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A QUALITATIVE EXPLORATION OF SUBSTANCE USE TREATMENT AMONG
GENDER DIVERSE COMMUNITY MEMBERS

by

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A Thesis

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Dedication

I dedicate this thesis to the members of this beautiful, diverse community who generously shared their time, experience, and expertise with me. Without them, this project would not be possible.

Abstract

The present study is a qualitative analysis of interviews with gender diverse community members about existing treatment conditions for gender diverse adults and potential suggestions for tailoring care to better reach and retain gender diverse populations. Eleven transgender and gender diverse (TGD) participants, aged 18-64, who had considered or participated in substance use treatment completed a brief questionnaire and an interview that explored their substance use histories and treatment experiences. Interviews were then reviewed and coded by a team of graduate students using Braun and Clarke's (2006) guidelines. Interview data was coded into four overarching themes including barriers, problems, successes, and recommendations and then further categorized into 23 related subthemes. Results suggest a lack of accessible, affirming services for TGD community members seeking help with substance use. Participant recommendations emphasized the importance of developing and disseminating culturally responsive care that addresses the unique needs and strengths of the TGD community.

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A Qualitative Exploration of Substance Use Treatment among Gender Diverse Community Members

Transgender and gender diverse (TGD) individuals are those whose gender does not align with the sex they were assigned at birth. The TGD community encompasses a great diversity of gender identities including but not limited to nonbinary, binary transgender (e.g., trans men and women), genderqueer, agender, genderfluid, and Two-Spirit. Transgender and gender diverse individuals bear a disproportionate burden of mental and physical health problems and increased exposure to adverse life events compared to their cisgender peers (Reisner et al., 2016).

Minority Stress Theory

These inequities are thought to be multicausal, stemming from systemic economic and social marginalization, stigma, discrimination, violence, and pathologization (Reisner et al., 2016). For example, compared to their cisgender peers, TGD people are less likely to have a college degree, have lower rates of employment, lower household incomes as well as higher rates of poverty (Carpenter et al., 2020). Lack of income and stable employment can also impact access to quality healthcare and may disadvantage transgender and gender diverse people who seek out treatment for problematic substance use. Notably, each of these factors may contribute to increased risk of substance use to cope with stress and negative affect. In a sample of US transgender adults, Wolfe and colleagues (2021) found a positive association between everyday experiences of discrimination and substance use frequency and quantity as well as diagnoses of substance use disorders.

Minority stress theory provides one potential explanation for these intersecting disparities and how we might begin to address substance use and treatment disparities. The theory posits that individuals with minority identities experience unique stressors (e.g., cissexism) in addition

to typical stressors faced by the general population (e.g., poverty) and these added stressors contribute to poorer health and social outcomes (Meyer, 2003). Minority stress theory was originally conceptualized to explain health disparities experienced by cisgender gay men (Meyer, 1995). However, in more recent years, the theory has been adapted to explain health disparities experienced by other marginalized groups including people of color and gender diverse folks (e.g., Cyrus, 2017; Hendricks & Testa, 2012). Within this theory, stressors are grouped into two broad categories of distal and proximal stressors. Distal stressors are external stressors such as experiences of gender-related discrimination, violence, victimization, rejection, non-affirmation, and cissexism. Conversely, proximal stressors are internal stressors such as internalized transphobia or cissexism, gender identity concealment, and negative expectations related to gender identity (e.g., expecting to be rejected or discriminated against). For example, TGD folks face unique stressors in seeking treatment including a lack of affirming care (i.e., distal stressor) and well-founded fears of prejudice or discrimination from providers (i.e., proximal stressors; Grant, 2011).

Testa and colleagues (2015) proposed an expansion of the gender minority stress theory to include community connectedness and pride as protective factors. These factors are theorized to act as buffers against some proximal and distal minority stressors. However, the literature is mixed as to whether community connectedness and pride meaningfully reduce the impact of gender-related stressors. Several studies reported that connection to a transgender community and gender diverse pride led to increased comfort and lower levels of suicidality and anxiety among gender diverse individuals (e.g., Testa et al., 2015). Similarly, disconnection from a gender diverse community and negative views of the gender diverse community (including oneself) have been linked to greater psychological distress (Sánchez and Vilain, 2009).

Conversely, other studies have found that community connectedness and pride are not associated with mental health outcomes (e.g., Cogan et al., 2020; Helsen et al., 2021). More nuanced research is needed to tease out which forms of resilience under what conditions provide a buffer against gender minority stressors.

Hatzenbuehler (2009) was among the first to propose an integrative mediational theoretical framework to bridge the gap between minority stress theory and the general psychological mediation framework of stress. This framework attempts to explain how minority stressors, general stressors, and general psychological processes interact to produce psychopathology. Specifically, he posits that sexual minority groups face increased stress due to social stigma and related factors, that this elevated stress leads to increases in emotion dysregulation and maladaptive cognitive processes, and that these elevations mediate the relationship between minority stress and psychopathology. As described below, this model has been applied to alcohol use disorders among sexual minorities; drinking to cope, social norms, and alcohol expectancies impacted by stigma-related stress are hypothesized to account for increased rates of alcohol use disorders in this population. Further investigation is needed to clarify the pathway between stressors, both general and identity specific, and outcomes including substance use. This information in turn will be useful for developing and modifying prevention and treatment efforts.

Substance Use in the Transgender and Gender Diverse Community

This disparity is particularly stark in the context of substance use and problems. Studies show that TGD individuals report higher rates of substance use and disorders compared to their cisgender peers (e.g., Kecojevic et al., 2012; Valentine & Shipherd, 2018). A large survey of adult transgender health in Colorado indicated elevated levels of substance use (Christian et al.,

2018). Almost a third of the sample reported currently using marijuana, a quarter of the sample reported past-month binge drinking, and nearly ten percent of respondents reported past year use of illicit and non-medical prescription drugs (Christian et al., 2018). Of note, the sample was relatively young compared to the general population with approximately 70% of the sample in the 18–44-year age range (vs. 49.2%) and another 25% in the 35-64 age range (vs. 33.7%).

Estimated rates of hazardous drinking in the TGD community vary widely—likely due to the absence of accurate population level surveys—with estimates of binge drinking ranging from 7-61%, proportion of individuals drinking to intoxication ranging from 25-58%, and prevalence of alcohol-related risky sexual behavior ranging from 32-53% (Gilbert et al., 2018). A large study of college-attending emerging adults aged 18-29 compared alcohol use and related problems among transgender individuals, cisgender women, and cisgender men (Coulter et al., 2015; $n=75,192$). Transgender respondents of different identities were combined into a single category, while cisgender respondents were separated for analyses, in part due to sample size limitations. Transgender and cisgender respondents had similar rates of lifetime and past-month alcohol use. However, transgender people reported more heavy episodic drinking days and had greater odds of past year alcohol-related sexual assault and suicidal ideation (Coulter et al., 2015). Of note, cisgender men had a higher prevalence of heavy episodic drinking, but this drinking took place across significantly fewer days compared to transgender respondents.

Stantan and colleagues (2021) studied electronic records from a large health care center in order to compare substance use symptoms, disorders, and treatment among cisgender and TGD adult patients aged 18 years or older ($n=29,988$). They found that nonbinary individuals assigned male at birth (AMAB), nonbinary individuals assigned female at birth (AFAB), and cisgender men were significantly more likely to have an alcohol use disorder compared to

cisgender women, transgender women, and transgender men. Nonbinary AMAB individuals were more likely than any other gender group to have a non-alcohol substance use disorder. Nonbinary individuals were also most likely to have dual mental health and substance use diagnoses. The proportion of individuals with a substance or alcohol use disorder to have attended at least one substance use appointment significantly differed by gender group with the highest proportions among cisgender men (10.1%), nonbinary AFAB individuals (9.2%), and nonbinary AMAB individuals (6.6%) respectively. Importantly, this was a mental health treatment-seeking population, and these results may not generalize to those who do not seek or have access to treatment.

