies too, are being influenced by informational erasure. Precisely, there is both a gap in accurate knowledge of transgender populations and their needs, as well as a transphobic component taking place, which appears to be reinforcing stigmatic policies/practices and passivity. As an exemplar, insurers require diagnosis of Gender Dysphoria (GD) in order for patients to receive coverage of trans-affirming medical procedures, yet, not all health plans are inclusive of these benefits…many insurers deem trans-affirming medical procedures as "cosmetic" or "medically unnecessary". In other words, even with a formal diagnosis of GD by a trained provider which takes time, due to discrimination, one may not be able to find a plan that covers their needs right away—if at all; ultimately, slowing down and limiting access to a resource that is vital to the wellbeing of transgender persons. Finally, together with all of this, some activists argue that any formal diagnosis related to "symptoms" of gender nonconformity serves to perpetuate stigma (Hughto et al., 2015).

What is more, some but not all health plans request additional documentation, before one can proceed with their desired medical procedures. For example, certain insurers require at least one letter from a physician documenting a given patient's gender dysphoria and medical necessity; others require further evidence, such as multiple letters from Ph.D. level physicians, making the barrier to entry even higher. In essence, despite insurers awareness of the existence of transgender persons, they have yet to grasp or place immediacy on meeting their needs.

Moreover, as an additional constraint, even though Section 1557 of the Affordable Care Act (ACA) explicitly prohibits health plans and activities, workplace organizations, hospitals and/or other medical facilities receiving federal funding from discriminating against individuals based on gender identity, it does not require health insurance policies to cover any particular procedure or treatment for transition-related care. Put another way, medical and surgical procedures must be offered in a non-discriminatory manner, however, there is no specific requirement that insurers must cover any trans-affirming procedures even when they're considered medically necessary (i.e., if a covered entity performs or pays for a particular procedure for some of its members—such as a hysterectomy used to prevent or treat cancer in cisgender women, it cannot use gender identity to avoid providing that procedure to a transgender individual).

Also due to the influence of informational erasure and transphobia, current U.S. laws and policies are divisive in terms of equal protections for gender-nonconforming individuals. As reinforced in the Introduction section of this paper, currently only 14 states contain LGBTQ protective laws against private insurance discrimination, 19 states include transgender health coverage and care within the Medicaid program, 17 states include transition-related healthcare in their state employment health benefits, 21 states contain laws prohibiting gender identity discrimination in private employment settings, and 31 states contain laws prohibiting gender identity discrimination in public (state) employment settings. Furthermore, a majority of the U.S. states contain municipalities which offer non-discrimination protections: in 21 states municipalities are one-hundred percent protected, in one state 50-99% of the population is protected against gender identity discrimination, in seven states 25-49% of the population is protected, and in 16 states 1-24% of the population is protected (MAP, 2019). However, as it stands, there are still no outright federal non-discrimination protections/laws.

In consequence of the of the above fragmented laws, certain individuals are at a higher risk of getting stigmatized against. For instance, a study by Tebbe et al., (2019) found that participants had higher work volition in areas with greater employment non-discrimination protections. On the other hand, transgender individuals that lived in areas with few legal protections—or individuals who had little knowledge of their state or local laws, reported lower levels of work volition. Moreover, due to lowered work volition, participants reported experiencing more instances of victimization, non-affirmation of their gender identities, perceived their social statuses as lesser than that of their cisgender coworkers, and overall wellbeing decreased.

Relatedly, White-Hughto et al., (2016) found that the percent of state voting Republican was the strongest and most significant predictor of healthcare mistreatment and refusal for participants. Additionally, those that lived in conservative voting areas reported poorer health-related outcomes, thought to be attributed to voters more direct opposition against gender minority persons, as well as slower to enact protective policies in these regions in general. Finally, prior research has found that Republican-identified voters are more likely to hold homophobic attitudes, have a greater fear of AIDs than Democratic-identified voters, hold more transphobic attitudes, and therefore, transgender individuals may be more likely to encounter biased providers. Ultimately, fear of mistreatment and healthcare refusal increases nervousness, anxiety, and hypervigilance.

Interpersonal Level Discrimination

A direct consequence of educational inefficiencies, as well as societal norms; stigma at the interpersonal level entails improper communication between majority and minority group members. Concerning the present topic, institutionalized transphobia is reflected in individuals’

overt and covert dialogue, when interacting with trans persons. During these relational encounters, biases may be expressed either explicitly which are known to the individual and within their control, or implicitly, in instances where one's subconscious automatically activates and responds in ways that are mostly outside of their awareness and control. However, in order for one to act upon their biases, they must first be aware that the person they are interacting with is transgender (Hughto et al., 2015).

