TRANS COLLECTIVE EXPERIENCE: HOW TRANSGENDER INDIVIDUALS SEARCH FOR PRIMARY CARE PHYSICIANS

By

Amanda M. Drake

A thesis submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Master of Arts in
Sociology

Charlotte

2019

Approved by:

_____
Dr. Kendra Jason

_____
Dr. Jill Yavorsky

_____
Dr. Sarah Pollock

ABSTRACT

AMANDA M. DRAKE. Trans Collective Experience: How Transgender Individuals Select Primary Care Physicians. (Under the direction of DR. KENDRA JASON)

The transgender population experience high rates of discrimination in healthcare settings, which has been well documented. Less is known about what is keeping transgender individuals from utilizing healthcare resources or their entry points to healthcare. With this qualitative exploratory study, I interviewed 10 transgender individuals from a large southeastern city about their primary healthcare provider search processes. Using inductive analysis methods, I explored the emergent themes that revealed a unique search process which included utilizing trans collective experience, informed searching, visiting a provider, assessing experience with the provider, and selection or rejection. Findings from this research has the potential to inform positive health care practice implications for the transgender community and for other marginalized groups that experience similar health disparities.

ACKNOWLEDGEMENTS

I would first and foremost like to thank those from the LGBTQ+ and transgender communities that made this research possible with their trust and candor. I would like to thank my Committee Chair, Dr. Kendra Jason, for her tireless efforts and unfaltering guidance. Thank you to my committee members, Drs. Jill Yavorsky and Sarah Pollock for their invaluable feedback. I thank the University of North Carolina at Charlotte's Sociology Department for allowing me the space and resources to pursue this research. And lastly, I thank my friends and family for you steady support and encouragement.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

There is a paucity of research that examines the struggles that transgender people face in gaining access to healthcare and what that means for general inequality processes. The transgender community, particularly transgender people of color, disproportionately experience obstacles in their personal and public lives such as high rates of unemployment, homelessness, discrimination, and violence that can hinder their sense of self and security (James et al. 2016). Healthcare settings can be particularly difficult places for transgender people because of the intimate nature of health care and the specific needs for transgender bodies. In fact, results from the National Transgender Discrimination Survey, which was the largest study of its kind at the time with about 6,400 interviews with transgender and gender non-conforming people in America, shows that 19% of transgender individuals surveyed have been refused healthcare, with even higher numbers for trans people of color (Grant et al. 2010).

The discrimination that transgender people face in health care, because they do not identify with the sex-determined gender they were assigned at birth, is a barrier they must overcome to get the specialized care they need (Bradford et al. 2012). Transgender stigma—the rejection trans people feel when they are experiencing or expecting discrimination—limits access to care (White, Hughto, Reisner, and Pachankis 2015). Other marginalized groups experience similar disparities in healthcare. Research shows that certain social groups experience stigma based on factors such as race and ethnicity (O'Brien 2011), socioeconomic status (Allen et al. 2014), chronic illness status (Earnshaw and Quinn 2012), and concealable identities like those with mental illness, addiction, or trauma from abuse. Everyone needs access to quality healthcare, but it could

be argued that transgender people need specialized care because of their unique biological, psychological, and psycho-social needs**.** Much of the stigma they experience is because of others' rejection of their gender identity and their apathy toward gender norms. Further, discrimination experienced at the hands of medical professionals is common, and often keeps transgender people from seeking routine care for fear of being mistreated or abused (Grant et al. 2010). The transgender community must also negotiate the deficiencies in medical training for trans-specific care (Noonan et al. 2018). This lack of training not only puts the trans patient in the position of having to "teach" care providers about trans needs, but it can also make the care provider feel less confident in the care being provided.

Face-to-face interactions with unfamiliar people can be met with discomfort based on outsiders' perceptions of the trans individual's ability to "pass," defined as the ability to fulfill gendered norms and expectations through their outward appearance, as well as any perceived notions of sexuality that are attached to gender (Pfeffer 2014). These expectations are what shape gendered interactions and any deviance from these established norms, in a society that relies heavily on them as a form of social order, can cause tension between individuals. This is particularly true in gendered spaces like restrooms, locker rooms, or even gender-specific professions (James et al. 2016). Stigma that transgender people have experienced in the past can shape their overall perceptions of how they expect to be treated in new settings, thus forming their collective experiences.

Due to the reasons mentioned above, the transgender community is particularly sensitive to their social interactions with others and derive meaning from those inter-

actions. This is why *symbolic interactionism*, a school of thought that explains behavior in terms of how individuals interact through symbols, influenced the shaping of this research (Blumer 1986). Stigma derived from social interactions also impact behaviors that attempt to curb said stigma, this process is also known as *stigma management*. This was another important influence because those with visible stigmas, like transgender individuals, are more vulnerable to mistreatment because their stigmatized status is more evident to others (Goffman 2009). Symbolic interactionism is a useful perspective that supports the concept of shared meaning in a community and how this might influence their experiences.

For the purpose of my research, I also leveraged the term *collective experiences* from Henriques (2014) where he contends that shared meanings have cultural and structural context that progresses from individual level to a societal level that reflect micro and macro social relations. I expand upon Henriques' work to coin *trans collective experience*, which refers to transgender individual experiences combined with the experiences of other transgender people and the historical context of their community. This new concept details how personal experiences and the narratives of similar others merge to inform decision making, their sense of self, and their place in the LGBTQ+ community. I found this concept to rely heavily on history and biography thus, it is a socially constructed term that can vary from person to person based on their experiences with, or information about, the trans community. For example, a trans youth in conservative rural Iowa with limited resources and trans community is going to have a different understanding of the trans collective experience than a trans youth from San

Francisco with several resources and an established trans community because historical framing and resources vary based on location.

In a recent report, the Williams Institute estimates that about 1.4 million people in the US adult population identify as transgender (Flores, Brown, and Herman 2016). Engaging the transgender community in research allows researchers and policy makers to hear valuable narratives that can help ensure improved outcomes for marginalized populations in healthcare, as well as other areas (Reisner, Keatley, and Baral 2016) such as workplaces. Something as simple as using preferred gender pronouns, or gender-neutral pronouns, such as "they," might lessen stigma for transgender patients in healthcare setting because intentionally mis-gendering a trans person is a form of discrimination that is common and leaves them feeling disrespected.

Sociological scholarship has predominantly focused on the transgender community's "gender deviance" or "gender difference," as well as the discrimination they experience (Schilt and Lagos 2017). We know little about their experiences within the health care system and what might make trans-specific care more accessible. Even less is known about the factors that keep transgender people from utilizing health care services. However, existing evidence supports the integration of social services, which could improve the utilization of health care services (Lerner and Robles 2017) for this population.

Existing sociological and health sciences research focuses on the experiences of transgender people while receiving healthcare, however there is a critical knowledge gap in understanding the search processes and entry points to healthcare through primary care physicians (PCPs). Through qualitative methods, I aim to fill this gap by sharing the

unique voices and identities of transgender people and examining their experiences seeking PCPs. This research has the potential to inform positive health care practice implications for the transgender community and for other marginalized groups that experience similar health disparities.

Stigma and Discrimination

Discrimination can be generated by the negative attitudes of cisgender hetero-sexual people toward transgender people. Cisgender people have gender identities that match their sex-determined gender they were assigned at birth. Anti-transgender atti-tudes are widespread and associated with "higher levels of psychological authoritarian-ism, political conservatism, and anti-egalitarianism, and (for women) religiosity" (Norton and Herek 2013). Previously documented interactions experienced by patients based on race and socioeconomic status show that low-income minority sub groups of transgender men are at a higher risk of discrimination in health contexts (Smedley et al. 2003). Furthermore, transgender individuals often cope with discrimination in health harming ways (e.g., smoking, drugs, alcohol, and suicide attempts) (Miller and Grollman 2015). Such behaviors can cause an even greater need for regular health care, but they are more likely to avoid care because of anticipated stigma from care providers.

Transgender persons that plan to seek medical transition report higher rates of discomfort. However, pre-visit discomfort can be decreased when they perceive that the general practitioner has more trans-specific knowledge (Bauer et al. 2015). Delays in seeking healthcare are significantly associated with the fear of discrimination, even when controlling for provider exclusivity (Seelman et al. 2017). Medical professionals need to ensure that all areas of their practices are free of transgender discrimination (Wagner et al. 2016). This would help trans patients know that they can come without having to experience any negative attitudes or abuse in an unfamiliar healthcare setting.

Negative attitudes can also contribute to the discrimination experienced when they are receiving care, in the form of verbal and physical abuse. The National Transgender Discrimination Survey reports that over a quarter (28%) of respondents had experienced verbal abuse, and some (2%) even report physical abuse, in doctor's offices. Those that are unemployed, working in underground economies (i.e. sex work, drug sales), transitioning before the age of 18, and the undocumented are more vulnerable to attacks (Grant et al. 2010). Gender non-conforming individuals also experience a disproportionate amount of prejudice.

Gender Non-Conformity Prejudice. While gender nonconformity prejudice is often connected with antigay prejudice (Gordon and Meyer 2007), nonbinary trans individuals face even more discrimination that increase their likelihood of health-harming behaviors. This finding also sheds light on how gender nonconformity can greatly influence the social experiences and overall well-being of trans people (Miller and Grollman 2015). Despite the level of importance gender non conformity plays in the lives of trans patients, it relatively underexplored in current research. Cruz (2014) points to this deficit to propose the use of innovate care that would tailor each trans patient's healthcare experience to their own unique self-conceptualization. This is particularly important for younger trans individuals under the age of 35, who reported higher rates of discrimination in health care settings (Kattari and Hasche 2016), much of which involved providers not showing respect to the patient's gender identity.