Hughto and colleagues (2021) examined US insurance records to compare the rates of ICD-10 substance use disorder diagnoses among cisgender male, cisgender female, transfeminine, and transmasculine adults aged 18 years or older ($n=62,548$). Compared to cisgender groups, transgender groups had higher prevalence of nicotine (16.6% vs 5.4%), alcohol (2.6% vs 0.9%), and drug (4.3% vs 1.2%) use disorders were significantly higher among transgender groups than cisgender groups. The most prevalent drug use disorder diagnoses among transgender adults were for cannabis (2.1%), opioid (1.3%), and cocaine (0.5%) use disorders. Among cisgender adults, cannabis and opioid use disorders were equally prevalent (0.4%) followed by cocaine use disorder (0.1%).

Kidd and colleagues (2021) analyzed data from the 2015 U.S. Transgender Survey, the largest national survey of gender diverse adults ages 18 and up in the U.S. to-date, to examine prescription drug misuse in the community, an understudied area given the current opioid epidemic. Within their analyses, four groups were created based on gender identity and sex-assigned-at birth: binary transgender men, nonbinary individuals assigned female at birth

(AFAB), binary transgender women, and nonbinary individuals assigned male at birth (AMAB). All four groups had rates of prescription drug misuse higher than the estimated rates for the general population from the 2015 National Survey on Drug Use and Health (SAMHSA, 2016). Rates for each group also exceeded estimated rates of use among cisgender LGBTQ+ individuals (Medley et al., 2016).

However, it is difficult to understand the true scale of the issue given the paucity of high quality, nationally representative data on substance use in the transgender and gender diverse community. The National Survey on Drug Use and Health (NSDUH) is one of the largest and most important sources of data on substance use in the United States, but the survey has not included a question about gender identity (only biological sex is queried). Additionally, the National Epidemiologic Survey on Alcohol and Related Conditions does not include a question about gender identity in any of the iterations of the survey. Studies including gender identity questions often provide limited or unhelpful response options that fail to accurately describe or capture gender diversity. For example, there is a trend of providing three gender options including “male,” “female,” and “transgender.” Such a response option forces gender diverse people to fit themselves into categories that may not be accurate. For example, a transgender woman responding to such a question must choose between transgender and female even though she may identify as both transgender and female, and a nonbinary respondent may not identify as transgender, female, or male and must either respond inaccurately or not at all. Even when gender identity is meaningfully assessed in large studies, TGD individuals are often combined with sexual minority individuals within analyses though their experiences as gender minorities may differ in important ways.

Substance Use Treatment and Barriers to Care

Given the unique needs and strengths of the transgender and gender diverse community, existing treatment practices may not be sufficient. Indeed, the present system is rife with obstacles to receiving affirming care. Even considering or accessing treatment can result in increased stress due to anticipated or enacted discriminatory experiences. Reisner and colleagues (2015) recently analyzed data from a national study of transgender men and found that 32-39% of the men delayed receiving care due to anticipated stigma and 14% were refused care by a provider. Over a quarter of the sample reported using substances to cope with mistreatment in healthcare settings and both enacted and anticipated stigma from healthcare providers were positively associated with substance use. A qualitative study of gender identity-related microaggressions experienced by TGD clients from providers reported the following themes: lack of respect for identity, lack of competency, saliency of identity (e.g., overemphasis or minimization of the role of gender identity), and gatekeeping (e.g., providers limited or denied access to services; Morris et al. (2020).

Twelve-step, mutual help groups are among the most widely accessible forms of intervention available to individuals in recovery. Alcoholics Anonymous (AA) is perhaps the most widespread and well-known of these groups. In recent years, LGBTQ+ specific meetings have become available across the country, which is a significant step forward for those who may fear or experience stigma and discrimination in less specialized meetings. However, relatively few meetings are specific to the gender diverse community and TGD individuals may still face gender-related stigma or discrimination from their cisgender LGBQ+ counterparts (Matsuzaka, 2018). In a qualitative study of the experiences of TGD adults participating in Alcoholics Anonymous, participants described experiences with both structural and interpersonal gender-

minority based stigma and microaggressions (Matsuzaka, 2018). Some participants felt that they had to downplay or even hide their gender identities to avoid uncomfortable or offensive interactions.

Transgender and gender diverse adults face similar and sometimes worse difficulties within residential addiction treatment centers. Lyons and colleagues (2015) conducted interviews with TGD adults who participated in residential treatment programs and spoke of experiences with social rejection, harassment, and violence from other patients as well as stigma and transphobia from both patients and counselors. Those who reported more negative experiences within treatment often prematurely left treatment while those who described positive and affirming experiences generally completed treatment (Lyons et al., 2015).

Little work has been done to validate existing evidence-based treatments in gender diverse populations (Mirabito, 2021). This may in part be a problem of data collection and publication by researchers who do not recruit gender diverse populations or fail to either ask about or report on gender identity. Indeed, Flentje and colleagues (2015) reviewed PsycINFO and PubMed and determined that non-binary gender identity was reported in 0% and 1.0% of the available substance use literature in 2007 and 2.3% and 1.9% of the 2012 PsycINFO and PubMed sample articles respectively. Additionally, a review by Glynn and van den Berg (2017) identified only two studies which specifically examined substance use treatment outcomes in a gender diverse population. The authors noted that a number of substance use publications reported gender diversity within their samples but either aggregated the outcomes of gender diverse and cisgender or LGBTQ+ participants or did not report treatment outcomes for gender diverse samples. Another recent review by Kidd and colleagues (2022) identified 71 articles published from 1985 to 2019 that examined substance use interventions for sexual and gender

minorities. Only three of these articles included large enough samples of gender diverse people to power analyses separated by gender identity. An additional five studies included gender diverse people but did not report outcomes by gender identity. Given the prevalence and consequences of problematic substance use in the gender diverse community, additional research specifically targeting this community should also be prioritized to reduce the current care gap.

Some scholars argue that beyond testing existing interventions in these communities, treatments should be adapted and tailored to fit the unique needs of the population and to ensure treatment engagement, retention, and efficacy (Castro, Barrera, & Martinez, 2004). A growing body of literature supports this assertion and indicates that culturally adapted interventions may be more efficacious in diverse populations compared to unadapted versions (e.g., Griner & Smith, 2006; Rathod et al., 2018). Successful treatment adaptation requires stakeholder involvement throughout the adaptation process (Moore et al., 2021). Perhaps the most important stakeholders are members of the gender diverse community with lived experiences with substance use and treatment.

The present study generated information about existing treatment conditions for gender diverse adults, barriers to care including stigma, and potential suggestions to tailor care to better reach and retain gender diverse populations. Specifically, information was collected on factors that may promote treatment access and engagement and facilitate recovery. Thus, the present study sought to explore the following research questions:

- 1) What experiences do gender diverse people have when seeking or participating in treatment for substance use?
- 2) What are some common difficulties and barriers that gender diverse people experience when seeking and participating in treatment for substance use?

- 3) What specific suggestions do gender diverse individuals have for improving substance use treatment for the gender diverse community?

Method

Participants

Eleven participants were recruited from across the United States to participate in the study. Eligible individuals were those between the ages of 18 and 64, with the ability to understand consent procedures, who self-identified as a gender different from their sex assigned at birth, and had either participated in or considered participating in alcohol or drug use treatment. No other exclusion criteria were used. Inclusion criteria were intentionally chosen to be broad and inclusive to facilitate recruitment and capture participants with diverse experiences and identities.