Generally, the less one aligns with the roles, expressions, and expectations of the binary system, the more discrimination they will face. For instance, according to White and Jenkins (2017) transgender people tend to encounter heightened every day and major discrimination, if their appearance more strongly misaligns with cisgender expectations. Resultantly, health-harming behaviors are high among transgender populations. Likewise, Rodriguez, Agardh, and Asamoah (2018) ascertained that discrimination occurs most frequently to those whose transgender identity is recognizable. Particularly, 33% of participants in their study reported experiencing discrimination in healthcare settings, between 4-7% experienced discrimination in rape/crisis centers and drug treatment programs, 14.5% within mental health settings, 16.8% in emergency room settings, and 28.7% in hospitals.

Disparately, other transgender identifying persons are not so outwardly recognizable. Although this may have something to do with the pursuance of medical and legal changes; the reason some individuals do not "appear" transgender is quite the contrary…they may be concealing their true gender identity in an attempt to avoid discrimination. In other words, some feel compelled to masquerade as the gender they were assigned at birth or otherwise, cross-dress to appear more gender congruent. Moreover, high gender congruence allows one to remain in the closet, since "coming out" puts persons in a similar position to those that are visibly transgender.

Alternatively, while conformity protects individuals, it can also be a significant source of stress; as several findings demonstrate, identity concealment increases psychological stress, internal unrest, hypervigilance, and even impacts other areas of life, such as satisfaction with one's job (see individual level subsection below) (Bockting et al., 2013; Mizock et al., 2014; Levitt et al., 2013; Martinez et al., 2017; Ozturk et al., 2015).

In any case, regardless of a person's discretion to express their gender identity or not, each decision presents its own set of challenges. For instance, in areas of employment, those with more visible identities are especially prone to changes in labor force status (Leppel, 2016). As an example, whether a potential employee pursues medical/legal procedural changes or not, so long as one's self-designated name and gender differ from what is presented on their legal identification documents, there is potential for discrimination. In other words, on top of physical characteristics which may give away a person's gender identity, many places of work require that individuals provide their driver's license, birth certificate, and/or social security info, among others, in order to continue with employment. Therefore, creating additional avenues for transphobic practice both throughout the hiring process and on the job (Shelton, 2015; Dietert et al., 2009; Winter et al., 2016).

The above variables compel many trans people to appear "not visibly transgender" (hide one's gender identity and expression) and "pass" (embodying whichever gender binary category a person resembles more closely—male or female) for job security and job satisfaction purposes. Nevertheless, while these safeguards may protect individuals against stigma during job interviews and day to day operations for the short-term, long-term inauthenticity can be trying. Eventually, the stress of it all leads some to risk coming out to their coworkers and employers; the ultimate goal of disclosure being, to progressively work towards identifying as one's most

inherent sense of self at work. However, while outing oneself to their place of employment can lead to positive results, it may also backfire. Thus, careful considerations should be made before proceeding, as such a decision cannot be reversed.

According to numerous findings, in instances where identity disclosure backfires, transgender employees tend to experience greater bouts of bullying, prejudice, and harassment from organizational staff (Ruggs, Martinez, Hebl, & Law, 2015; Budge, Tebbe, & Howard, 2010; Levitt & Ippolito, 2014; Schilt & Connell, 2007). Consequently, this creates career barriers for individuals, whom often get socially excluded and denied promotional opportunities as a result of their minority status. (Brown et al., 2012). Moreover, a study by Brewster, Velez, Mennicke, and Tebbe (2014) found that working around hostile and more inexperienced colleagues, tended to increase participants reporting's of heightened transgender discrimination, once out the company. Discriminatory behavior ranged from misunderstandings regarding pronoun usage and the differences among the LGBTQ spectrum—which several individuals frustratingly felt they had to "teach" others about, to more damaging effects such as, getting socially isolated, receiving violent threats, facing immediate termination upon disclosure, suffering ridicule from others, and some were even told to change their gender presentation (e.g., one participant mentioned that they had to, "take their makeup off and put on men's clothes for work," which was humiliating) (Brewster et al., 2014).

An outcome of the above adversities, transgender people are more prone to encountering financial constraints throughout their lifespan. Case in point, after interviewing several transgender employees in their study, Mizock et al., (2017) found that, due to discriminatory practices: all interviewees experienced a job loss at some point over their lifetime, had experienced a cut to their work hours, were forced to take on lesser paying jobs, and found

greater difficulties in securing a living wage despite having an education and skills. Coupled with these issues, Leppel (2016) notes that finding work can be especially challenging, given job seekers may not be willing to apply for places which fail to provide trans-inclusivity and benefits. In essence, these individuals do not want to be put in harmful employment situations and if a particular community doesn't happen to offer said job requisites, it is not uncommon for people to become discouraged and drop out of the labor force.