Disrespect of Patient Gender Identity. Transgender people, similar to gender nonconforming people, do not always identify with the gender binary, but rather fall somewhere on a spectrum. If they wish to change their gender on forms of identification,

they are thus, challenging the institutional and bureaucratic systems that use sex as an identification marker. Such systems require bodily change to align with their desired identity sex markers, rather than changing their criteria for such identification (Currah and Moore 2009). Medical providers of both intersex and transgender patients follow the concept of "giving gender", or through "giving sex", or fulfilling desired gender expression through surgical intervention (Davis, Dewey, and Murphy 2016). This is another misconception that is a result of lack of information about the complexities of transgender identities. Transgender individuals may find it unnecessary to undergo certain surgeries to match their gender identities. They would rather embrace the complexities of their identities, thus resisting heteronormative ideas of categorization (McPhail 2004).

It is commonly assumed that transgender patients wish to undergo full surgical interventions to maintain the gender binary. Connell (2009) argues it might be more useful to think about transgender identity as a “change in historical process,” or a continuously changing rather than a fixed identity. This means that most medical providers report that successful interventions happen when patients abide by heteronormative gender archetypes (Davis et al. 2016). It is hard to say whether this is related to an alignment of identity or the binary, which would likely cause less tension in public settings. Some gender scholars beg the question of whether we actually need gender, stressing that binary sex categories are based on systems that punish those that stray from racialized hegemonic masculinity and femininity (Davis 2017). Protecting the individual choice of transgender people, no matter the intended outcome of their transition’s

journey, can allow them space and support to explore and form their own identities (Lo and Horton 2016).

Identity formation is influenced by the availability of resources, the ability to cope, as well as the perceived consequences of transition (Levitt and Ippolito 2014). In a study of transgender emotional and coping processes, Budge et al. (2013) found that despite the hardships transgender people experienced throughout the transition process, they feel that it was the best decision they could have made. Transgender patients report being mis-gendered by medical professional, being told that they were misdiagnosed as transgender, or even being made fun of. Transgender people also experience difficulty with insurance providers that deny coverage for gender-specific routine care that they need (i.e., transgender men that need pap smears or breast cancer screenings) (James et al. 2016:96). While some healthcare providers find ways around this predicament, many use it as an opportunity to refuse care without directing stating it is because of their discomfort with trans patients.

Providers that are less familiar with varied expressions of gender identity are more likely to exhibit stigmatizing attitudes toward transgender patients (Poteat, German, and Kerrigan 2013). Research also shows that increasing transgender visibility in dominant institutions, particularly in middle and high school, could promote earlier self-awareness and social acceptance (Austin 2016). Improving transgender curriculum and additional training for licensed professionals could not only ease the discomfort experienced by transgender patients, but the care providers as well, and reduce healthcare avoidance in trans patients.

Healthcare Avoidance. Gendered perspectives on healthcare and avoidance have been found to be rooted in gender beliefs and masculinities shared by both men and women (Himmelstein and Sanchez 2016). These are deep seeded beliefs that influence how and when people seek care. Such behaviors of avoidance are likely relating to insecurities and self-esteem. This has been exemplified in the Contingencies of Self-Worth (CSW) theory, in which one's successes and failure determine their self-worth and self-regulation (Crocker and Wolfe 2001). Masculinities also decrease healthcare seeking behavior in general (Calasanti 2004; Courtenay, Mccreary, and Merighi 2002; O'Brien, Hunt, and Hart 2005; Springer and Mouzon 2011). These gendered perspectives of healthcare avoidance are important to this research because transgender people, especially minorities, could be conflicted in their perception and utilization of these gendered norms and behaviors.

Marginalized communities that hold masculine ideologies are often mistrusting of the medical community, particularly minority male populations in the United States (Hammond 2010). This community has a particular need to be self-reliant to avoid dependence, which encourages healthcare provider distrust (Hammond et al. 2010). Black men who have sex with men experience even more distrust because they also anticipate stigma from healthcare providers on the basis of sexuality and perceived HIV status (Eaton et al. 2015). Similarly, transgender individuals also anticipate similar stigma in healthcare.

Provider Related Challenges

Insufficient Professional Training. Provider training is possibly one of the largest barriers to health care that transgender people face and few medical care providers are

willing to treat transgender people (Green 2016). After compiling a comprehensive review of transgender healthcare disparities, Redfern and Sinclair found that "health care providers can take a variety of practical steps in several key areas: office environment, registration forms, initial interview and assessment, confidentiality, personnel training, awareness of and compliance with applicable antidiscrimination legislation, health insurance-related issues, and outreach and transgender health promotion" (Redfern and Sinclair 2014:25). All of these steps could be implemented into standard care practices that are taught in the medical professional training institutions in order to improve these disparities.

Integrating transgender disparities in curriculum would allow increased awareness and provide the opportunity for students and providers to confront their own feelings about the transgender community (Mollon 2012). Healthcare professionals desire additional training in transgender-related care to address the lack of confidence they feel when treating transgender patients (Vance, Halpern-Felsher, and Rosenthal 2015; Moll et al. 2014). The nursing profession would also benefit from additional transgender training and licensure because they are working closely with patients on a daily basis (Kellett and Fitton 2017), especially if they are working in a facility that provides HRT services or other reproductive health services.

Complicated situations can arise when a patient is undergoing HRT but needs to receive another treatment at the same time. They may choose to decline any other medical interventions for unrelated illnesses for fear of having to cease their hormone treatments. There is also need for gender transition related care that also considers HIV status and treatment (Sevelius et al. 2014). Lack of training and understanding leads to

ambivalence and uncertainty when treating transgender patients, thus upsetting the balance of the patient-provider relationship The anticipation of having to educate health care providers significantly increases the likelihood of transgender patients will avoid or delay medical care (Jaffee, Shires, and Stroumsa 2016). Trans patients are also very aware of the importance of the legislation in relation to provider training and implementation.

A majority (86%) of the 2015 U.S Transgender Survey respondents feel that policies aimed at training healthcare providers about transgender health issues and care are very important (James et al. 2016). Healthcare deficits are further exacerbated by failure to make accommodations in sex-segregated healthcare, as well as a tendency to place too much focus on transgender status in psychological evaluations (Snelgrove et al. 2012). Diagnosis of the transgender population shapes how they view themselves as mentally disordered, as well as how healthcare professionals view their identity as disordered. This negative connotation could lead to them receiving less effect healthcare from providers.

Unethical Health Professionals. The American Public Health Association's code of ethics states that, "public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure the basic resources and conditions necessary for health are accessible to all" (Wang and Cahill 2018), thus, public health professionals have an obligation to oppose the threats to transgender health and access to care. Additional legal protections and health care provider training are crucial for the improvement of health outcomes for the transgender population (Bradford

et al. 2012). These protections regulate the acts of unethical healthcare professionals and have the potential to improve overall access to care.

For transgender patients, access to care can be influenced by the way the medical community frames and diagnoses them (Winter et al. 2016). Like most people seeking specialized medical care, they must first get a diagnosis from a PCP. The search process can be intimidating, and the diagnosis can be emotionally grueling because the medical community at large still frames transgender people as mentally disordered (Kreukels, Steensma, and Vries 2014: 172-174). However, the World Health Organization currently supports the discontinuation of this psychopathological model (Winter et al. 2016). These efforts have the potential to improve the lives of transgender people by improving their experiences in health care. It could also allow them more autonomy and control over the care that they seek and receive.

Lack of Access

High Cost. Cost is another major barrier for the transgender people when seeking health care. The 2015 U.S. Transgender Survey reports that about a third of respondents did not seek medical attention when they needed it in the past year because of cost, and even more common among transgender people of color (James et al. 2016:98). The cost of care can also be exacerbated by the lack of coverage for trans-specific care, which can vary by state based on the protections that are in place (Gorton and Grubb 2014). Rising medical costs and lack of coverage can seem even more stifling for transgender people in precarious financial situations, such as the unemployed or homeless, which disproportionately impact the transgender community (Grant et al. 2010). Issues of access and cost

can be further exacerbated when you also consider where a trans patient lives or where healthcare providers are more prevalent.

Geographic Location. Distance to LGBTQ+ friendly health care providers is another factor that can determine whether a transgender person seeks regular routine care. This includes counseling, hormone therapy, puberty blocking hormones, surgeries, or other procedures (James et al. 2016). Nearby health care providers are just one aspect of geographic location. Having nearby transgender communities is another issue that greatly impacts how transgender people seek health care. Most major cities often have community resource groups that can assist in the search process. Transgender people in rural areas are forced to seek care providers and other resources through online networks. They may still anticipate mistreatment from other patients or staff if they are able to locate a willing PCP nearby, which might influence their decision to show up to the appointment, thus added to issues of access to care.

A previous study by Abraham and colleagues (2011) explored the set of factors that cisgender consumers consider when selecting a primary care physician. They found that the most important factors for consumers were the physician's information and history, recommendations from informal sources (e.g. family, friends, coworkers), and physician recommendations. Factors that were less important to respondents included website information, physician personality, location, and physician specialty. This leads to the purpose of my study, which explores the search process to support the importance of these factors and understand the mechanisms in the process to better serve trans patients.

RESEARCH QUESTION

In this research, I aim to discover what might be driving general healthcare disparities within transgender communities. I will do this through the exploration of the decision making and selection processes that lead transgender individuals to a primary care physician. Research has demonstrated that the uncertainty of stigma and discrimination based on their own previous experiences, or the experiences of other members of their community, makes selection of a care provider more difficult than cisgender adults. Thus, my research question is: *How do the collective experiences of transgender persons shape individual perceptions and selection of primary care physicians?*

DATA & METHODS

For this exploratory study, I used qualitative methods to investigate how the collective experiences of transgender persons shape individual perceptions and selection of primary care physicians. After receiving approval from the Institutional Review Board at UNC Charlotte, I interviewed 10 transgender people from February 2019 to April 2019 about their experiences in searching for and receiving healthcare. I gained access to this particular group by volunteering at an LGBTQ+ youth center in a large southeastern city. By the time the study began, I had volunteered for eight months, in which time I was able to gain a deeper understanding of what the LGBTQ+ community experienced. I was able to become better acquainted with the directors of the youth center, thus using them as contacts to reach out to the local transgender support group and an LGBTQ+ caucus at a large state university, which is a group of faculty and staff who work toward inclusion and safety measure on campus. My commitment to the youth center increased my legitimacy with both groups and allowed me to make important connections with people that encouraged participation, which was vital to this process because of the delicate nature of the topic, trust was an important aspect to sampling and data collection (Feldman, Bell, and Berger 2003).