Of the 128 individuals who completed the screening survey, 13 individuals were ineligible due to age, 22 individuals were excluded for self-identifying as cisgender, and eight individuals were excluded because they had not thought about or participated in treatment for drug or alcohol use. Of the 85 eligible individuals, 12 participants responded to study staff outreach and agreed to participate. One individual completed the baseline questionnaire but did not complete the interview. Only one individual who participated was referred by another study participant. The final sample was comprised of eleven individuals. Six participants completed in-person interviews and five participants completed interviews via Zoom. Participants ranged in age from 18-64 ($M = 29.18$, $SD = 12.27$) and most identified themselves as White or European American (72.7%), single or never married (72.7%), employed (63.6%), and as having a disability (63.6%). The sample included genderqueer individuals (27.3 %), transgender men (27.3 %), transgender women (18.2%), nonbinary individuals (18.2%), and one genderfluid

individual (9.1%). Additional demographic information can be found in Table 1. While not systematically assessed, participants were able to report additional aspects of their identities or backgrounds “that would be useful for [study team] to know.” Eight participants reported identifying as sexual minorities (e.g., “queer,” “gay,” “pansexual,” “lesbian,” “queer identified). Participants also included information related to their upbringing, neurodiversity, religion and spirituality, and geographic region.

Measures

Outcomes of the present study include information on substance use, substance use treatment experiences, stigma experienced when considering or seeking treatment, barriers to care, as well as suggestions to improve sensitive and affirming care for gender diverse communities. Demographic information was also collected including age, racial identity, gender, pronouns, disability status, individual and parental education level, employment status, household income, and marital status. It is possible that any number of these factors may shape experiences in addition to or beyond gender identity, so the interview also included a question about the perceived impact of individual factors outside of gender identity. See the Appendix for the complete list of questions.

Procedure

The study was conducted in an individual in-person or Zoom interview format based on a standard questionnaire. Participants were recruited via community organizations that serve the population of interest (e.g., OUTMemphis, My Sistah’s House, Love Doesn’t Hurt, and providers listed on OUTMemphis’ Trans Best of Memphis guide) as well as via paid social media advertising. The study staff contacted representatives from community organizations to explain the study and seek permission to post flyers in physical community spaces. Receptive

organization representatives were also be asked to share a digital version of the study flyer with members via social media and email listservs. The flyers contained information about the study's purpose and procedures, eligibility, and the link to a screening survey hosted on Qualtrics secure online survey platform. Interested individuals were asked to complete the screening survey with information about their age, sex assigned at birth, gender identity, whether they had ever engaged in or thought about engaging in alcohol or drug use treatment, an email address, and a phone number they would like to be contacted at. The informed consent form was embedded in the screening survey and potential participants were asked to indicate their consent electronically prior to beginning the screening questions. The screening survey also included a question asking for permission to call and/or text the individual at the phone number provided and a note that eligible participants would be contacted by study staff within seven days. Ineligible individuals received a message thanking them for their time and noting that they are not eligible to participate in the study.

Study staff contacted eligible individuals via a Google Voice call to reiterate study details (e.g., procedures, confidentiality, and compensation) and to confirm eligibility and interest in participating in the study. Then study staff verbally reviewed consent information and procedures with participants and scheduled the interview appointment with the participant and sent a text message with the appointment date, time, and location. Participants were also sent a link to a baseline survey to collect information about their demographics (e.g., age, gender identity, race/ethnicity, etc.), drug and alcohol use, and preliminary information about treatment experiences. Participants who did not complete the baseline survey prior to their interview were asked to complete the survey with the interviewer during their scheduled interview. Interviews

were conducted in-person in the Health Addiction and Behavioral Intervention Team (HABIT) lab space and remotely via Zoom.

The interview sessions were recorded for later review and transcription purposes. No other identifying information (e.g., name, date of birth, etc.) was collected. If identifying information arose during the interview, it was removed during the transcription process. Prior to the start of each interview, consent procedures were presented again, and participants were given the opportunity to ask questions or opt out of the study. During the interview, participants were asked questions about their perceptions about and experiences with substance use treatment including whether they had experienced stigma related to their substance use and/or gender identity (or another factor). They were also asked for suggestions about how substance use treatment could be made more sensitive and affirming to transgender and gender diverse people and their unique needs. The interviews ranged in length from approximately 20 to 75 minutes.

At the close of each interview, participants were thanked for their time, encouraged to tell their gender diverse friends about the study, provided with local and national affirming resources, and walked through compensation procedures. Participants received \$50 for completing the baseline questionnaire and interview. They were paid using an electronic payment method such as Venmo or Cash App within one week of participation in the study. Participants were also able to refer up to two friends to complete the study. If these friends were eligible and completed the study, the referring participant received an additional \$10 via Venmo or Cash App for each friend, up to two friends and \$20. Referring participants were asked to share their phone number with these friends and the referred friends provided this information when they participated, which allowed the study staff to send additional compensation.

Following the completion of the interviews, each interview was transcribed in preparation for coding. The author conducted, transcribed, and deidentified each interview. The author led a coding team of three cisgender graduate students, including the author. The coding team was trained in thematic analysis methodology using Braun and Clarke's 2006 guidelines and reviewed several exemplar papers demonstrating rigorous thematic analysis. Prior to the start of analyses, the coding team met to discuss and document coding procedures, potential biases, analytic assumptions, as well as their assumptions about the data and how their particular identities and values may influence their analysis of the data. The coding team agreed to a deductive, theoretical approach informed by the research questions previously described above. Data were coded at the latent level such that the coders sought to identify the potential underlying meaning of participants words rather than taking them at face value. For example, in response to a question soliciting recommendations for improved substance use treatment, participant #005 stated:

I would definitely have animals there. [pause] I would have an art room. Um... [pause] I feel like my three things would be like an art room, a library, and pets, but I am a little bit more of a quiet person, but I know when you first get sober, like you don't always wanna talk about things, at least for me. Also, I had attended a whole lot of therapy over the years, starting, I guess when I was 17 and CPS made it mandatory. So, there are a lot of things that I had just talked about over and over, explained to different people, just talked about a billion times before, and... So, there was a lot of stuff I didn't wanna talk about when I first got sober, but having an art room and having animals around gave me some comfort that without me having to talk or cry or explain myself or feel defensive about what had happened to me in the past. Just having like quiet spaces. It was nice.

The coding team interpreted this unit of text as a recommendation for “holistic care” given the emphasis on features that may not be considered directly related to reducing substance use.

Rather, these recommendations were interpreted as being rooted in a whole-person approach to view individuals as beings with complex emotional, spiritual, psychological, and physical needs beyond substance detoxification and abstinence.

Analysis

A qualitative thematic analysis (TA) of participants’ interview responses was conducted by a research team of three coders following Braun and Clarke’s (2006) procedures. As described above, the coding team was comprised of three cisgender graduate students, including the author. The coders variously self-identified as White, cisgender, and queer. The coding team first individually reviewed and familiarized themselves with the interview data to develop ideas for initial codes capturing the essential elements of the interviews. The coders then met to discuss their initial reactions and potential theme ideas. Through discussion, the coders collaboratively generated four overarching themes as well as various subthemes described below. Per Braun and Clarke (2006), themes must encompass something important about the data as it relates to the proposed research question and represents a pattern of response within the dataset. In the next step, the coding team manually reviewed each interview again, with the established themes in mind, took notes, and sorted units of text into the various themes and subthemes. Each interview was reviewed twice, once by the author and a second time by another coder. Discrepancies were discussed and resolved, and themes and subthemes were further refined during this process. The author then collected all coded units of text into a master document which was subdivided by themes and subthemes. The final phase of the thematic analysis process involved the creation of a final report in which the author defined the final themes,

described their presence within the dataset, and selected individual exemplars of each theme. When units of text aligned well with multiple themes, they were sorted into all relevant themes.

Braun and Clarke (2013, p. 50) recommend sample sizes of 6-10 for small interview-based projects. However, the rationale for this guideline is not clearly explained. Fugard and Potts (2015) proposed a tool to help determine sample size in thematic analysis based on the population theme prevalence of the least prevalent theme, the desired instances of the theme and the power of the study. This is presented as a table in which the required sample size is a function of the estimated population theme prevalence and how many occurrences of the theme are desired. The table used in the present study estimates sample size assuming an 80% chance of observing that desired number as a proxy for statistical power. These recommendations were taken into consideration when determining the desired sample size of the present study.