Alternatively, others may not be able to afford to drop out of the workforce, as low wages from previous discrimination can lead to lower levels of savings, wealth, and investment income, further reducing income overall (Leppel, 2016). Consequently, limited funds force transgender individuals to remain in the labor force and for some, this means continuing employment with organizations that are low-paying and hostile. Unsurprisingly, as Divan, Cortez, Smelyanskaya, and Keatley (2016) indicate, the above-mentioned discriminatory and exclusionary measures, are likely a reflection of higher unemployment, homelessness, and poverty rates, among transgender populations in the United States. Eventuating from this, other domains suffer—particularly, in areas of healthcare.

At the heart of it all, individuals seek alignment with their internal sense of selves and for many transgender persons, that entails gaining access to gender-affirming procedures. However, due to financial constraints, along with the discriminatory nature of the healthcare system and its providers, access becomes limited. For one thing, the very interactions between professionals and health-seekers are often erroneous…causing many to delay needed medical care. As a matter of fact, Lerner et al., (2017) impart that over 50% of transgender people, on average, delay needed medical care compared with about 20% of the cisgender population in the U.S. (as cited in Cruz, 2014). The high percentage is partially attributed to cultural incompetence on the part of

providers, as misconceptions surrounding transgender issues, correct terminology, and pathologization, come up frequently and must be unlearned, which, to the frustration of transgender clientele, they are often the “teachers” (Kattari et al., 2016; Kcomt, 2019; Grant et al., 2011; Lerner et al., 2017).

Relatedly, a structural and interpersonal level issue, *embodied disruption* frequently occurs between patients and doctors once one’s gender identity becomes known. During these interactions, patients’ experience feelings such as confusion, fear, panic, distress, and/or even elation at the thought of their gender identity getting both mis/recognized. Meanwhile, doctors’ handling of either correctly identifying or misgendering a patient’s identity—embodied disruption, impacts the doctor-patient relationship in four negative ways: 1) through disengagement (providers no longer talk or meet patient’s eyes); 2) sorting (providers attempt to sort patients into binary medical categories of sex/gender); 3) denial (providers challenge the validity of patients’ identities and/or deny them care); and 4) discipline (providers chastise patients for their identities/embodiments). Ultimately, the literature revealed that due to the poor management of embodied disruption on the part of a majority of providers, most participants decided to discontinue healthcare arrangements and care, despite having unmet needs (Paine, 2018).

In accordance with this, many other forms of discrimination exist, which cause individuals to avoid and/or delay necessary care. Typically, though this list is not exhaustive, transgender people face the following issues in healthcare settings: service denial, breaches of confidentiality from providers, verbal harassment, mental illness stigma/instability, sometimes physical assault, and in extreme cases, worsening of health conditions or death if denied care in urgent/emergency situations (Kattari et al., 2016; Hughto et al., 2015; Rodriguez et al., 2017;

Divan et al., 2016). Further constraining, Wagner, Kunkel, Asbury, and Soto (2016) found that the narratives of other trans individuals, acts as a powerful influencer of one's health-seeking behaviors. In other words, even if a person has never experienced a particular stigmatic health situation before; knowing people in the community that have, instills fears, apprehensions, and an "anticipation" of discrimination. Therefore, postponing potential health-seekers further from reaching out.

Effects of Discrimination at the Individual Level

Although at first developed to study the, "LGB" of the LGBTQ spectrum; in recent years, researchers have decided to apply the Minority Stress Model to transgender populations as well (Meyer, 2003; Hendricks & Testa, 2012; Hatzenbuehler et al., 2016). Fittingly, in alignment with the present topic this framework considers how relational difficulties at the interpersonal level, as well as hampering institutional norms and policies at the structural level cause stress for minority individuals, which accrue overtime, resulting in long-term health deficits (Hughto et al., 2015). Particularly, the minority stress theory distinguishes between *distal* and *proximal* stress processes. Distal stress processes are external to the minority individual and include experiences such as: overt rejection, prejudice, discrimination, and victimization, which frequently take place in employment and healthcare domains, among others. On the other hand, proximal stress processes are internal and often the byproduct of distal stressors, they include: fear of discrimination and stigma avoidance, internalized transphobia, and stigma concealment (Seelman et al., 2016; Hughto et al., 2015).