I used maximum variation sampling because I aimed to capture the central themes in the search process of a very specific group (Patton 1990). I sent a recruitment flyer to the LGBTQ+ caucus and they sent the flyer to the members on their email list-serve. This method produced three responses, but only I interviewed a total of two, one trans femme respondent and non-binary respondent. I attended one transgender support group meeting

where I intro-duce myself and my project to members of the group before the meeting began. I brought two transgender friends with me who had never been to the meeting before. We arrived two hours before the meeting to play board games with some of the members. I used this time to informally introduce myself to some of the members and talk about my volunteer work at the youth center.

After the meeting, several members approached me about meeting for an interview, which produced interviews with four trans women, and two non-binary members. Finally, I decided to use snowball sampling in order to locate two more respondents, both recommended by friends or acquaintances (Weiss 1995:51). I chose this method because I was no longer getting any responses from support group members or about the flyer that was sent to caucus members. Members of the LGBTQ+ commu-nity are difficult to recruit for participation in research studies because they have long been stigmatized (Sadler et al. 2010; Browne 2005; Gorbach et al. 2009). Face to face recruiting yielded the best response rate because I was able interact with participants, as well as express my desire to share their experiences through my research.

My data collecting methods consisted of a brief written survey and semi-structured interviews. The written survey comprised of basic demographic questions about age, race, gender, income, education level, and a few questions about health coverage. I also included a question about respondents' primary sources of information regarding health care which included: doctors, clinics, friends, online written forums, social media, YouTube, or books. They were able to select all that applied. I included a Likert scale that measured the trustworthiness on a scale of 1 (extremely untrustworthy) to 5 (extremely trustworthy) of all the same resources that were in the previous question.

The written surveys were followed by semi-structured interviews with questions about LGBTQ+ community involvement, past and present search processes, past experiences, avoidance of care, and suggestions for a better search process. (See appendix for data collection materials)

Table 1. Sample Demographics

Respondent Name	Age	Race	Gender	Pronouns	Insurance Source	Yearly Income	Highest Degree
Cleo	47	Black	Trans Femme	She/Her	Medicare	N/A	Some College
Sammie	26	White	Non-Binary	They/Them, He/Him	Employer	$14,000	Some College
Makena	27	Black	Trans Femme	She/Her	Employer	$15,000	Bachelor's
Kristin	47	White	Non-Binary	They/Them, She/Her	Medicare/VA	$20,000	Master's
Nora	54	White	Trans Femme	She/Her	Employer	$56,000	Master's
Julia	49	White	Trans Femme	She/Her	ACA	$50,000	Associate's
Evie	35	White	Non-Binary	They/Them, She/Her	Employer	$75,000	Bachelor's
Alexia	28	White	Trans Femme	She/Her	Uninsured	N/A	Some College
Peyton	22	White	Non-Binary	They/Them, He/Him	Uninsured	$35,000	Some College
Ike	23	White	Trans Masculine	He/Him, They/Them	Employer	$18,500	Bachelor's

I interviewed 10 transgender individuals, five of which were trans femme, four non-binary respondents, and one transmasculine. Respondents were between the ages of 22 and 54, six of which were under the age of 35, making it a fairly young sample. Eight of the respondents were white and two were black. Half of the sample received health care from their employer, however it was unclear how comprehensive that care was. Others responded that they received healthcare from other sources such as Medicare, Veteran's Affairs, and The Affordable Care Act (ACA). The most common income range was between $10,001 and $25,000, with only two respondents in the $50,001 to $75,000 range. The most common response for highest degree earned was "some college," while two respondents reported having master's degrees.

The interviews lasted between thirty minutes to one and a half hours and were recorded with an audio recording device. After transcription, I used the collected data to explore the emergent themes (Patton 1990:442) of the transgender individuals' search process for selecting healthcare providers. To achieve this I used an inductive analysis coding process on NVivo to narrow data to segments of text which became segments of information to create categories, labeled those segments into categories, then reduced overlap in the categories, and finally created a model incorporating the most important categories that depicted the search process (Thomas 2003). In my analysis, I also use the respondents' respective pronouns (she/he/they) based on their written survey response, thus "they" is an appropriate pronoun for non-binary respondents (Darr and Kibbey 2016). Pseudonyms were used to protect the identities of respondents.

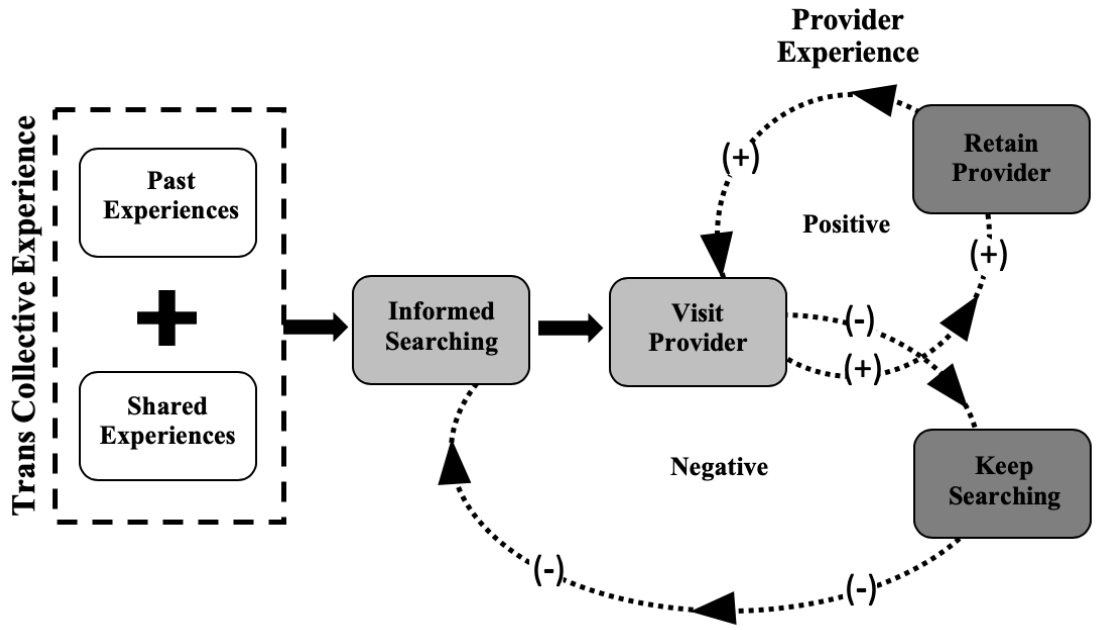
ANALYSIS

In their interviews, the respondents described a search process. The transgender search process is more complicated and influenced by specific needs and a sense of safety. The data show that the trans search process's first step was the trans collective experience where the individual's pre-transition experiences and the shared experiences of the LGBTQ+ and trans communities combine to inform their search process. Thus, the next step was informed searching where the respondents used the trans collective experience to determine what they were looking for from a healthcare provider. The following step was the provider visit which was followed by an assessment of the provider visit. The final step took place after their assessment where would decide to either select or reject the healthcare provider. The bulk of this process consists of preparing for a healthcare provider.

Preparing for a health provider visit is particularly important for a transgender person's experience because many transgender people experience gender dysphoria. Gender dysphoria is the severe distress that one can experience when their gender identity does not match their gender presentation (Erickson-Schroth 2014), is fairly common in the trans community and can cause anxiety and depression (Jackman et al. 2018; Kozee, Tylka, and Bauerband 2012). Often times it is something that must be diagnosed before patients can begin Hormone Replacement Therapy (HRT), which is used as a treatment for the disorder. Dysphoria, and the extent to which Trans patients experience it, can also influence not just how a Trans person searches for a doctor, but whether or not they receive HRT or surgical procedures. Because of this technicality, one's level of dysphoria is a determinate of their "transness," it causes a lot of debate in

the trans community and makes trans people uncertain about their trans identities, thus influencing their personal experiences in health care.

Figure 1. Transgender Provider Search Process



Trans Collective Experience

Throughout the interviews, respondents answered questions about past experiences, the experiences of others, and how they influence their search process, which is how the specifics of the trans collective experience surfaced. Most respondents searched multiple sources of information to get a sense of what to expect. This usually involved learning more about the local care providers, what they offer, what the cost might be, much like a typical new patient. However, unlike typical patients, they also had to consider the treatment they might expect from the provider and staff. Thus, the transgender search process began to surface. The importance of this information gathering process could not be understated. It allowed respondents to be prepared for any

pushback they may receive or to change providers if they feel that the doctor is avoiding care. This is exemplified with Kristin, a 47-year-old trans femme:

> I went in there armed to the teeth because I knew what I wanted. I had done a lot of research and I wasn't going to accept any less… you don't tell me what I'm going to do.

"Armed to the teeth" is a helpful way to think about this early step in the overall search process because it alludes to the armor that the respondents built around them before attempting to visit a care provider. This "armor" is formed through the historical framing of experiences in the LGBTQ+ and trans communities, shared experiences in their support networks, and their own experiences in similar settings. Because they anticipate stigma, their metaphorical armor not only helps shield them from and anticipated stigma and pushes them to find the courage to enter the health care provider space. The level of anticipated stigma, and the amount of armor needed, was shaped by the first part of the search process, which is the conceptualization of those past and shared, or trans collective experiences.