Results

Participants reported a history of using a variety of substances including alcohol, cannabis, amphetamines, cocaine, opiates, hallucinogens, solvents and inhalants, GHB and related substances, as well as sedatives and painkillers not as prescribed. The majority of individuals also reported behaviors that may indicate risky use including using more than one substance on the same occasion (including alcohol; 81.8%), experiencing negative or unpleasant consequences as a result of use (90.9%), and attempts to cut back on use (90.9%). Many participants also indicated that others had expressed concern about their use and/or suggested that they cut back (72.7%). Additional details regarding participants' past and current substance use can be found in Tables 2 and 3.

Most participants had engaged in treatment in the past (63.6%) and some participants were currently engaged in treatment (27.3%) or currently exploring treatment options (27.3%). A

range of treatment experiences were reported including individual therapy or counseling (54.5%), rehabilitation facilities (18.2%), Alcoholics Anonymous or Narcotics Anonymous (45.5%), “spiritual” healing (9.1%), medications to reduce cravings (9.1%), and a harm reduction course (9.1%). Some participants also described receiving informal help from friends and family members (63.4%), peer supports (9.1%), and social media (e.g., the harm reduction community on TikTok; 9.1%). When asked to rate the overall helpfulness of the treatment and help that participants had received on a Likert-type scale, all participants indicated positive experiences that ranged from *somewhat helpful* (37.5%) to *very helpful* (37.5%). Participants also rated their overall treatment and help experiences as *neither unaffirming nor affirming* (12.5%), *affirming* (37.5%), or *very affirming* (50%).

The coding team identified and categorized units of text into four overarching themes and 23 subthemes (see Table 4). The four overarching themes reflected barriers to treatment, problems in treatment, successes in treatment, and recommendations for future practice. As might be expected, the majority of participants discussed both positive and negative experiences when seeking or receiving treatment. Some participants indicated a range of experiences even within the same facility, group, or with a single provider.

Barriers

Participants described a number of barriers that deterred them from seeking or receiving treatment. These barriers ranged from logistical issues such as high treatment costs to more abstract issues such as perceived and actual stigma related to gender diversity, substance use, or the intersection of the two. The coding team defined six subthemes that described barriers to receiving care for substance use. Notably, a seventh potential theme labeled “lack of substance-free reinforcers” was proposed. However, it was determined that there was not sufficient

prevalence for its inclusion (e.g., five occurrences across two interviews). Future research may consider how a lack of substance-free reinforcers may impact TGD individuals' substance use patterns and treatment trajectories (e.g., Murphy et al., 2012; Tucker et al., 1994).

Lack of Support

Seven participants indicated that they had encountered a lack of support when pursuing or engaging in treatment. In some cases, friends and peers were unaware of their difficulties with use or unsupportive of their efforts to quit or seek treatment. Participant #008 reported, "I would tell my friends and they would laugh at me... I would get laughed at by my friends and stuff, but that really didn't bother me, so that's like the only kinda push back I got from it." This lack of support was also present at a more systemic level and interacted with geographic and financial difficulties. Participant #012 lamented the lack of support and resources available to her: "Yeah, I think it is kind of like in... I don't know. If you know you are in need like don't bother, there's not like a support system to like help." Others were met with a lack of inclusion within recovery spaces that were not designed with TGD folks in mind.

#005: With getting involved in AA, being sober and stuff, it's just been... I guess what I already said, kind of. It's just hard to find a spot in recovery being genderqueer, and not everybody kind of has the attitude to do it, 'cause you have to make space for yourself, there's not space for us yet.

#001: When I was in rehab, I was also the person wanting to advocate for that because you know, I think mental health field, right now, in treatment centers at least is just "get them in, get them out and I don't give a fuck who they are or how they identify.

Stigma & Discrimination

The impact of perceived and enacted stigma and discrimination was frequently discussed in nine of the interviews. Some of the stigma was around receiving help for substance use generally (e.g., #004: “I think mostly just stigma or the idea of the label of substance abuse disorder or whatever... Or just saying, you abuse substances in general is a very weighty term”). There were also reports of stigma and discrimination related to gender identity and presentation. In both cases, several participants described the internalization of this stigma and the consequent impact on their beliefs about needing or deserving treatment. Perceived external stigma and risk of discrimination made participants reluctant to engage in treatment and in some cases kept them out of certain types of treatment, particularly residential or inpatient treatment. Participants feared entering intensive or long-term treatment spaces where they may not receive adequate care or might encounter harm from providers and other clients without respite. Participant #003 explicitly stated that “[lack of LGBTQ+ friendliness] was one of the reasons I chose not to go to rehab, even though I should have gone, and I do regret not going.” He further explained:

#003: There were some other concerns of just like how well-educated people were as well as like... I have a history of childhood sexual abuse, and I know a lot of people wanna focus on like, 'Oh, you're trans because you were sexual abused,' and I had already had that experience and I didn't wanna be locked in the place where we went over that so.

Participant #010 expressed somewhat similar concerns:

I think it's easier to cast away that part of me for minimal amounts of time, like an eight-week course, once a week, once an hour kind of thing... or when I'm talking to my primary care provider and they're talking to me about cutting down on alcohol, I can cast away my queerness easily because it's like succinct times. So, it feels manageable, but the

idea of going into a 24/7 area where that wouldn't be affirmed... Is terrifying, quite frankly.

Direct experiences of stigmatization and discrimination also occurred in treatment and recovery spaces, which negatively impacted individuals' ability to benefit from treatment as well as their willingness to stay in treatment or seek it in the future. Participant #001 explained that “when was younger, I had a lot of counselors that were very homophobic, transphobic, that was definitely a deterrent as I became older to seek therapy.”

#008: I was talking to someone a little while ago, and they said, they were talking to me about how they had gotten help through a church, but I can't do that 'cause of the fact that... Well, I guess it also plays into the gender thing, but they never said it but every church I've ever been to, they explicitly said that I would have to identify as a girl and that they would not appreciate... They would not allow me to be in their church actively if I was still identifying as trans 'cause I was "going against the Bible" or whatever they believe, and so I remember that that's the only thing that I could really do anything like that because that guy had gotten help through a church and through a priest, and I could have done that 'cause there's a lot of churches around me, but I'm trans and most likely I'd discriminated against in a church, or the type of church I've been to, I've been discriminated against.

Cost & Limited Insurance Coverage

Cost and insurance limitations were barriers encountered by at least nine of the participants. Treatment, particularly high-quality inpatient treatment, was tremendously expensive. Participant #002 emphasized, “You know the cost... I think for the average person, that's probably prohibitive, it isn't cheap, and it's a profit center for a lot of big companies.”

Another participant reported that their 30-day stint in a rehabilitation facility cost around \$20,000 USD before insurance coverage, which still does not include lost wages due to an inability to work during this time. Fortunately, many participants were able to get access via student health centers, the financial support of loved ones, or health insurance. In some instances, participants were able to stay on parents' insurance plans and receive covered inpatient treatment prior to turning 26 years old and losing parental coverage. Other participants discussed the high cost of individual therapy copays as well as the challenges of finding an affirming therapist who was covered by insurance and had availability on their caseload. Though participants did not explicitly mention it, insurance-imposed restrictions on the number of sessions per year may also present a related barrier.

#011: It's a very small list and my insurance does not cover those three therapists in my area [who are explicitly affirming] ... There's one therapist that I've considered paying out of pocket for, but I just don't have the money for that, but really, I think it's just the need for individualized care, and somehow, I feel like... it would be easier for a cis het person who has an addiction or has any issue that they need taken care of through therapy, because most therapists are cis and are straight, so it's like you just have a broader array of people available to you who have similar identities to you, who you could maybe relate to or feel comfortable with, versus there are three people and most of them are full... And don't take my insurance... So insurance doesn't really account for that, insurance is just kind of like, 'Here are the therapists that we cover, pick one,' so just kind of being able to navigate that system to know that I'm going to end up with a therapist who's going to understand me has been really difficult, especially just because even within the queer community, there's so much diversity...