As emphasized previously (see structural level subsection) distal stressors at the structural level entail existent laws, policies, cultural, and institutional norms, that inhibit one's ability to obtain equal access to resources. For instance, currently there are no outright federal

protections against gender identity discrimination nor do all states and localities protect individuals within employment and/or healthcare domains, among others. Resultantly, this continues to allow places of employment, healthcare institutions, etc., to deny transgender persons access to important privileges such as, the freedom to self-select which bathroom to use, safety from repeated harassment and misgendering, safety from discrimination in public spaces (e.g., restaurants, hotels, and retail stores), safety from healthcare institutions that do not receive federal funding, and safety from discrimination in housing, as some areas currently allow landlords and real estate companies as well as banks/other lenders to deny transgender people loans and property benefits ("The Equality Act: What Transgender People Need to Know", 2019). Further constraining, workplace organizations and healthcare providers may not be required to include gender identity inclusive/protective policies, both because of divided state/municipality laws, as well as because employers are given the ability to enact their own policies…often left unclearly defined and unenforced (Movement Advancement Project [MAP], 2019; Human Rights Campaign [HRC], n.d.; Ruggs et al., 2015). Finally, as the various literature has pointed out so far, many disciplines within the education system lack emphasis on curricular exposure to and learning of transgender perspectives; thus perpetuating transphobic beliefs/behaviors at various social-ecological levels, which constrain effected individuals (Kcomt, 2018; Hughto et al., 2015; Obedim-Maliver et al., 2011; Sawning et al., 2017; Moll et al., 2014; O'Hara et al., 2013; Makadon, 2008; Solursh et al., 2003; Lurie, 2005; Poteat et al., 2013; & Rudin et al., 2015).

More easily identifiable, distal stressors at the interpersonal level, then, involve actual discriminatory relations between persons. As the aforementioned research highlights (see interpersonal level subsection) stigma most frequently occurs to those that hold a visible

transgender identity and whom are out of the closet (Hughto et al., 2015; White et al., 2017; Rodriguez et al., 2018; Leppel, 2016). A repercussion of norms at the structural level; the culture of the gender binary system pressures people to identity with the, "male or female" paradigm, including gender stereotypes and expressions (Goldberg et al., 2019; Fiani et al., 2018; & Thorne et al., 2018). In other words, when seeking services—or work in the case of employment; in order for discriminatory behavior to occur providers, healthcare staff, employers, employees, and other stakeholders must be aware that a given recipient is transgender and the less congruent/in alignment they are with normalized standards, typically, the more discomfort dominant figures will express. Most frequently, the kinds of discrimination that take place in these environments, entail oppressors misuse of gender pronouns, denial of healthcare services, denial of employment and promotional opportunities, enactment of employment terminations, social exclusionary measures, use of harassing and threatening language, and sometimes oppressors may even inflict physical harm upon victims; all of which, the above-mentioned distal stressors create proximal stressors at the individual level (Shelton, 2015; Dietert et al., 2009; Winter et al., 2016; Ruggs et al., 2015; Budge et al., 2010; Levitt et al., 2014; Schilt et al., 2007; Brown et al., 2012; Brewster et al., 2014; Mizock et al., 2017; Lerner et al., 2017; Rodriguez et al., 2017; Kattari et al., 2016; Grant et al., 2011; Paine, 2018; & Divan et al., 2016).

Mentioned briefly, when external stigma is inflicted upon the individual, they tend to develop an aversion to the given stimuli—whether that be themselves or a particular environment (Kattari et al., 2016; Hughto et al., 2015; Rodriguez et al., 2017; Divan et al., 2016; Bockting et al., 2013; Mizock et al., 2014; Levitt et al., 2013; Martinez et al., 2017; Ozturk et al., 2015; Paine, 2018; & Wagner et al., 2016). Put another way, these aversions occur internally and are considered to be proximal stressors. For example, there is a kind of proximal stressor which

arises due to pressures of cissexism as well as negative social messages, referred to as internalized transphobia (Rood et al., 2017; Breslow et al., 2015). Particularly, these social messages happen to minimize, devalue, and denigrate transgender identities via stereotypes, derogatory labels/slurs, misperceptions, and unsupported assertions about ability or social status. In the study by Rood et al., (2017) for instance, participants shared being called, "freaks", "monsters", "sexual predators/mentally ill" "undesirable" as romantic partners and community members/friends, were considered deceptive/dishonest because of their efforts to live as their inherent gender, and some were even told their gender identity is a choice and is not "real".

Such messages caused participants to feel upset and angry, which, as various other studies have identified; overtime individuals tend to internalize negative messages as truths and thus, this leads to lower levels of self-appraisal. Moreover, together, the numerous findings reveal that high levels of internalized transphobia can lead to the following mental and physical health problems: increased suicidal attempts, psychological distress, depression, life stress, anxiety, substance abuse, risky sexual behavior, and low self-esteem (Rood et al., 2017; Breslow et al., 2015; Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015; Nemoto, Operario, Keatley, & Villegas, 2004; Reisner, Perkovich, & Mimiaga, 2010). Correspondingly, another proximal stressor relevant to transgender populations, happens to center around identity concealment. Prevalent across nearly all settings, individuals often feel compelled to "pass" or hide their nonconforming gender identity, as discriminatory encounters occur frequently…especially for those that stray farther from gender binary expectations (Bockting et al., 2013; Beemyn & Rankin, 2011).