Pre-transition Experiences. Transition refers to the conscious decision to move forward with changes to gender presentation that match their gender identity and can include: changes is appearance, name change, hormone replacement therapy. It can be misunderstood by the general public and medical community because the narrative surrounding gender transition is usually focused on medical transition (Erickson-Schroth 2014:121). This was even more common when they spoke of their experiences in offices of providers they had regularly visited before beginning transition[1]. Often, the

[1] Transition refers to the conscious decision to move forward with changes to gender presentation that match their gender identity and can include: changes is appearance, name change, hormone replacement therapy. It can be misunderstood by the general public and medical community because the narrative surrounding gender transition is usually focused on medical transition (Erickson-Schroth 2014:121).

appointments system and paperwork will have their birth name on them, so the respondents had to request that the front desk staff to correct them about their preferred name and pronouns. Peyton, a 22-year-old non-binary adult, experienced this after "coming out[2]" to the front desk staff at their family's primary care doctor. Peyton explains:

> I went, "Hey listen, stop calling me by my birth name in the waiting room, this is shitty. You guys are shitty." And got my prescription refilled. Then sure enough, I was supposed to have a follow-up appointment the next week...When I walked in, they were just like, "Yeah, by the way, we're good. You're good, we're good."

Peyton's vexed tone implied that "we're good" actually means "we're finished here," thus ending Peyton's time with that care provider. This aligned with an experience that Peyton's trans friend experienced at the same provider where they were asked to find a new provider on the grounds of aging out of the practice. Peyton clarified that the care provider was a family doctor, not a pediatrician, thus making the provider's reasoning invalid. Merely asking the office staff to respect their desired name and pronouns was enough to be rejected from the practice. Much of the data show that trans patients have experienced the incorrect use of pronouns and "dead naming[3]," or the use of the name they were given at birth. Paperwork and medical records in healthcare systems are not set up to allow seamless name changes to occur even though name changes are common. For instance, it is an Americanized norm for women to change their last names when married. When transgender people change their names, the reaction from others is different and

---

[2] "Coming out" is a term used in the LGBTQ+ community that refers to an individual disclosing the status of their gender or sexuality (Hunter 2012).
[3] The use of the name a Trans person was given at birth and can cause physical and emotional distress.

extremely problematic for trans patients. These micro-aggressions act as subtle hints and reminders that trans people do not fit into the standard medical space from the moment they enter and go to the reception desk (Johnson 2014). Peyton's experience with their family doctor after coming out is an excellent example of micro-aggressions that happen in medical care settings.

On the other hand, it is also possible for care providers and their staff to be too enthusiastic about the patient's medical transition which can also lead to negative experiences. Some of the respondents reported feeling uncomfortable when medical staff or providers expressed enthusiasm about their transition, whether that be words of encouragement or pressing the patient to move faster in the process than they are ready to. The data show that there can be multiple reasons for this discomfort or hesitance to expedite the transition process such as housing insecurities, financial constraints, interpersonal relationships, or job status. For instance, in 27-year-old trans femme Makena's experience, she was expecting push back from the care provider and was happy to find that they weren't trying to stop her from transitioning, but was taken aback by the perceived over excitement on the part of the care provider and their staff:

> My cynicism about the process was kind of abated…They're not trying to stop this process from happening…It was weird cause they seemed like some of the people I talked to were like, like more excited about it than I was.

Several respondents expressed the desire to pursue their transition at their own pace and did not feel comfortable with doctors or staff pressuring them to undergo surgical procedures that they did not request information on. This was particularly common in non-binary respondents that do not feel that it is necessary to fully commit to binary gender ideals.

Despite stories like Peyton and Makena's, there are trans positive medical settings where trans identities were not only respected but celebrated. Sammie shared a positive experience that they had with a cosmetic surgeon:

> Part of the reason I went was because she actually developed her own method of doing top surgery[4]…I was like, well damn this lady knows what she's doing. Everyone who's seen her seems to be pretty happy and [the staff] were so friendly. That was actually a really good healthcare experience that I had.

Sammie's experience was greatly improved by the positive atmosphere, excellent reviews, the presence of affirming care and members of the trans community on staff. Trans representation in the office itself could have an influence on the patients, other members of staff, and the care providers in that office through exposure and normalization. Their positive experience later influenced how they would search for care providers.

Shared Experiences. The shared experiences of the trans community involve a historical framing of not only their own individual experiences, but those of other trans people. Shared experiences are narratives or events that the individual has seen or heard in the media or within the LGBTQ+ and trans communities. For instance, Cleo, a 47-year-old trans femme, recalled a news story that she saw over 20 years ago about the health department releasing the classified information of gay and transgender patients. This remained with her and not only influenced her distrust of healthcare providers, it also caused her to avoid seeking medical care for an infection that could have killed her had her mother not forced her to go to the emergency room. Cleo's mother is a member

[4] Top surgery is a term used in the transgender community that refers to the surgical removal or reconstruction of one's breasts to look more masculine.

of her informal network (friends, family, or online connections) that provided information and support.

My data show that formal networks consisted of counselors, trans friendly health professionals, support groups, and health care alliances. Because they consisted of more legitimized resources in the trans and medical communities, they were able to exacerbate considerable amounts of uncertainty. Fear of rejection and physical and emotional safety pervade the day-to-day lives of trans people and shape the way that they conceptualize the ability to go from place to place. Julia explains:

> I live in fear constantly from moment I leave my house…There is no safe space out there. The things that a cis person would take for granted are terrifying for people like me.

This constant concern of their physical safety influences their thoughts and decisions that they make in nearly every setting, but even more so in a medical setting because of the intimate nature of health care.

Having a formal network that includes counselors and healthcare providers that have experience in the trans and LGBTQ+ communities positively influence their effectiveness. Shared experiences are not exclusively used to alert trans people to the dangers of the outside world, but to help others feel validated in their own trans experiences. When Ike, a 23-year-old non-binary respondent, was asked about the importance of sharing experiences with others, they responded that "reaching out to other individuals and sharing your own stories…validates everything that you're feeling to some degree." Trans people are able to see what is possible for them through the experiences of others and learn more about the search process so that they can make informed decisions with more confidence than before.

Informed Searching

The first step in the search process is, "informed searching," where the individuals have more information about the trans collective experience which helps them know what to look for, what to avoid, and what kind of care they will need to achieve their desired results. My data show this part of the search process relies heavily on counselor recommendations, online resources, and word of mouth.

Counselor Recommendations. Using counselors as a trusted source is another common theme because most respondents were already seeking mental health care from professional counselors in order to address their uncertainty about their gender identity or to get clearance to receive HRT. Because of the tedious and often traumatizing transition process, many trans individuals use this key member of their formal network to access the counselor's network in order to find a doctor that also shares the counselor's understanding and participation in the trans community. Alexia explains the process:

> I was looking for someone who had a reputation in the community, which was more important to me than getting an immediate appointment. [My counselor] helped me work through several things because it took about six months of me seeing her before I finally got the recommendation to my current primary care provider.

Alexia's account of using her counselor as a resource showed the importance of that open participation in the trans and LGBTQ+ communities. When respondents spoke of care providers, many respondents noted an uncertainty about whether the providers were "for me or against me." Several also expressed a desire to have some indication that the care providers understand to the experiences of the trans community, in particular.

Online Resources. Web based search resources was an important tool in this informed searching process, particularly Google, where one respondent mentioned entering "LGBTQ+ therapist" and expand the search radius by 50 miles just to find someone who specialized in non-binary care. These resources allowed people to search a wide area, but also seek information safely and anonymously. For Makena, seeking help and information through web-based forums was the safest route to find the care that she needed because she was not "out" at the time of her initial search process. Online searching allowed her to search for information anonymously and safely. She was relatively young and did not see a primary care physician on a regular basis. In fact, her family doctor that she saw as a teen and in her early twenties was located in another town that was too far for regular visits. Makena's limited experience in searching for doctors led her to more public resources, like her insurance provider's search engine. Using this open resource, she was able to see which doctors provided hormone therapy, but little more beyond that:

> Things were coming up indicating "This place does hormone therapy." There wasn't [any] indication of "This is trans friendly." I felt like it was kind of a shot in the dark.

Online written forums are another important source of information for the respondents in this sample and nearly all (90%) selected them as a primary source of information in the written survey that was completed before interviews took place. Reddit, a website with specific trans topic groups that respondents used, was by far the most popular online forum. However, many also referenced blog sites like Tumblr and The Odyssey, which were used to share experiences and locate information about available resources. The blog sites operated a little differently that the discussion website

based on level of interaction. Reddit users often used this forum to make connections, as well as ask and answer questions. The blog sites were used to express feelings and share experiences with readers, with little expectation of interaction between content producer and consumer.

Most respondents mentioned the local trans health alliance and Planned Parenthood when we spoke about online resources. Though these resources are not exclusively web-based, many respondents said that they went to these websites seeking information about options and services that are offered locally. As a veteran, Kristin was even able locate information through the healthcare alliance about who she could contact at Veteran's Affairs (VA):

> I came across the Transgender Healthcare website and one of the contacts was the director of the LGBT clinic at the VA. So, I thought, what the hell. So, I sent him an email and told him my situation and said again, you know, I'm doing this one way or the other.

Thanks to the trans healthcare alliance website, she was able to make contact with someone inside an institution that she thought to be anti-trans and was able to receive the help that she needed to pursue HRT using her VA benefits, which is extremely helpful to someone on disability (heart failure) with limited funds.

Word of Mouth. The most popular form of search resource in the informed searching step was word of mouth recommendations. While it was similar to counselor recommendations, the scope extended beyond the counselor's networks to the networks of those in the respondents' local support networks. These local support networks include friends, schoolmates, and fellow members of trans support groups that meet in person. Trans femme Nora, 54, shared her feelings on the significance of these networks:

> I will take word of mouth for anything. Over a review online, over a website over, over an ad, over anything…If somebody else has seen or talked to [a doctor], I will always take that as the number one thing to go with.