Well-founded Apprehension

Among the most regularly discussed barriers to care was a well-founded apprehension and distrust of the healthcare system and recovery spaces that made participants hesitant to seek out treatment. Nine participants discussed various reservations they had about getting help due to detrimental past experiences with providers and group settings. Even those who did not recount personal experiences indicated knowing someone in the TGD community who had negative experiences. However, many participants persisted in seeking out and engaging with treatment, though perhaps with greater caution and research to determine whether spaces might be safe. As described above, participant #010 reported that they were able to access outpatient care because they felt they could withstand being misgendered and misidentified (as a cis woman) for short amounts of time (e.g., a couple hours per week), but decided against inpatient services due to fears of not being affirmed: “the idea of going into a 24/7 area where [gender identity] wouldn't be affirmed... Is terrifying, quite frankly.” They further explained:

#010: I've considered - part of me - going to inpatient treatment, like residential facilities, and one of my biggest concerns is related to my queerness, and obviously all the standard concerns that people fear when they go into those settings, but my gender and my sexuality is like a whole another level, I would say, on top of that...

Other participants also had concerns related to their gender and sexual orientation discrimination within group settings (e.g., AA meetings).

#009: I guess I have, from the start, been worried that someone would say something weird or express explicit discomfort or just do something... Um around my being in a meeting. It comes up with... I mean regardless of meeting, if I go to just sort of like a whoever meeting, then I'm worried because it's more likely that it's not a room full of

people who are at least trying to be allies, which is part of the reason I don't go to non-queer or non-women's meetings often, at least not alone...I do feel specific worry in women's meetings as well, just around like, "Okay, am I gonna be the only person who's not cis here? How are these gonna people feel about me?" Every time I go to a meeting specifically for women, it's like, "Okay, what's their definition?" [laughter] And then "who's gonna have a problem with my being here?" and obviously, it sucks because that shouldn't be a thing. We're all there for the same thing...

Limited Treatment Access

Seven participants discussed difficulties finding treatment options that were accessible (e.g., in terms of cost and location), were accepting new clients, fit their needs related to substance use care, and were openly inclusive and affirming. Participant #010 was particularly interested in providers who worked within a harm reduction framework, which was challenging given that many substance use treatment facilities and groups promote or require only abstinence-focused treatment: "I learned about harm reduction and decided that it was the model that fit best for me, and had a lot of trouble finding a program or a therapist that would operate in that model." Some participants also highlighted how time consuming it is to navigate insurance and conduct research to ensure that a therapist or facility is accepting and affirming.

#011: I never have enough time for anything, so taking the... Especially with what I mentioned earlier about having to find personalized care and somebody that's gonna be comfortable with all of these parts of me... The time that it takes to do that. Oh my gosh. It's unbearable...because in the beginning stages it's literally just looking for lists of who my insurance will cover for therapy, and then trying to find lists that either don't exist or are incomplete or are not updated of who in my area is queer-friendly, and then just the

time that all of that takes... I'm like, Okay, this part is not helping, so this is just not worth it.

#009: Another one was definitely wanting to seek out spaces that were explicitly queer and trans affirming as well as just women's spaces, and so there are a lot fewer meetings that that is the case for, so... Yeah, a matter of finding those... And then with therapy, it's just hard to find a therapist who has availability, it's hard to find one who you click with or feel like you're being helped by...

Community Norms

Nine participants expressed the ways in which perceived norms within their community – both the TGD community broadly and their specific local networks – influenced their perception of their own use. For some, high rates of use in those around them led them to downplay the seriousness of their own use even as it adversely affected their own lives and health. For example, participant #011 expressed how this showed up in their own life:

I don't think this is related to me being queer though it might be, but I have the tendency to kind of dismiss myself in thinking that I don't really have a problem, definitely a lot of denial when it comes to trying to seek help, and I think part of that is just because I know that I know people personally who do more drugs than I do, or who drink more than I do, or I see like... I have friends who do a lot of drugs, and I'm like, 'Okay, well, I just have... I might just have a drinking problem, so it's not as bad,' so there's that, the self-denial of like, "Do I have a problem, do I need help? Am I worth somebody's time and energy to go get help because I'm not as bad as I could be?"

Those who had friend groups and communities with relatively high rates of use sometimes received pushback or were dismissed when they expressed concern about their use or a possible desire for treatment to assist in cutting back. Participant #008 stated “I feel like, again, with specifically the trans community, I don't know a single person who did not at one point do stuff like smoke [weed or nicotine].” Similarly, participant #001 described how widespread and normalized use was in his community:

#001: I think almost every single trans person I can think of off the top of my head has substance abuse problems for sure - and gay people as well. So, I think it's pretty normalized too, at least for me, growing up in the scenes that I did to like "get blackout drunk, it's funny. This is fine. This is whatever."... It's just the popularity of you know the "this is so cool, it's so good, it's so fun" until it's not... So yeah, I definitely think it's a huge, huge part of the community.

Problems

Despite barriers, over half of the sample had received treatment in the past or were currently in treatment related to their substance use. Unfortunately, many participants encountered further troubles within treatment contexts. Such troubles included providers and systems who lacked comprehensive or even basic training in working with TGD folks, disregarded or disrespected their identities, made inappropriate assumptions about them, and more. The coding team defined five subthemes to illustrate these troubles.

Disregard for Identity

At least five of the participants reported disrespect or disregard for their gender identities. This included both procedures and policies that were designed without TGD folks in mind and also overt and intentional acts of disrespect. Misgendering and deadnaming was common among

providers as was a lack of knowledge about even basic information related to gender diversity. This resulted in harm and distress for the participants. Some participants reported malicious and intentional disrespect from providers or other clients receiving treatment, including anti-gay slurs.

#005: ...the last AA conference that I went to, they do young people's conferences around the US for AA. And the last one we had, they were supposed to have an LGBTQ panel, 'cause there's usually one at every conference, and they cancel it because they said that that was not AA related for them to have an LGBTQ panel. They call stuff like that "outside issues" like things that aren't intrinsically related to AA, but they have meetings specifically from college people, they had speakers specifically talking about Zoom meetings versus in-person AA meetings, but then they just canceled the LGBTQ panel because they thought it was a problem or wasn't inclusive...

#008: I feel like a lot of the trans people fear institutions, 'cause again, a lot of us have mental health issues or something like that, and so I know quite a couple of people who were institutionalized simply for mental health reasons, and they are absolutely terrified of anything to do with an institution or anything to do with this, and so I know my friends went to an institution, this was horrible for them, I don't wanna go through that now, and so we kind of fear institutions in a way, not only because of the fact that it's not affirming to be called your dead name and be known as a patient and not be known... As like, what you identify as, especially since for trans people, a lot of our expression is through our clothing, 'cause I don't feel like a dude unless I'm wearing specific clothing and I'm doing this and I'm doing that, we can't wear those specific clothing in an

institution. I can't dress the way that makes me least dysphoric in an institution, and so I feel like a lot of us just dislike institutions simply for the fact that they cause more dysphoria, we can't express ourselves away that we want, and we maybe get called the name that we don't know, that we don't identify as or they don't know us as the person instead of just our name and our names might not even be the name that we even go by.

Lack of Training & Knowledge

Seven participants described interactions with providers who had little to no understanding of or training on working with TGD individuals. In many cases, this resulted in participants having to perform emotional labor to explain themselves to paid providers who were not always receptive or respectful. Unfortunately, some providers and facilities who did not know how to serve TGD community members, simply opted not to serve them at all. Participant #001 summarized providers' response to him as "we don't know what to do so we're not gonna do anything." Several participants also encountered a lack of familiarity with certain treatment approaches they were most interested in, such as harm reduction. In example, participant #010 stated, "I had to kind of teach [current therapist] about how harm reduction looks in alcohol, 'cause people see it mostly for opioids and don't really see how it can translate to other facets." Even well-intentioned and well-meaning providers often lacked the knowledge and skills to effectively help their TGD clients. As participant #005 put it, "even the cis het people that mean well just aren't very informed around here."