In particular, many transgender people decide to conceal their gender identity in employment settings not only to avoid general harassment/derogatory insults, but as one study

relates, especially for male-to-female workers (or for those that are seeking more feminizing treatments, such as being given increased doses of estrogen) transitioning later in life may confer economic benefits, since presumed “males” are typically able to earn more (Schilt & Wiswall, 2008). Furthermore, many employees choose to remain hidden in an attempt to maintain their job status, as well as window of promotional opportunities and thus, a more stable income (Budge et al., 2010; Collins, McFadden, Rocco, & Mathis, 2015; Shelton, 2015; Dietert et al., 2009; Winter et al., 2016). Similarly, in healthcare settings the main reason individuals choose to withhold their gender identity status, is in fear of being discriminated against. More specifically, multiple findings relate that due to transphobic practices and educational inefficiencies, it is not uncommon for providers to deny care to transgender patients (Kcomt, 2019; James et al., 2016; Hughto, Murchison, Clark, Pachankis, & Reisner, 2016; Paine, 2018). Finally, restroom harassment and “gender panics” (deep, cultural fear, set off when the "naturalness" of a male-female gender binary is challenged) influence persons to conceal their gender identity, given there is an increased chance that one will get either wrongfully accused of being a perpetrator, threatened, and/or beat up for using the assumed “incorrect” bathroom (Westbrook & Schilt, 2014; Elias, 2017).

In spite of decreased stigma at concealing one’s transgender identity, there are also numerous adverse consequences that result in living inauthentically. For instance, countless findings report that, remaining in the closet can lead to various physical and mental health problems, like: increased psychological distress, suicidal thoughts, depressive symptoms, negative affect and anxiety, poor self-esteem, elevated psychiatric symptoms, hypervigilance, and a preoccupation with passing (Mizock et al., 2014; Hughto et al., 2015; Rudin et al., 2015; Hatzenbuehler et al., 2016; Testa et al., 2017). Moreover, while disclosure can be voluntary,

oftentimes it is still forced and necessary given one must be visibly out in order to acquire transition-related healthcare, employment medical leave, dependent benefits, adequate medical services, appropriate preventative care, and mental health interventions (Hughto et al., 2015; Kcomt, 2018; Collins et al., 2015; Hatzenbuehler et al., 2016). Lastly, transgender people can also be forced into disclosure by a change in appearance or demeanor upon pursuance of gender-affirming procedures; one of many reasons for why employment status changes more frequently among transgender populations (Collins et al., 2015; Yavorsky, 2016; Smoyak, 2015).

In addition to anti-transgender internalizations and pressures to conceal one's identity, individuals often develop anticipations of and aversions to stigma over time. To illustrate, several researchers found that participants who had been refused care in the past and/or experienced verbal and physical mistreatment from providers (*enacted* stigma*)*, were more likely to avoid seeking health services going forward, including delaying needed medical care when sick/injured and delaying routine preventive medical care. Accordingly, delays in both needed and preventive care (*anticipated* stigma) resulted in poorer mental health outcomes and substance use issues—conduct utilized to cope with mistreatment (Reisner et al., 2015). Lastly, both findings conceded that while healthcare avoidance may be initially protective against the psychological distress associated with stigmatizing encounters, avoiding healthcare can have serious adverse health consequences…including delaying care to the point that one experiences a medical emergency.

Relatedly, Brewster et al., (2014) revealed that in areas of employment, potential transgender employees frequently experience distress, nervousness, anxiety, depression, and fear related to transitioning. These feelings were linked to uncertainties of changes in job status, stigmatization by coworkers, and other stressors stemmed from participants feeling as though

they were not visibly congruent enough. Consistent with the above findings, Budge et al., (2010) relate that transitioning brought forth a lot of emotional, psychological, physical, and financial uncertainties for binary transgender participants in their study. Precisely, they focused on how the different stages of transitioning (pretransition phase, during, and post-transition phase) impacted treatment, as well as any changes to employment status. The following adverse themes came up: participants described presenting as their assigned sex at work to minimize discrimination, many felt pressured to seek legal advice and "prepare" for workplace transitioning by researching what others experiences were like, many described feeling anxious and suicidal regarding how to deal with their transition at work, once out of the closet mixed reactions led some to lose their job/eminent status, a majority of individuals felt "passing" was important given treatment tended to be better for those that aligned more closely with gender/sex norms, rejected individuals frequently reported experiencing physical/verbal harassment and isolation, and even post-transition many experienced job changes as they were hoping to fit in better—"pass" and start over on more equal footing.