The importance of these recommendations cannot be overstated because they allow others in the same group to signal to others their good and bad experiences with care providers. Another respondent, non-binary 35-year-old Evie, shared with their trans friends that Dr. Williams, their longtime primary care doctor, was performing breast exams at every visit. Evie's friends did not receive that same screening at every doctor's visit, so this was a red flag for Evie. They now perceive this screening procedure as out of the ordinary and a physical violation because their friends did not experience the same screening. They trusted their friends and quickly began looking for a new care provider that would not violate them during each visit. Without their connectedness to other trans people, they might have experienced much worse abuse from this formerly trusted care provider who was supposed to be helping her.

These recommendations are likely more salient to other members because of the originator's involvement in the trans community and it is understood that they have nothing to gain from misinformation. There is also, as we've seen, an understood sense of collective care in the trans respondents where members of the trans community look out for the well-being of other members' physical and emotional safety. Alexia talks about her own experience with recommendations:

> I got several recommendations for Dr. Blair and then I've heard about Dr. Williams, I got several recommendations to avoid Dr. Williams. I believe he sexually assaulted two trans women that I know who went to him. And, I've heard that he likes to push surgical procedures as well. And both of my friends who saw him had no interest in surgical procedures.

For Alexia, this sense of collective care in her friend group allowed her to feel more confident in her decision to see Dr. Blair and avoid the physical and emotional harm that might have had with Dr. Williams. These recommendations are more reliable in that the provider is unable to manipulate them in any way. If they were online reviews, which all of his were very positive, he might have been able to have the review site's administrators remove any negative comments or incriminating information. But with word of mouth, he has no way to control that beyond any possible legal agreements that might have been reached in legal proceedings, which in this case happened out of court, thus making word of mouth recommendations even more important to the trans community.

Visit Provider

After informed searching, another step in the search process surfaced that involved actually visiting the care provider for an appointment if they had passed all of the checkpoints thus far. This was a riskier step for respondent, so it is important that they were diligent in the informed searching part of their process to avoid any physical or emotional harm that might happen, leading some to perform small tests with the reception staff. Peyton shared some of the methods that they use when visiting a new provider:

> I definitely will test the waters first. [I'll] either let the receptionist know "Hey, this isn't my name. I know this is what's on my driver's license, but this isn't the name that I go by." If they're inquisitive about it, I kind of test it from there…Until you walk into it there's not a way to know… You're walking into a lion's den because you really don't know.

The front desk staff was just as important to the search process and a fairly good indicator of the care provider's trans positivity. The best providers had adequately trained their

front desk staff on how to handle names and pronouns that do not match a patient's identification or previous paperwork, and most respondents were very intentional in informing the providers of this change in information.

Another important test that respondents utilized was reading the body language and comfort level of the care provider in the appointment. Some of them mentioned the importance of rapport, "spirit," or ease in discussing more sensitive topics. There was also a prevalent desire to have a care provider who does not sugar coat needed information. This all collectively signals a need for care providers who are willing and capable of being at ease with the trans community as well as having the necessary knowledge of their specific needs so that patients do not feel as though they are constantly educating their care provider, which was exhausting for patients and did not instill confidence in the provider's abilities.

Assessing Experiences with Provider

It could be assumed that the previous step, visiting a provider, was the end of the search process. However, in my data, assessing their experience with a provider emerged as a pivotal step within the process. This less obvious step often occurred after their initial visit with a provider and involved weighing the positives and negatives of their interactions with the care provider to determine selection and prolonged care. It should be noted that positive and negative experiences are not mutually exclusive and can counteract one another at any given time based on the level at which the individual measures the experiences, or perceived obstacles. Obstacles are considered to be any aspects of the care provider's practice that might keep trans patients from moving forward with care and fluctuate based on a patient's level of tolerance for each obstacle.

Three major obstacles surfaced in the interviews: distance, limited information, and respect of identity.

Distance. Accessibility was an issue that frequently surfaced in the interviews. The most common sentiment was that respondents were aware of good doctors, but they were all so far away, some even being in completely different states. Even more so with doctors that worked in informed consent clinics, where patients are required to sign a release form in order to receive HRT or surgical procedure without a prescription or referral from a mental health practitioner. Informed consent clinics are controversial because they stray from the traditional medical model of trans health care, but highly sought by trans patients because they give patients more agency in their medical transition process.

Sammie (non-binary, 26) describes how distance acts as a barrier for trans patients that work in industries with little to no paid time off to travel to and from on a regular basis:

> I don't know a ton about looking for doctors. I haven't really had that experience before. So, I [found] one that's not too far away from me. I can go to an office that I don't have to drive a million hours to.

For someone with little experience searching for doctors, choosing a doctor that was just on the other side of the city was a gamble. Distance was further complicated by precarious schedules for those who worked in a retail or service industry setting that still required them to be present most days of the week. Many even considered the financial and logistical aspects involved in using the pharmacy located at the doctor's office because they were more affordable. Using a pharmacy at the doctor's office made sense

at the time of their appointments but became cumbersome and risky when considering the long-term aspects of maintaining HRT.

Limited Information. A lack of available information was another common theme in regard to barriers in the search process. Most report having struggled to discern if they can expect discrimination from a doctor based on the limited information available on online provider profiles. Some common observations were that profiles had very little in the way of LGBTQIA+ care, let alone trans specific care, or even profile photos. It was also common for profiles to be outdated, or completely incorrect, like Evie's search experience using local resources to find care just a decade ago:

> I tried to look [care providers] up using the counselors [I had seen] …But back then it was two people and one of them no longer took clients and had retired. And the other one was not a doctor but a weight loss clinic.

While resources for information has improved since the early 2000s, there was still a very common occurrence of there being outdated information, limited provider options, and limited space for new patients. Those that were able to get through to a local doctor were usually put on a waiting list for up to several months, which shows a gross lack of providers who work with transgender patients. It was unclear if this shortage was due to unwillingness or lack of training in trans specific healthcare practices.

Respect of Identity. A great deal of the data show that many patients have experienced the incorrect use of pronouns and dead naming. These microaggressions acted as subtle hints and reminders that trans people did not fit into the standard medical space. These could happen by accident or due to a lack of training, which can be distressing but excusable. But when it happens on purpose and with complete disregard

for the respondents' requests to be referred to by their chosen name and pronouns, it causes distress and frustration, which Peyton shared in their interview:

> Honestly, it's a really annoying process…The simplest things become so difficult because people choose not to accept your identity…Telling [them] that I'm queer and trans and I use they/them pronouns, it doesn't affect [them]. So, there's really no reason for [them] to have an opinion about it.

Most of the other respondents also expressed some form of frustration with the process of correcting others about their names and pronouns. Also, to their point, while it can be difficult for people to adapt to using "they/them" pronouns in place of the traditional binary pronouns, it is important to try to respect their identities.

Kristin's experience with her provider shows the power of self-advocacy and performing preliminary research in order to improve the chances of a positive experience in care provider's office. She had been previously diagnosed with Congestive Heart Failure and considered to be terminally ill. Her prognosis pushed her to be more aggressive with her approach to transition. But because of her illness, she also needed to be prepared to explain exactly what she wanted to improve the chances of a positive experience. Kristin explained what her first interaction with her current doctor was like:

> My attitude was literally [to the doctor] "I can't die as a dude… Here's what current bleeding edge research shows to be safe. You're going to put me right here in terms of levels and that's how we're going to do it." I had a little bit of pushback about the level…They acquiesced about halfway between what they usually consider their ceiling and what I wanted. They have been very good with me, but they haven't been perfect.

Kristin was able to use the knowledge she gained from informed searching to improve her overall experience despite the care provider not "being perfect" with her. Many respondents provided similar statements that clearly depict an ability to still have a

positive experience with a provider even if the provider isn't "perfect," but is at least trying to help them to make the best choices.

Selection or Rejection

The final step in the search process was the decision to either select or reject the healthcare provider based on how the provider's ability to pass or fail the obstacles portion of the process. Assessment of the obstacles that a care provider presented worked like a sliding scale where positive aspects had the ability to counter the negative aspects, thus allowing the trans patient to overlook some negative qualities or experiences in order to receive care. However, if the respondents' experienced the bad rather than good, depending on the level of trauma the poor treatment caused, they choose to reject the care provider and go back to informed searching.

Selection of Provider. Nora's experience depicted this process in a clear way. Nora first began HRT in her home state in the northeast where she finally managed to find a care provider through the informed searching process:

> My [first] endocrinologist had me on super low doses and was not convinced that my counselor was correct in diagnosing me, he was a real jerk. But he was the guy to go to.

For Nora, options were limited, and she was willing to overlook the care provider's insults because based on her informed searching, he was the "guy to go to." This also speaks to Nora's reliance on word of mouth recommendation, even over her own experiences with the doctor.

However, when Nora moved south, she was able to make a change in care provider, so she began the search process with informed searching. She used her experiences with her previous doctor to adjust her perception of what obstacles she was

willing to overlook and what was unacceptable. When Nora located Dr. Williams, she was extremely impressed with the way that he affirmed her identity and that he was willing to increase her hormone levels to produce more physical change. However, it was not long before Nora experienced major chest pains and was taken to the hospital where they found bilateral blood clots in both lungs:

> I got on the pills and Dr. Williams wasn't monitoring me closely …so [the hospital] took me off estrogen.

This was a huge blow to Nora's process, and she mentioned feelings of despair and hopelessness when asked about not being able to move forward with her transition due to health problems. She never spoke poorly of Dr. Williams' methods, but casually mentioned that Dr. Williams had seen this happen in several patients and switched her to injections to avoid further clots. Nora still sees Dr. Williams, despite the major medical issues that were cause by his limited monitoring. It's as if Dr. Williams' affirmation of her identity and willingness to be aggressive with HRT treatment outweighed the threat to life that his lack of monitoring produced. These examples illustrate how important it is for a trans patient's identity is to them and how this can influence the obstacles they will tolerate in a health care setting.