#005: It's ridiculous, the amount of schooling and people can go through and still have to be explained the concept of trans people...It's absolutely insane that you can spend that much money and go to school for that many years and not understand how hormone therapy works or what they/them pronouns are. And I think just having people that will

listen and also know what you're talking about, I think that would be a really good start...a position I've been in a lot of times is trying to educate this person that's like a doctor that's getting paid for their services and then I'm the one actually explaining shit to them. It can be super frustrating, and I wish people like doctors and stuff would be inclined to explore knowledge outside of what they've been taught, because there's not a lot of inclusivity like taught in the medical field and people don't try to learn more...

Predominantly White & Cisgender Providers and Spaces

In eight of the interviews, participants that their providers and the recovery spaces they entered were often majority cisgender and White. While many reported positive experiences with these providers and settings, they expressed a desire for greater diversity. Even when providers or spaces were affirming or queer, there was not often intersectional diversity that included people of color, neurodiverse people, or gender diverse people. Some felt that it was more difficult to connect with cisgender and White providers with whom they sometimes had little in common. It also seemed that rather than a mutual or collaborative environment, the onus was on the participants to continually explain themselves and work to establish connection and the right to take up space in those settings.

#011: Like my last therapist was an openly gay man, but he was also cis, he was also White, he was also neurotypical from what I gathered in our sessions, and so it's like even just... Even finding a queer therapist isn't always enough, it feels like such a personal thing that it's hard to kind of find somebody who I'm comfortable sharing all sides of my identity with, or who I feel like understands or takes them seriously... ..therapy feels very individualized, and I think up until my last therapist, I had primarily had kind of older white women, like cishet white women therapists, and I was just like, "Oh, this is what a

therapist looks like, because this is all I've had since literally middle school." And so, I think that has always made it kind of difficult just because I don't have... I have very little in common with an older cis het white person in general.

#005: when it comes to AA events and activities, it's still just very men and women, and it can get awkward for nonbinary people, and trans people, like my trans friends are constantly being outed by other people in AA, and even the ones that try to be accepting, like don't understand that talking about it so much is not acceptance it's just reminding everybody that somebody is trans and talking about it all the time and not letting them just exist.

Inappropriate Assumptions

Seven participants reported encountering providers who made inappropriate assumptions about them and their use based on preconceived notions of what it means to be gender diverse and how gender diverse individuals 'should' present. Such assumptions included the belief that gender identity was either a result of trauma and substance use or that problematic substance use was inherently linked to one's gender identity. Providers also made unhelpful assumptions about participants' situations, desires, and needs related to treatment based on stereotypic understandings of gender diverse individuals (e.g., assuming family abandonment, assuming medical transition). Some participants also expressed that providers did not fully understand hormone replacement therapy (HRT) and sometimes blamed substance use issues on HRT or hormone levels.

#005: I've had therapists in the past try to invalidate [my pansexual identity] or lump it in with the alcoholism or telling me my sexuality or my gender exploration is because of my

trauma, and I mean I'm used to it, especially saying that my gender and sexuality come from my trauma. I get that a lot, so it was... I had just kind of heard the same things over and over before, so even in therapy, and in AA I don't usually talk about my gender, my sexuality much, 'cause yeah, with the sexuality thing like people either think it's because I am bipolar and alcoholic and all that jazz, or they like kind of fetishize it. And I don't know, act like it's some weird kinky thing, and it's just like a normal thing you know.

#001: Um, and then I think a lot of treatment even outside of rehab, just like mental health counselors or like psychiatrists especially, uh they always blame it on the hormones and it's never like oh let's identify the rest of it. It's that barrier is your identity, is your transness or whatever, that's the problem. It's the hormones or the lack of hormones or whatever, and sometimes it is and sometimes your levels are a little bit off but when that's all a doctor can see, that's a ginormous barrier.

Rigid & Unnecessary Gendering of Treatment

A major logistical difficulty that four participants discussed was the ways in which treatment and recovery spaces enforce a gender binary. In rehabilitation facilities, participants rarely encountered inclusive accommodations. Instead, they were sometimes placed in gendered spaces that were inconsistent with their gender (e.g., a trans man made to participate in women's activities) or asked to self-select into male or female spaces despite identifying as neither. Other times, there were excluded entirely because there was not yet a space for trans and nonbinary people. Rigid gender binaries were also encountered in AA and NA meetings given the ways in which sponsors are selected and activities are sometimes divided into "men's and women's"

subgroups. Even the way that substance use, particularly alcohol use, is discussed is often gendered.

#005: That would be, I guess, where the separation of men and women comes in, 'cause I'm nonbinary...But sponsorship is part of it, like when you go in AA, you typically get a sponsor as fast as you can, and they all take you to through 12 steps, and they want women to stay with women and men to stay with men. And I think I get along with guys better, which I know sounds cliché and silly, but I can just converse with them better, but they wanted me to have a girl sponsor, and so I did, but I think for me at least, and my nonbinary friends a bit, it can get... Well, it just gets awkward and a little uncomfortable 'cause I don't get invited to girl staff and I don't get invited to boy stuff... So when it comes to AA staff, we just kind of either try to fall into the male or female category or just don't participate, and yeah, a lot of the times it's easier to just not participate than to awkwardly try to fit in somewhere in a place that doesn't have room for you yet.

#001 [trans man]: I just didn't really receive treatment the first few times that I went because it was the mental health side. I didn't benefit from that. I was gendered as a woman, I was on the woman's side, going to the women's groups and all this, it was just... That dysphoria that it reiterated every single day all day. You know "Women go to dinner at this time." It was just like I couldn't... There was nothing to get past that. That was just a huge wall...

Successes

All participants indicated having at least partially positive experiences when considering, pursuing, or engaging in treatment. The coding team sorted these successes into four subthemes.

Supportive communities, helpful resources, and affirming groups and providers were central to participant's experiences. Additionally, six clients indicated that they successfully made changes in their drug or alcohol use outside of treatment. The frequency with which participants highlighted these factors speaks to their importance in conceptualizing successful treatment and recovery in the TGD community.

Good Resources (If You Can Find and Access Them)

Individuals who actively sought treatment encountered many potential options. The availability of useful resources was discussed in nine of the interviews. Frequently cited resources included AA and NA groups as well as individual therapy and rehabilitation facilities. Participants also described community organizations responsible for disseminating information about substance use and treatment in the community as well as access to important services (e.g., HIV testing). Notably, many of the resources identified in the interviews extended beyond specific treatment providers to include supplies (e.g., fentanyl test strips, naloxone kits), information hubs and lists (e.g., participant #001 found a physician via a local list of trans friendly providers), social media resources and communities, and community partnerships.

Unfortunately, resources were often challenging to find due to lack of advertising, dissemination, and community outreach. In some instances, resources were available but difficult to access due to location, cost, or other logistical issues (e.g., a participant was aware of treatment centers, but unable to access them without parental permission until he turned 18), or perceived exclusion of gender diverse individuals (e.g., gender-segregated rehabilitation centers).

#006: ...we have [LGBTQ+ CENTER]. I know everyone goes to them first in their mind because they're a hub and it's in the name, but they're a wonderful resource, at least I know they were for me when I was in college, and I know they've only expanded since

then... they did have that down and I really like that about them, like you just walked into the big living room, there was just information right there like... Just pick whatever you needed. It was all right there. And [COMMUNITY HEALTH AND REPRODUCTIVE HEALTH CENTERS] provided things, like there was definitely an AIR of community effort... They were really like the hub, but you could access different points of information from within that space, and I really like that, and I think that should be like a default model for community centers...

#010: It was like a course; I think it was two months. It was with a couple of other folks from around the country, and it was led by a licensed therapist who worked in a harm reduction model, and I think that individualization and attention that I felt from the therapist plus a bit of that group mentality of the folks I was with, that kind of interconnection between personalization and building community in that space...