On the other hand though, others didn't feel it a choice to undergo changes in work status, given many experienced a job loss only after coming out. Moreover, applying for jobs and maintaining employment became more difficult for some upon transitioning, as several participants recall being told they cannot be at work if they happen to be "disturbing" customers/coworkers, a couple of individuals mentioned getting assaulted and/or receiving property damage after disclosure, others revealed that people constantly used their pronouns and name incorrectly which caused a lot of emotional distress, and finally, whenever discriminatory hiring/firing practices occurred, hirers always fabricated reasons for why a potential employee could not be employed through them (e.g., budget cuts, improper conduct at work, coming off as

deceptive/inauthentic, and so on). Finally, several participants expressed fears regarding bathroom usage and safety, changes in social status as a result of their perceived or actual gender (e.g., a male-to-female transition may demote a person's financial and power status), and a vast majority of people did not believe they can have whatever job they want as they felt organizations won't hire them because of their "strange" looks. In a nutshell, a lot of negative affect was described in the interviews…not only did transgender individuals "anticipate" stigma with every thoughtful worry of what will come of disclosure, but many attempted to avoid discrimination via concealment and switching career/life paths more regularly.

Multi-level Stigma Interventions

Structural, interpersonal, and individual level stigma may look differently in both research and everyday contexts, however, in reality these processes essentially create and reinforce one another. Rather than looking at stigma interventions separately within each layer; a multi-level approach will be used instead, to help individuals see the fuller picture. On the other hand though, an appreciation and breakdown of the structural level must be listed first, as the origins of transphobia can be traced there. Put another way, both the lack of content focusing on LGBTQ—particularly the "TQ" in educational institutes, as well as long-held cultural and gender binary norms; perpetuate knowledge inefficiencies even among "professionals". Moreover, government laws and policies are reflective of this belief system…all of which, the aforementioned structural constrictions and among others hostility/misunderstanding at the interpersonal level, cause individual level resource and health constraints.

For starters, a term originally coined by West and Zimmerman (1987) "doing gender" is a concept policed at all social-ecological levels: accountability to self, accountability to others, and accountability to society. More specifically, doing gender has a large impact on the system, as it

defines gender, sex, and sexuality within heteronormative and cisnormative boundaries. Any attempt to step outside of these boundaries—especially for nonbinary individuals, is met with a lot of discomfort, anxiety, and/or anger (Darwin, 2017). Furthermore, though some nonsexual environments attempt to police gender; it is particularly prevalent in gender-segregated spaces, wherein those with "inappropriate" genitalia/other sexualized body parts or those that appear more visibly incongruous, get punished either through resource depletion or socially. One such study suggests, that in order to change this structure gender must be un/re/done, however, not by "doing transgender" as Connell (2010) suggests, but rather, by *redoing* transgender (Darwin, 2017).

In other words, overall there isn't much information/acknowledgement beyond binary cisgender and transgender orientations, thus, the focus should be on challenging both "doing gender" and "doing transgender," through expressing oneself in a manner that tests these normative scripts. Moreover, by challenging binary accountability within both scripts, by "doing nonbinary gender" this unique, interactive process drives others to be confronted with/recognize its existence (e.g., strangers may begin to resist labeling individuals such as, "he/she or him/her", but rather, through use of gender-neutral pronouns like, "they/them/their" or via a mix of pronouns depending on the individual's nonbinary identity, "Ms., Mrs., Mr., and/or Mx."). Nevertheless, while transgender and nonbinary identity visibility may act as an initiator to change; in order to reach larger masses, it is necessary that these individuals' thoughts and experiences be captured and reflected in educational realms, which, unfortunately, has been neglected until only recently.

Among many stimuli, researchers cite the following situations as most commonly contributory to transphobia/oppression: there appears to be a lack of hours dedicated to

transgender content, a lack of quality LGBTQ program/training sessions in workplace and other settings, a lack of positive intergroup experiences, and it seems overarching domains frequently contain outdated practices/policies that are deficient in inclusivity. To illustrate, several studies suggest ways in which academic disciplines can improve student knowledge and skills both before entrance into the workforce and after; Hugh et al., (2015) and Paine, (2018) for example, discussed incorporating "Transgender 101" trainings into medical curriculum. Particularly, they found these trainings improve cultural competence by exposing healthcare providers to health barriers experienced by trans patients, the conduct of quality and sensitive care, what the specific gender-affirming medical procedures are (e.g., hormonal therapy), and also, provider's own implicit attitudes are often addressed. Moreover, use of multiple educational media appears to be a reliable trend among various studies, as Walker, Arbour, and Waryold, (2016) found in nursing programs, use of case studies, blogs, journals, discussion board assignments, and group work (either face-to-face or in a virtual classroom) allowed students the ability to gain an understanding of LGBTQ terminology, examine personal biases, learn how to take a respectful and competent sexual health history, provide comprehensive patient education, and initiate referrals when needed. Finally, Quereshi et al., (2017) mentioned that even within existing educational programs, LGBTQ content and competency trainings must be frequently reassessed, as to help alleviate many of the existing barriers to care (e.g., an avoidance of care due to discriminatory attitudes/behaviors).