Rejection of Provider. It is important to note that Dr. Williams is also the doctor that Evie mentioned in their interview that was giving them unnecessary breast exams at each visit. Evie was not unhappy with the care that they were receiving. They tolerated his odd behavior and pressure to pursue surgical options because Dr. Williams was one of the only doctors in the area willing to accept trans patients. Limited options and previous experiences of rejected by care providers can influence one's level of tolerance. Once Evie was made aware that the breast exams they received were not normal routine care,

they made the decision to reject Dr. Williams and sought word of mouth recommendations to avoid another abusive care provider.

Again, Evie was willing to tolerate some of the things that Dr. Williams did that made them uncomfortable because they needed care. They were also inexperienced in dealing with care providers when it came to trans specific care, which left them vulnerable to sexual abuse at the hands of their doctor. This illustrates how sense of physical and emotional safety pervades the selection process for trans patients. They quickly become intolerant of the obstacles that were previously tolerable and reject the care provider, thus returning to the informed searching step of the process to seek a new healthcare provider.

The transgender search process is complex and relies heavily on the historical framing of the LGBTQ+ and transgender communities, as well as the past experiences of the individual. While it is certainly more complicated than an able-bodied cisgender person's process, it can be improved by the use of formal and informal networks. The available resources also provide a little help in making the process less triggering for those with gender dysphoria that can interfere with their day to day lives. However, available information is sometimes difficult to find and even more difficult to discern if it is credible. All of these things combined exemplify the transgender search process.

DISCUSSION

For this exploratory study, I identified the trans collective experience through the investigation of search processes for primary care physicians. My findings indicate that the trans collective experience influences the search and selection process through informing their search methods, as well as what constitutes a good or bad visit with a provider. A specific search process surfaced in the data that consisted of the following elements: utilizing trans collective experiences, informed searching, visiting a provider, and selection or rejection. Another important element of this process was how an individual's experience with a provider can either initiate selection or force the individual to return to informed searching. Most respondents reported that they considered the doctors that they see for transition related care to also be their primary care physician because they either did not want to look for a separate doctor, they could not afford another doctor, or they preferred their level of trust with their current provider.

Previous research shows that the transgender population experiences disproportionate levels of discrimination, including refusal of healthcare (Grant et al. 2010), stigma that limits access to healthcare (White Hughto et al. 2015), and financial limitations (James et al. 2016). Much of the research has merely focused on transgender experiences in healthcare settings, but this leaves out a large portion of the trans community that does not seek care. The themes previously mentioned pervade the trans community and shape individual perspectives that influence decision making, hence the trans collective experience. The trans collective experience is a large part of what makes the transgender search process so unique. Understanding the search process of transgender individuals can help creators of search resources better serve the community,

inform care providers how to reach and retain trans patients, and it can also inform policy for improving the lives in the trans community. Knowing this also helps us better understand the search process so that we can see the hindering factors more clearly,

With this research I have contributed to the transgender health and sociological literature through examining the search process for primary healthcare providers, which is an important aspect in addressing inequality in the healthcare system for transgender individuals. The data also led me to find a link between previous research on bounded communities and the importance of authenticity, where limited access to resources or benefits affect how members evaluate moral character in the actions of others (Reilly 2018). For the transgender community, membership and participation in the trans community is paramount, but perceived authenticity of a care provider is shaped by their experiences with a specific care provider.

As with all exploratory studies, there are limitations to address. A small sample size and lack of minority respondents narrows the scope of racialized experiences for trans respondents, which is likely an important intersection of stigma for trans individuals. I aimed to recruit more transmasculine respondents but two of the non-binary respondents were masculine presenting, which can be similarly assessed to the trans-masculine experience. This small sample population also makes it more difficult to make assessments about the population, particularly with this sample because it lacked trans-masculine. However, it doesn't invalidate the experiences of those participants. Location is also limited to a large southeastern city, which could be shaping the narratives of anticipated stigma and negative care provider experiences. The South is notorious for

having negative feelings towards the LGBTQ+ community as well as more conservative viewpoints and policy, which infiltrate the treatment they receive in their day to day lives.

However, despite limitations, the research is valuable because the basis of the transgender search process is still useful in understanding how transgender people make decisions in selecting healthcare providers and how they conceptualize and minimize anticipated stigma. Beyond transgender research, the concepts of specific collective experiences and search processes can be used in other marginalized populations to determine their access and retention in healthcare, which could positively impact rates of preventative care and ease the burden on emergent care. It could also apply beyond the scope of healthcare to other institutions such as workplaces and educational or legal institutions.

As the previous literature shows, transgender patients have different priorities than cisgender patients when selecting a primary care provider. They find online resource, distance, personality, and physician specialty to be of great importance and fertile grounds for research. According to Safer and colleagues (2016:3), “future research should determine knowledge and biases of the medical work force across the spectrum of medical training with regard to transgender medical care; adequacy of sufficient providers for the care required, larger social barriers and status of a framework to pay for appropriate care," as well as proposals and validation of potential solutions for gaps. The framework that emerged from this research can be used to improve resources for the trans community and to inform doctors and other healthcare professionals how to better serve the trans community. This framework could also benefit other invisible populations that

experience stigma in healthcare settings, thus highlighting the broader implications of this research and the impact it could have on policy and practice.

Structural changes need to be made in the medical field and prior research supports that consideration of implicit biases can have a positive impact on policy formation (Nosek and Riskind 2012), which would then influences standardized care across the medical field that would improve the experiences of trans patients. The data showed that changing intake forms and record keeping systems to be more inclusive of chosen names and pronouns to be of utmost importance to trans patients. Training and establishing standardized practices for healthcare providers and their staff would also help familiarize them with the needs of trans patients and allow them the opportunity to become more comfortable with the trans population, thus effecting change on the individual level. Boyer and Lutfey (2010) also suggested that rebuilding the primary care sector with a "sociologically informed strategy" could not only improve healthcare delivery, but patient outcomes as well.

In my future research, I aim to expand sample size and recruit respondents from more varied age and racial categories to get a clearer picture of how historical context and racial stigma could be influencing the search process. Recruiting from other regions could also give a clearer picture of how accessible resources and political framing could be influencing stigma and the search process. Another avenue of research that would be interesting in relation to the search process and access to resources would be the transgender community's cultural participation in different institutions. There is much to be explored in sociology and health fields in regard to the transgender community. All of

which can shed light on our gender beliefs, as well as how marginalized groups perceive stigma and participate in search processes.

REFERENCES

Abraham, Jean. 2011. “Selecting a Provider: What Factors Influence Patients’ Decision Making?” *JOURNAL OF HEALTHCARE MANAGEMENT*:17.

Allen, Heidi, Bill J. Wright, Kristin Harding, and Lauren Broffman. 2014. “The Role of Stigma in Access to Health Care for the Poor.” *The Milbank Quarterly* 92(2):289–318.

Austin, Ashley. 2016. “‘There I Am’: A Grounded Theory Study of Young Adults Navigating a Transgender or Gender Nonconforming Identity within a Context of Oppression and Invisibility.” *Sex Roles* 75(5–6):215–30.

Bauer, Greta R., Xuchen Zong, Ayden I. Scheim, Rebecca Hammond, and Amardeep Thind. 2015. “Factors Impacting Transgender Patients’ Discomfort with Their Family Physicians: A Respondent-Driven Sampling Survey” edited by J. L. Clark. *PLOS ONE* 10(12):e0145046.

Blumer, Herbert. 1986. *Symbolic Interactionism: Perspective and Method*. University of California Press.

Boyer, Carol A. and Karen E. Lutfey. 2010. “Examining Critical Health Policy Issues within and beyond the Clinical Encounter: Patient-Provider Relationships and Help-Seeking Behaviors.” *Journal of Health and Social Behavior* 51(1):S80–93.

Bradford, Judith, Sari L. Reisner, Julie A. Honnold, and Jessica Xavier. 2012. “Experiences of Transgender-Related Discrimination and Implications for Health: Results From the Virginia Transgender Health Initiative Study.” *American Journal of Public Health* 103(10):1820–29.

Browne, Kath. 2005. “Snowball Sampling: Using Social Networks to Research Non-heterosexual Women.” *International Journal of Social Research Methodology* 8(1):47–60.

Budge, Stephanie L., Sabra L. Katz-Wise, Esther N. Tebbe, Kimberly A. S. Howard, Carrie L. Schneider, and Adriana Rodriguez. 2013. “Transgender Emotional and Coping Processes: Facilitative and Avoidant Coping Throughout Gender Transitioning.” *The Counseling Psychologist* 41(4):601–47.

Calasanti, Toni. 2004. “Feminist Gerontology and Old Men.” *The Journals of Gerontology: Series B* 59(6):S305–14.

Connell, Raewyn. 2009. *Gender: Short Introductions*. Malden, M.A.: Blackwell.

Courtenay, Will H., Donald R. Mccreary, and Joseph R. Merighi. 2002. “Gender and Ethnic Differences in Health Beliefs and Behaviors.” *Journal of Health Psychology* 7(3):219–31.

Crocker, Jennifer and Connie T. Wolfe. 2001. “Contingencies of Self-Worth.” *Psychological Review* 108(3):593–623.

Currah, Paisley and Lisa J. Moore. 2009. “‘We Won’t Know Who You Are’: Contesting Sex Designations in New York City Birth Certificates.” *Hypatia* 24(3):113–35.

Darr, Brandon and Tyler Kibbey. 2016. “Pronouns and Thoughts on Neutrality: Gender Concerns in Modern Grammar.” *Pursuit - The Journal of Undergraduate Research at the University of Tennessee* 7(1).