Positive and/or Affirming Providers and Groups

To some degree, all eleven participants described providers, groups, and interactions that were positive and/or affirming. Despite many shortcomings, participants found providers who were affirming and respectful of their identities and provided a safe space in which to explore issues related to their substance use. Many participants also had positive experiences in rehabilitation facilities centers as well as Alcoholics Anonymous and Narcotics Anonymous groups, including several LGBTQ+-specific groups. In many cases, affirming groups and environments were forged by gender diverse people in response to a lack of inclusion, respect, and affirmation within existing groups and treatment settings. Some providers and group members also served as advocates for TGD folks to ensure that they were receiving the

appropriate care and support. Participant #005 became the treatment representative for their home Alcoholics Anonymous (AA) group in order to make intentional space for the gender diversity community because they themselves had not found that space in their early recovery:

It's just hard to find a spot in recovery being genderqueer, and not everybody kind of has the attitude to do it 'cause you have to make space for yourself. There's not space for us yet. And when I first got sober, I definitely would not have been able to do the things that I do now. But yeah, we're working on it. We do have an LGBTQ meeting, like I said... and we just kind of try to recruit all the queer people that we meet, and you know straight people and cis people too, but it's very alienating to just try to do it yourself. Before I started going to the queer meeting... I hadn't even started using they/them pronouns yet 'cause I didn't have enough people around me that actually understood the concept and would pay attention to it. And so that meeting really changed my recovery, really changed my sobriety, I would not have gotten comfortable enough to do the things that I do as treatment rep if I didn't have that meeting, 'cause even the cishet people that mean well just aren't very informed around here.

#009: There's this meeting that I haven't been to in a while. It's on Zoom. I think it's called like [NAME] or something, which I have some feelings about, but it is explicitly for trans women and trans femmes... But there just kinda being the sense of commonality and shared history or concerns... Yeah, that meeting always felt good to be in, and I think also finding other trans women and trans femmes who are in the program, or are sober, but elsewhere... Yeah, it feels nice to know that it's... Other people are doing it, and it is possible and... Yeah, but it's not uncool or boring or less queer or less trans or something,

if you're in recovery versus partying or clubbing or something every weekend or... Yeah, I think having found people with same or similar identities who are also doing this feels really, feels really good... It feels good to not be the only trans person in the room when I'm at a meeting, just feels a little like safer. I can kind of relax a little more. There's also a feeling of like, "Okay, there's people here who can relate even more to my experience."

#001: One of the guys that works [at rehabilitation center] on staff, he was gay, and he was the one that proposed that they do the thing that I signed about self-harm so that I could get in there. So, he actually was the reason that they let me in so yeah, I had to mention him because he was very, very important. And I met him the night I got there, and he was like, "I'm so excited! I'm glad you're here. I'm not, but I'm glad you made it here." And no other treatment centers would take me. So, in some ways, I think that that guy really put out his neck for me and saved my life in some ways.

Supportive Relationships & Communities

The coding team identified descriptions of experiences with supportive relationships and communities across all 11 interviews. Each participant recounted stories of friends, partners, family members, peers, and group members who supported them on their recovery journeys. This support took many different forms including financial assistance, logistical assistance (e.g., help exploring treatment options, rides to and from treatment, picking up medications), encouragement, emotional support (e.g., attending initial meetings with participants), nonjudgmental conversations about their substance use and treatment options, accountability, advocacy, sharing resources, and providing substance-free spaces and reinforcers. Participants

also shared the profound impact that this support had on their willingness and ability to seek out help and work on their recovery.

#010: Well, I think trans and queer people in general, just do a really awesome job of caring for each other as a community and showing love and compassion, so I think I would kind of utilize that and just remember that even just being there for someone and able to be there for them (also in an affirming way) is enough and that showing up is enough, and then I would try to point them to the sparse resources that I've seen.

#001: I think, fortunately for me, I had the really special case of having people around me, my first time I went to treatment that really cared about me way more than I realized at the time and cared about me way more than I cared about myself. I did drag for a long time, I was a drag king and my drag family, basically just let me stay with them. My drag brother [laughter] brought out one of those ketchup cups you get at a restaurant and would give me my meds every morning and make me eat, took me to my PHP and IOP programs at [PSYCH HOSPITAL] and just really... I had people that really cared enough, and that was really big for me because I hadn't really experienced that... But knowing that when I got out and I was doing the partial hospitalization and half days of treatment and stuff, I had a friend that was gonna pick me up, make sure I ate, make sure I took my meds. Those were really, really life-changing things...

Successful Reductions Outside of Treatment

For a variety of reasons, some enumerated above, not all participants received treatment for their substance use. However, several participants were able to make changes in their drug or alcohol use outside of a treatment context. The coding team identified six participants who had

made such changes. Some of those participants later pursued treatment and/or mutual help groups to help support or maintain their recovery. Participant #003 indicated that without treatment, he “was able to stop drinking but [he] was unable to stop using drugs.” He later sought treatment to stop his drug use. Other participants had goals related to reduction and moderation, rather than sobriety and pursued harm reduction techniques on their own.

#009: ...for the first almost two months, I wasn't in therapy, and I hadn't found my way to AA yet and... Yeah, so at first it was just like white knuckling it in a way. It didn't feel like that, because I kind of had a reason to be taking a break, and that is kind of how I saw it. It was just like, "Yeah, I'm taking a break for this energy healing training that's coming up." But then after the three-week period after that is up, then I'll go back to it, but it was sort of like some clarity around that, and then some clarity around just not drinking every day. That kind of helped me see that like, "Oh, I can't do this, I can't go back to that." And then it got more difficult and then I sought help, but at first, I did it just by myself and I didn't really talk to anyone about it. I read some things and that felt helpful, but at first, I did it alone and it got a lot easier when I wasn't doing it alone.

Recommendations

Participants drew on their lived experiences and expertise to provide suggestions to improve access to treatment as well as the content and quality of treatment options. The coding team further categorized these recommendations into eight subthemes. Some recommendations were born of positive experiences that participants thought should be more common and accessible. Others were made in response to unhelpful, disrespectful, or harmful experiences that community members endured or that kept folks from pursuing treatment (e.g., examples described within the apprehension subtheme). Finally, some ideas were not rooted in any prior

treatment experiences – addiction-related or otherwise – but emerged from strengths specific to the community and the ways in which the community rejects binary thinking and embraces flexibility, care, and open-mindedness.

Diverse, Flexible, & Accessible Treatment Options

Eight participants articulated the need for more varied options for treatment and recovery. When asked how to support TGD individuals interested in substance use treatment, participant #006 explained, “I think it depends entirely on the person you're about to be talking to, there's not a one-size-fits all, at least not that I know of, way to approach people...” A diverse community deserves diverse treatment options that are flexible, accessible, and responsive to the shifting needs of individuals and the community. Proposed options included more free and low-cost services, explicitly LGBTQ+ friendly group and individual therapy, nongendered or gender inclusive services, greater individualization of treatment, harm reduction approaches, and greater variety in types of therapy available (e.g., art therapy, animal-assisted therapy). Some participants also highlighted other aspects of diversity within the community that should be addressed.

#003: I think having also diversity of community members would be important... That attend so you know not just a white queer space, 'cause I think that's really common in [CITY], as well as not just a young person queer space would be important... Having different types of programs to fit different needs.

#010: I really think... Different models and options... I know for me, it was very much like, I wanna change how I'm drinking, but the only option I see is rehab and I don't want to be sober, and that was my mindset for many years until I was able to find an option

that more works with me. So I think in that regard, the more models that don't just quite look like what we've seen in the discourse, which is get dropped off by your parents and get picked up two weeks later, like summer camp, but a hospital [laughter], the more I think options we can show that don't look like that, the better.