Even more effective than content-based education, intergroup contact between dominant and marginalized populations (cisgender and transgender people in this case) works well to reduce transphobic attitudes. For instance, utilizing the Genderism and Transphobia Scale (GTS) Walch et al., (2012) measured transphobic attitudes across a group of participants: comparing the

effects a traditional lecture on transgender issues has in reducing overall levels of transphobia versus a speaker panel made up of four transgender lecturers. Results indicated that, the transgender speaker panel evidenced steeper reductions in transphobia than did the lecture. Furthermore, multiple studies verify that having had prior contact with or knowing a loved one that is transgender, reduces overall transphobic beliefs, behaviors, and negative intentions; all the while increasing positive attitudes/intentions and public support (Acker, 2017; Mizock et al., 2017; Barbir et al., 2017).

Versatile in its use, intergroup contact exposure can be implemented in various ways. While the study by Walch et al., (2012) utilized a transgender speaker panel; Hughto et al., (2015) describes the effectiveness of a campaign video referred to as *I AM Trans People Speak* developed by the Massachusetts Transgender Political Association (MTPC, 2013). Considered multi-level in effectiveness, the video acted as a self-affirmation intervention to aid in trans persons coping with stigma, as well as aimed to reduce transphobia among non-transgender audiences, by educating the public about trans people's lives and eliminating stereotypes through exposure. What was especially helpful regarding the video, was that it featured family members, partners, and other transgender allies telling their narratives of heartbreak, acceptance, and unconditional love, which, as Ruggs et al., (2015) perfectly frames it, it is better for non-stigmatized groups to advocate on behalf of stigmatized groups, as those who advocate on their own behalf can be labeled as "whiners" and "complainers" even when they have been the victims of objective discrimination.

In addition to the need for increased educational exposure to transgender persons/content, stakeholders in numerous domains must be cognizant of the policies/practices they are both creating and enforcing. For example, Seelman et al., (2017) describes that it is the role of the

provider to consistently and clearly communicate the measures they have in place to affirm transgender health and competently serve this population, such as through clear non-discrimination policies, intake forms that sensitively ask for gender identity, training and accountability for trans-inclusivity among providers and healthcare staff (including front desk and administrative staff), and the medical establishment needs to make sure to fully integrate trans-sensitive care into its professional standard to be part of a broader commitment to cultural competence. All of this must be done in order to counteract fears of discrimination (hypervigilance/anxiety), as well as an avoidance of care. Relatedly, Galupo et al., (2016) also highlight the need to create clearer policies, as their study found that unclear workplace policies play a huge factor in microaggressions. Specifically, they mentioned there are commonly "grey areas" found under policy, which reinforce the allowance of more subtle forms of discrimination (i.e., many participants discussed feeling left out or excluded from office events and these instances tend to not be covered under anti-discrimination policies).

Galupo et al., (2016) described that in order to reduce these instances, organizations should frequently review their stated policies in light of the vision, mission, and value of the company to ensure there is no disconnect, as inconsistencies may send confusing messages to employees. Moreover, when writing anti-bias employment policies, they need to be specific, precise, comprehensive, and employees should be advised on how to avoid stigmatic acts. Precisely, definitions of microaggressions should be presented to employees in addition to giving concrete examples, as to assist them in recognizing discriminatory behavior that they may not realize is offensive. Lastly, organizations need to make sure all involved parties are aware such policies exist and have a means of enforcing them. In doing so, ideally, coworkers sensitivity/understanding will increase once they begin working with trans employees.

As was previously mentioned (see Introduction section) with transgender identities—and even more so nonbinary transgender identities being left out of research demographics, "erasure" has limited the spread of information across educational institutions as well as the general public. Resultantly, transphobia and stigma occur frequently…causing many adverse effects, also previously mentioned in various subsections. However, by utilizing a multi-level approach and "redoing" trans/cis binary norms, by capturing transgender peoples' experiences and demographics in research, by holding educational programs and institutions accountable in both their policies/practices and course requirements (which encompasses integrating positive intergroup contact experiences), and by changing/implementing and enforcing inclusive organizational policies, then, at the individual level, there will likely be an observable increase to wellbeing and resource access among transgender populations. Nevertheless, while the system and its overarching binary standards can be redone; the residual effects of past discrimination cannot be overlooked. Therefore, at the individual level, the focus of intervention has and should continue to be on both coping strategies and advocacy.