Davis, Georgiann, Jodie M. Dewey, and Erin L. Murphy. 2016. “Giving Sex: Deconstructing Intersex and Trans Medicalization Practices.” *Gender & Society* 30(3):490–514.

Davis, Heath Fogg. 2017. *Beyond Trans: Does Gender Matter?* NYU Press.

Earnshaw, Valerie A. and Diane M. Quinn. 2012. “The Impact of Stigma in Healthcare on People Living with Chronic Illnesses.” *Journal of Health Psychology* 17(2):157–68.

Eaton, Lisa A., Daniel D. Driffin, Christopher Kegler, Harlan Smith, Christopher Conway-Washington, Denise White, and Chauncey Cherry. 2015. “The Role of Stigma and Medical Mistrust in the Routine Health Care Engagement of Black Men Who Have Sex With Men.” *American Journal of Public Health* 105(2):e75–82.

Erickson-Schroth, Laura. 2014. *Trans Bodies, Trans Selves: A Resource for the Transgender Community*. Oxford University Press.

Feldman, Martha S., Jeannine Bell, and Michele Tracy Berger. 2003. *Gaining Access: A Practical and Theoretical Guide for Qualitative Researchers*. Rowman Altamira.

Flores, Andrew R., Taylor N. T. Brown, and Jody L. Herman. 2016. “RACE AND ETHNICITY OF ADULTS WHO IDENTIFY AS TRANSGENDER IN THE UNITED STATES.” 15.

Goffman, Erving. 2009. *Stigma: Notes on the Management of Spoiled Identity*. Simon and Schuster.

Gorbach, Pamina M., Ryan Murphy, Robert E. Weiss, Christopher Hucks-Ortiz, and Steven Shoptaw. 2009. “Bridging Sexual Boundaries: Men Who Have Sex with Men and Women in a Street-Based Sample in Los Angeles.” *Journal of Urban Health* 86(1):63–76.

Gordon, Allegra R. and Ilan H. Meyer. 2007. “Gender Nonconformity as a Target of Prejudice, Discrimination, and Violence Against LGB Individuals.” *Journal of LGBT Health Research* 3(3):55–71.

Gorton, Nick and Hilary Maia Grubb. 2014. “General, Sexual, and Reproductive Health.” in *Trans Bodies, Trans Selves: A Resource for the Transgender Community*. Oxford University Press.

Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jody L. Herman, Jack Harrison, and Mara Keisling. 2010. *National Transgender Discrimination Survey Report on Health and Health Care: Findings of a Study by the National Center for Transgender Equality and the National Gay and Lesbian Task Force*. National Center for Transgender Equality.

Green, Jamison. 2016. “Transgender: Why Should We Care?” *The Lancet* 388(10042):334–35.

Hammond, Wizdom Powell. 2010. “Psychosocial Correlates of Medical Mistrust Among African American Men.” *American Journal of Community Psychology* 45(1–2):87–106.

Hammond, Wizdom Powell, Derrick Matthews, Dinushika Mohottige, Amma Agyemang, and Giselle Corbie-Smith. 2010. “Masculinity, Medical Mistrust, and Preventive Health Services Delays Among Community-Dwelling African-American Men.” *Journal of General Internal Medicine* 25(12):1300–1308.

Henriques, Gabriel. 2014. “In Search of Collective Experience and Meaning: A Transcendental Phenomenological Methodology for Organizational Research.” *Human Studies* 37(4):451–68.

Himmelstein, Mary S. and Diana T. Sanchez. 2016. “Masculinity Impediments: Internalized Masculinity Contributes to Healthcare Avoidance in Men and Women.” *Journal of Health Psychology* 21(7):1283–92.

Hunter, Ski. 2012. *Coming Out and Disclosures: LGBT Persons Across the Life Span*. 1st ed. Routledge.

Jackman, Kasey B., Curtis Dolezal, Bruce Levin, Judy C. Honig, and Walter O. Bockting. 2018. “Stigma, Gender Dysphoria, and Nonsuicidal Self-Injury in a Community Sample of Transgender Individuals.” *Psychiatry Research* 269:602–9.

Jaffee, Kim D., Deirdre A. Shires, and Daphna Stroumsa. 2016. “Discrimination and Delayed Health Care Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery.” *Medical Care* 54(11):1010–16.

James, Sandy E., Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma’ayan Anafi. 2016. *The Report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality.

Johnson, Daniel Ervin. 2014. *Impact of Microaggressions in Therapy on Transgender and Gender-Nonconforming Clients: A Concurrent Nested Design Study*.

Kattari, Shanna K. and Leslie Hasche. 2016. "Differences Across Age Groups in Transgender and Gender Non-Conforming People's Experiences of Health Care Discrimination, Harassment, and Victimization." *Journal of Aging and Health* 28(2):285–306.

Kellett, Peter and Chantelle Fitton. 2017. "Supporting Transvisibility and Gender Diversity in Nursing Practice and Education: Embracing Cultural Safety." *Nursing Inquiry* 24(1):e12146.

Kozee, Holly B., Tracy L. Tylka, and L. Andrew Bauerband. 2012. "Measuring Transgender Individuals' Comfort With Gender Identity and Appearance: Development and Validation of the Transgender Congruence Scale." *Psychology of Women Quarterly* 36(2):179–96.

Kreukels, Baudewijntje P. C., Thomas D. Steensma, and Annelou L. C. de Vries, eds. 2014. *Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge*. New York ; Heidelberg: Springer.

Lerner, Justin E. and Gabriel Robles. 2017. "Perceived Barriers and Facilitators to Health Care Utilization in the United States for Transgender People: A Review of Recent Literature." *Journal of Health Care for the Poor and Underserved* 28(1):127–52.

Levitt, Heidi M. and Maria R. Ippolito. 2014. "Being Transgender: The Experience of Transgender Identity Development." *Journal of Homosexuality* 61(12):1727–58.

Lo, Selina and Richard Horton. 2016. "Transgender Health: An Opportunity for Global Health Equity." *The Lancet* 388(10042):316–18.

McPhail, Beverly A. 2004. "Questioning Gender and Sexuality Binaries." *Journal of Gay & Lesbian Social Services* 17(1):3–21.

Miller, Lisa R. and Eric Anthony Grollman. 2015. "The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health." *Sociological Forum* 30(3):809–31.

Moll, Joel, Paul Krieger, Lisa Moreno-Walton, Benjamin Lee, Ellen Slaven, Thea James, Dustin Hill, Susan Podolsky, Theodore Corbin, and Sheryl L. Heron. 2014. "The Prevalence of Lesbian, Gay, Bisexual, and Transgender Health Education and Training in Emergency Medicine Residency Programs: What Do We Know?" *Academic Emergency Medicine* 21(5):608–11.

Mollon, Lea. 2012. "The Forgotten Minorities: Health Disparities of the Lesbian, Gay, Bisexual, and Transgendered Communities." *Journal of Health Care for the Poor and Underserved* 23(1):1–6.

Noonan, Emily J., Susan Sawning, Ryan Combs, Laura A. Weingartner, Leslee J. Martin, V. Faye Jones, and Amy Holthouser. 2018. "Engaging the Transgender Community to Improve Medical Education and Prioritize Healthcare Initiatives." *Teaching & Learning in Medicine* 30(2):119–32.

Norton, Aaron T. and Gregory M. Herek. 2013. "Heterosexuals' Attitudes Toward Transgender People: Findings from a National Probability Sample of U.S. Adults." *Sex Roles; New York* 68(11–12):738–53.

Nosek, Brian A. and Rachel G. Riskind. 2012. "Policy Implications of Implicit Social Cognition: Implicit Social Cognition." *Social Issues and Policy Review* 6(1):113–47.

O'Brien, John. 2011. "Spoiled Group Identities and Backstage Work: A Theory of Stigma Management Rehearsals." *Social Psychology Quarterly* 74(3):291–309.

O'Brien, Rosaleen, Kate Hunt, and Graham Hart. 2005. "'It's Caveman Stuff, but That Is to a Certain Extent How Guys Still Operate': Men's Accounts of Masculinity and Help Seeking." *Social Science & Medicine* 61(3):503–16.

Patton, Michael Quinn. 1990. *Qualitative Evaluation and Research Methods, 2nd Ed*. Thousand Oaks, CA, US: Sage Publications, Inc.

Pfeffer, Carla A. 2014. "'I Don't Like Passing as a Straight Woman': Queer Negotiations of Identity and Social Group Membership." *American Journal of Sociology* 120(1):1–44.

Poteat, Tonia, Danielle German, and Deanna Kerrigan. 2013. "Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters." *Social Science & Medicine* 84:22–29.

Redfern, Jan S. and Bill Sinclair. 2014. "Improving Health Care Encounters and Communication with Transgender Patients." *Journal of Communication in Healthcare* 7(1):25–40.

Reilly, Patrick. 2018. "No Laughter among Thieves: Authenticity and the Enforcement of Community Norms in Stand-Up Comedy." *American Sociological Review* 26.

Reisner, Sari, JoAnne Keatley, and Stefan Baral. 2016. "Transgender Community Voices: A Participatory Population Perspective." *The Lancet* 388(10042):327–30.

Sadler, Georgia Robins, Hau-Chen Lee, Rod Seung-Hwan Lim, and Judith Fullerton. 2010. "Research Article: Recruitment of Hard-to-Reach Population Subgroups via Adaptations of the Snowball Sampling Strategy." *Nursing & Health Sciences* 12(3):369–74.

Safer, Joshua D., Eli Coleman, Jamie Feldman, Robert Garofalo, Wylie Hembree, Asa Radix, and Jae Sevelius. 2016. "Barriers to Health Care for Transgender

Individuals." *Current Opinion in Endocrinology, Diabetes, and Obesity* 23(2):168–71.

Schilt, Kristen and Danya Lagos. 2017. "The Development of Transgender Studies in Sociology." *Annual Review of Sociology* 43(1):425–43.