Particularly, several researchers have laid out a set of coping strategies which take place at individual, interpersonal, and structural levels. At the individual level, the following techniques were mentioned: gender-normative coping (modifying one's gender presentation and utilizing traditional gender coping styles to deal with experiences of transphobia [e.g., a trans female participant in one of the studies stated at one point that their cis female therapist advised them to "avoid firing off" at work, as is typically associated with a more masculine trait]), self-affirming coping (asserting one's strengths, sense of self, being confidently authentic/genuine, and persevering in the face of stigma), emotional-regulation coping (managing one's emotions in response to trauma such as, using relaxation techniques, staying active, and addressing difficult

emotions to develop greater resiliency), and cognitive-reframing coping (reframing experiences, developing a sense of understanding of the perpetrator of transphobia, and thinking positively). As for the interpersonal level then, researchers made suggestions that participants engage with any relational supports they may have (i.e., seeking advocates, family support, and peer support), as well build new relationships and challenge/communicate about transphobia in others. Moreover, anticipating stigma (expecting and preparing for stigma, all the while seeking out more tolerant environments), disengaging from it (emotionally detaching/ignoring it), and making careful decisions about disclosure (will revealing identity be safe and will it lead to the desired outcome) proved helpful. Finally, as a structural level coping strategy, researchers mentioned that using various services and information can be helpful (i.e., seeking legal recourse, utilizing social media to connect with peers and trans organizations, seeking mental health services, reaching within one's spiritual and/or religious affiliation, and engaging in activism and advocacy to educate others, which ultimately may help promote/protect the rights of trans people, improve policy development/the quality of trans organizations, and increase research participation and awareness, among other prospects (Mizock et al., 2014; Mizock et al., 2017; Budge, Chin, & Minero, 2017).

Conclusion

Through use of a social-ecological framework, patterns are able to be drawn regarding the origins and reinforcing nature of transphobia. Thus far results have shown that structural level forces such as, cultural sex, gender, and sexuality norms, have marginalized transgender populations by way of informational erasure and exclusion. Moreover, policies, practices, and present governmental laws, which are a direct reflection of dominant culture, deprive trans individuals of equal access to healthcare and employment resources, in addition to certain public

spaces, such as bathrooms. The above tribulations then present themselves in everyday contexts, wherein a vast majority of transgender individuals report experiencing stigma from providers, medical staff, helping professionals, workplace colleagues, employers, HR, and other stakeholders, due to a lack of comfort and knowledge. Consequently, causing implicit health disparities like increased suicidal ideation, substance abuse, psychological/mental health adversities, hypervigilance, and an avoidance of healthcare; while explicit discrimination has led to higher rates of unemployment, underemployment, physical assault, greater financial loss/instability, and an underutilization of care.

Given the application of a multi-pronged approach applied throughout, naturally, it appeared most suitable to focus on multi-level intervention strategies as well. First, these findings suggest that the system must be "redone" in order improve access to equal opportunities and overall wellbeing, which, entails including diverse gender identities in population-based research studies and prevailing educational programs. However, simply acknowledging the existence of transgender identities cannot lead to long-term changes, thus, what is recommended is the enforcement of inclusive policies and practices. In other words, non-discrimination policies must not only be frequently updated to reflect organizational mission statements and values but must be specific on what counts as discriminatory—what behaviors/actions are considered transphobic…in doing so, non-marginalized groups will be held accountable of any possible breaches. Along with these strategies, much success was shown through use of positive intergroup contact approaches, as direct exposure to the experiences and adversities of transgender people, both decreases transphobia among non-marginalized and marginalized individuals (internalized transphobia); all the while increasing understanding and empathy between groups.

Finally, these findings stress the importance of individual level coping strategies since inevitably, all trans individuals are subject to stigma—whether beyond their field of awareness or not. Particularly, what is emphasized is coaching clients to positively reframe their experiences, assess their strengths and sense of self (work toward improving self-esteem, resiliency, and helping one achieve greater authenticity), teach them calming/relaxation techniques to help with emotional regulation, allow clients to openly express their gender identity and if requested teach them gender-normative coping strategies to reduce potential discrimination, with careful consideration of the client's best interest disengagement coping may be taught to decrease stigma, guide the client through disclosure and anticipatory concerns of stigma and spend some time going over preventative-preparation strategies if need be, assess clients current support system and help them determine their goals, and finally, act as an advocate on their behalf and guide them in the direction of relevant resources so that they can feel empowered (e.g., aid them in finding trans organizations in their area or if there are research studies they can sign up for, etc.,). As a potential drawback of this project, while the overall focus covered a broad range of transgender identities, it did not specifically weigh in how race/ethnicity, age, sexual orientation, and physical ability, among others, can impact the trans experience. Moreover, because the focus was broader by nature, certain details and intervention strategies may have been overlooked.

The implications of these findings suggest the need to increasingly analyze transgender populations and research from a multifaceted lens. Thus, the information contained in this project may be beneficial, as it could potentially be a starting point for some; while for others who are more acquainted with this topic, might utilize certain informational pieces to either reinforce their understanding or otherwise, add it to their current practice. Lastly, a future direction for research might be to include the previously mentioned demographics whether

conducting an actual study or literature review, so that a more accurate representation of the lived experiences of transgender people can be captured.

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