Seelman, Kristie L., Matthew J. P. Colón-Diaz, Rebecca H. LeCroix, Marik Xavier-Brier, and Leonardo Kattari. 2017. "Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults." *Transgender Health* 2(1):17–28.

Sevelius, Jae M., Enzo Patouhas, JoAnne G. Keatley, and Mallory O. Johnson. 2014. "Barriers and Facilitators to Engagement and Retention in Care among Transgender Women Living with Human Immunodeficiency Virus." *Annals of Behavioral Medicine* 47(1):5–16.

Smedley, Brian D., Adrienne Y. Stith, Alan R. Nelson, and Institute of Medicine (U. S.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: National Academy Press.

Snelgrove, John W., Amanda M. Jasudavisius, Bradley W. Rowe, Evan M. Head, and Greta R. Bauer. 2012. "'Completely out-at-Sea' with 'Two-Gender Medicine': A Qualitative Analysis of Physician-Side Barriers to Providing Healthcare for Transgender Patients." *BMC Health Services Research; London* 12:110.

Springer, Kristen W. and Dawne M. Mouzon. 2011. "'Macho Men' and Preventive Health Care: Implications for Older Men in Different Social Classes." *Journal of Health and Social Behavior* 52(2):212–27.

Thomas, D. Roland. 2003. "A General Inductive Approach for Qualitative Data Analysis."

Vance, Stanley R., Bonnie L. Halpern-Felsher, and Stephen M. Rosenthal. 2015. "Health Care Providers' Comfort With and Barriers to Care of Transgender Youth." *Journal of Adolescent Health* 56(2):251–53.

Wagner, Phil E., Adrianne Kunkel, Mary Beth Asbury, and Frances Soto. 2016. "Health (Trans)Gressions: Identity and Stigma Management in Trans* Healthcare Support Seeking." *Women & Language* 39(1):49–74.

Wang, Timothy and Sean Cahill. 2018. "Antitransgender Political Backlash Threatens Health and Access to Care." *American Journal of Public Health* 108(5):609–10.

Weiss, Robert S. 1995. *Learning From Strangers: The Art and Method of Qualitative Interview Studies*. Simon and Schuster.

White Hughto, Jaclyn M., Sari L. Reisner, and John E. Pachankis. 2015. “Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions.” *Social Science & Medicine* 147:222–31.

Winter, Sam, Milton Diamond, Jamison Green, Dan Karasic, Terry Reed, Stephen Whittle, and Kevan Wylie. 2016. “Transgender People: Health at the Margins of Society.” *The Lancet* 388(10042):390–400.

APPENDIX A: FLYER FOR RESPONDENT RECRUITMENT

UNC CHARLOTTE
College of Liberal Arts & Sciences
Department of Sociology
The University of North Carolina at Charlotte
9201 University City Boulevard
Charlotte, NC 28223-0001

Study on Transgender Experiences in Searching For Primary Care Physicians

I am a Sociology graduate student at UNC Charlotte, and I will be conducting interviews with the transgender community about health care related decisions. My goal is to share the transgender community's experiences in their own voices.

Qualifications to participate…

- You are transgender
- At least 18 years old
- Live in **********
- Able to meet for 1 hour in a safe LGBTQ friendly location*

To learn more about the study or to sign up for an appointment, please email or call: adrake10@uncc.edu, (***) *-****

*This can be one of several locations based on what is most convenient

This research has been approved by the UNC Charlotte IRB #*****. To participate in the study, you must be **at least 18 years old**. This study is being conducted as an MA thesis project by Amanda M. Drake (adrake10@uncc.edu) under the supervision of Dr. Kendra Jason (kjsaon@uncc.edu).

APPENDIX B: IN-PERSON RECRUITMENT SCRIPT

Researcher: Hello, my name is Amanda Drake and I am a sociology master's student at UNC Charlotte. I am interviewing people from the transgender community about how they search for primary care doctors. My aim is to shed light on the experiences of the transgender community through focusing on what is or isn't working in the search process. Would you be interested in participating?

Participant: Sure

Researcher: Are you at least 18 and living in the Charlotte area?

Participant: Yes

Researcher: Great, the interview will take anywhere from 30 minutes to 1 hour to complete. Do you currently have time to complete the interview?

Participant: Sure

Researcher: If you will follow me, we will go to the conference room to conduct the interview for privacy. I will also provide you with a consent form that has more details about the study and your rights as a participant.

APPENDIX C: RECRUITMENT RESPONSE EMAIL

Hello,

Thank you for your interest in participating in my study! I am available at your convenience for an interview if you choose to take part. I have a couple of options for a meeting place. We could meet at **********. If you are not familiar, this is a great LGBTQIA+ friendly location where we will meet in the conference room. It has plenty of parking and is on a **** bus line. We could also meet at your nearest public library if that is more convenient. I would reserve a private room where we could hold the interview without interruptions. I have both AM and PM appointments available, as well.

If you could please reply with the days and times that are most convenient for you, as well as your preferred contact info and your pronouns, I would greatly appreciate it.

I look forward to speaking with you and hearing about your experiences!

Warm Regards,

Amanda M. Drake
MA Student, Sociology
Graduate Teaching and Research Assistant, Sociology
President, Sociology Graduate Student Association
The University of North Carolina at Charlotte
Pronouns: She/Her/Hers

APPENDIX D: INTERVIEW SCRIPT

INTRODUCTION

I'd like to start by getting to know you, just tell me about yourself (Conversationally. Allow them to talk and follow up with any remaining topics or questions).

Where were you born?

How old are you?

Where did you go to school?

What do you do for a living?

Where are you currently living (rural or urban)?

What are your preferred gender pronouns?

How long have you been living fulltime as your preferred gender?

What race or ethnicity do you identify as?

How involved would you say you are in the LGBTQ community, locally or online?

SEARCH PROCESS

Now I'd like to ask you some questions about searching for primary care doctors, not necessarily just for transition related care but also general care…

Can you tell me about your search process when looking for a doctor? Are there any specific things that you look for?

Have you ever used a specific alliance or group to connect with doctors and how did you find out about them?

Did their involvement influence your experiences? Did going through an alliance make the process easier or more difficult?

What about word of mouth referrals from others in the LGBTQ community?

How important are these referrals to you and why?

Are there any specific incidents that happened to them that might have influenced your own decisions or search process?

Do you ever feel like you're anticipating similar experiences or treatment? Why?

PERSONAL EXPERIENCES

Now I'd like you think back on your own past experiences with doctors…

Has there ever been an instance, or several, where you felt uncomfortable or threatened in a doctor's office? What, specifically, made you feel this way?

Can you tell me about any times where you feel like you had a particularly good experience with a doctor?

What was your search process that lead to you finding the doctor/doctors that you had positive experiences with? Were they referred to you through friends, LGBTQ community members, or an alliance/advocacy group?

How might those resources have improved your search process and overall experiences?

Can you recall any times where you have avoided going to the doctor because of any mistreatment you have experienced in the past?

Have you ever avoided the doctor because of the experiences of others?

What are some suggestions that might improve the overall process of searching for doctors?

Is there anything else you would like to add that we did not discuss or anything you would like to say more about?

I really appreciate your input, thank you so much for your time! Do you know anyone else that might be interested in being interviewed?

APPENDIX E: RESPONDENT CONSENT FORM

Department of Sociology
9201 University City Boulevard, Charlotte, NC 28223-0001
t/ 704-687-7806 f/ 704-687-1397 www.sociology.uncc.edu

Informed Consent for
Collective Experiences and Anticipated Stigma: How Transgender Individuals Select Primary Care Physicians

Project Title and Purpose:
You are invited to participate in a research study entitled *Collective Experiences and Anticipated Stigma: How Transgender Individuals Select Primary Care Physicians*. This is a study to explore the experiences of the transgender community in their search for primary care physicians. It aims to further the understanding of the academic and medical communities through engaging the transgender community in sharing their experiences in this process.

Investigator(s):
This study is being conducted by Amanda M. Drake, of the UNCC Department of Sociology.

Description of Participation:
You will be participating in an in-depth interview. With permission, your responses will be recorded with an audio recording phone application. This audio recording is strictly for the use of the researcher and will be stored in a secure file. The audio file will only be used for transcription. If you would prefer, the file can and will be destroyed after transcription. While the data may be used in academic meetings/conferences, there will be no identifiable information published, nor will it be publicly available.

Length of Participation
Your participation in this project will take approximately 30 minutes to 1 hour. If you decide to participate, you will be one of 20 subjects in this study.

Risks and Benefits of Participation:
There are no known risks to participation in this study. However, there may be risks which are currently unforeseeable. There are no direct benefits to participants in this

study, however their input may positively benefit society through the contribution of experiences and perspectives often overlooked in academic and public discourse.

Volunteer Statement:
You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may stop at any time. You will not be treated any differently if you decide not to participate or if you stop once you have started.

Confidentiality:
Any information about your participation, including your identity, will be kept confidential to the extent possible. Because your voice will be potentially identifiable by anyone who hears the tape/digital recording, your confidentiality for things you say on the tape cannot be guaranteed although the researcher will try to limit access to the tape/digital recording as described below.

The following steps will be taken to ensure this confidentiality:
Printed surveys will be destroyed immediately after being entered into a spreadsheet where each respondent will be assigned an unidentifiable number. All audio recordings will be stored in a protected file that only the researcher can access. Any information stored in the coding software will also be protected by password. all information obtained in this study will be held confidential unless disclosure is required by law.

Fair Treatment and Respect:
UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the Office of Research Compliance at 704.687.1871 or uncc-irb@uncc.edu if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact Amanda M. Drake at 704.701.3075.

This form was approved for use on *Month Day, Year* for a period of one (1) year.

Participant Consent
I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the Principal Investigator.

_____
Participant Name (PRINT)

_____ _____
Participant Signature DATE

_____ _____
Investigator Signature DATE