LGBTQ+ Providers

Nine participants spoke of the need for treatment providers who are part of the LGBTQ+ community, who they perceived as being more able to understand and relate to them. Providers within the community also offer identity-matched role models, which may be especially valuable given the stereotypes and perceived norms related to substance use in the LGBTQ+ community. Participant #3 stated, "I think it's important to have queer people working in a queer space." This simple sentiment was echoed by participant #001 as well "...I think if you have anybody that's under the [laughter] rainbow umbrella, it's really, really helpful." A step further, some participants noted that providers who were members of both the LGBTQ+ and recovery communities with professional expertise and lived experiences would be particularly helpful.

#004: ...hiring individuals who've completed the program, if not for the therapeutic or social work positions then for peer support leaders. So that you're hiring people with the lived experience who have went through, which should be a priority before people even complete the program, you should be looking to hire those kind of people then especially once you completed people from your own program re-hiring them, if they desire that, to be the support and mentorship for others in the program, I think goes a long way.

#011: Staff that not only has read about what it's like to be a trans person but actual trans people, 'cause they exist. [laughter] Trans medical providers definitely exist, and if we

could be... I would much rather have treatment at the hands of somebody who has gone through the things that I've gone through; I think that's why cisnet people like cisnet therapists.

Improved Training & Education

Even more frequently mentioned than the desire for identity-matched providers was the need for providers at all levels to receive better training and education regarding the TGD community and their unique strengths, needs, and preferences. All 11 participants discussed the need for improved education and training around a diversity of community-relevant issues including but not limited to basic terminology, greater understanding of dysphoria, a better working knowledge of hormones and medical transition and their impact on mental health, as well as how to approach each of these topics with sensitivity and respect. For several participants what *not* to say and do was equally important as what providers should be saying and doing. Some also recommended that providers become more well-versed in harm reduction approaches and embrace flexible strategies to meet clients where they're at.

#009: I think sensitivity around what to say, what not to say, what to ask, what not to ask. Things like that. Maybe talking about experience with working with trans folks, I feel like if I were to meet a therapist for the first time, or if I really go to a program or something, and they... Yeah, we've worked with other trans people in recovery before, or we've had this number of people like go through program or there's others here or... I'm seeing other clients who are... Yeah, I think some demonstration of knowledge, but also of history or if there isn't much to maybe say that too. Like "I haven't really worked with any trans or nonbinary folks, or I don't work with many, but... Is there anything I should know?" or "I'm working on keeping myself educated" or things like that... I think like

basics, just around labels, terms, maybe statistics or... Yeah, things like that, things like reasons why we might be hesitant to seek treatment or why we might be more likely to leave.

#006: ...we still need to have more structure in people understanding that there's still sensitivity to being an ally and the impact of your words and your actions, and thinking specifically of my introduction to safe zone training, which I did my first year of college, and just already knowing that I was on board of being an ally, even just learning... It was so fundamental, I learned that that was a word for one thing, and I was like, oh yeah, duh, but still beyond that, you still have to apply it and here's how... And also, equally as importantly, here's how not to... In tandem with more drug and alcohol education and awareness, I think that goes hand-in-hand with that if you're thinking about it in this context. So, I would love to see more trainings about that, I know they're very popular on college campuses, but I'd like to see them more in the workplace, it's not like you stop being gay or trans at work, it needs to apply everywhere.

Specific Transgender and Gender Diverse Spaces

Seven participants highlighted the importance of having safe and affirming spaces that catered specifically to the TGD community. As previously described, treatment and recovery spaces were typically, if unintentionally, cisgender-centric, which sometimes provoked feelings of apprehension, otherness, and discomfort. Intentionally cultivating TGD-oriented spaces may help reduce some barriers to treatment by decreasing apprehension related to gender identity stigma and discrimination. These spaces may also increase desire for treatment and change as participant #010 noted, “[I]f I saw something geared towards me, that would be a motivator.”

Additionally, being able to connect with and relate to others who share similar histories and identities may enhance social support and optimism, which are important factors in recovery.

#011: One thing would definitely be kind of identity-specific groups, like group therapy sessions... Definitely optional group therapy sessions, this is under the first one, where it could be like a group for non-binary people, a group for trans women, a group for trans mascs, a group for people who identify as gay or lesbian, like having those kinds of specific identity-specific groups, just because I think you used the phrase "Access and norms" earlier, those are different for different groups at least from my experience, what I've seen, definitely different for different groups.

#009: I think... Things specifically for the community are helpful, so maybe whether that's like different programs or meetings or treatment types or centers or things like that, that are just for trans folks or are explicitly inclusive of and clear about the ways in which they are.

Holistic Care

There was a common desire to be seen not only as patients and not only as transgender or gender diverse people, but to be seen and cared for as whole, complex being with unique physical, emotional, and spiritual needs. Ten participants offered suggestions that ranged from providing access to food and other material resources to shifting the way that providers conceptualize and respond to clients. Participant #003 emphasized the importance of holistic care given the significant impact that addiction can have on all areas of a person's life including access to basic resources: "I think having resources outside of addiction 'cause I think addiction

creates a lot more of the problems than just the active using, you know... Perhaps access to housing and clothing, stuff like that.”

#008: I wouldn't want it to look like a hospital building or medical building, I'd want it to look kind of home-y, I want there to be like a garden or something like that, 'cause I feel like having that welcoming look like homey look, it makes it more approachable than it looking like a stainless steel with concrete building...cause a lot of the trans people have trauma with medical places, so making it not look like a medical place might be helpful... Make it to where they can kind of express themselves in a way that's safe for everyone, and still allows them to feel like less dysphoric in the present and also just simply respecting them as a person and not as a patient, 'cause a lot of the places that I go to, like doctor's office and therapy and stuff like that, they see me as kinda like a patient like, okay, person, this is a number, okay, so this patient needs, this, this, this, and this. I'm kinda not seen as... I'm this person who has these needs and these wants, and I wanna do this, and they don't see me as a person, so I feel like simply making it homier, allowing them to express themselves in a safe way. And then also just making sure that they're seen as people, that they're not just seen as... Like we get to know everybody kind of thing...

Community Context

Four participants argued that culturally tailored treatments would need to address the complex, nuanced relationships between the TGD community, gender identity and dysphoria, and substance use. For example, participant #010 asserted that “there are a lot more nuances with, I think how gender and sexuality relate to substance use that can be flushed out and really leveraged for more effective programming and treatment options.” Participant #011 affirmed this

perspective and also highlighted that access and use of drugs may look different in a TGD-specific context: "...Maybe having knowledge of the intricacies of the trans-drug scene, and being able to talk about that..." This understanding may shape recommendations made in treatment. For example, AA and NA emphasize the need to seek out new "people, places, and things" in recovery and other treatment may highlight the importance of finding substance-free reinforcement and socialization (Wilson, 2002). As previously described (e.g., participants #002 and #011's statements regarding community context), many TGD social spaces center on nightlife and substance use and asking folks to remove themselves from these spaces in early recovery may have unintended negative effects on their social supports. However, it is important that providers explore these potential issues thoughtfully and avoid making assumptions about links between a client's gender identity and substance use. As participant #010 pointed out, "I would say that my transness... That my transness does influence my relationship with drugs and alcohol, but not in the way you might think."

#009: Yeah, I think it's helpful when the person who's leading the meeting or like a therapist or would assume someone in a treatment program kind of model that and then use gender-inclusive language and... Have a knowledge of identities and specific barriers to treatment for trans and queer people and that relationship that we have to substances and substance abuse.

#011: It's not so much knowing as it is understanding, I wish that they would just understand that... I don't know, gender is kind of an important part of my identity, and it has definitely shaped the relationship that I have with drugs and alcohol and has at times

been part of the reason for the abuse of alcohol, particularly alcohol, just like that kind of understanding and knowledge of who I am being centered in that.

Thorough & Accessible Resources

Across all 11 interviews, participants described a need for more thorough and accessible resources to address the diverse needs of the community. Suggestions included community-facing supports and materials (e.g., increased availability of Narcan and fentanyl test strips, information related to substance use and treatment options) as well as vetted and interactive lists of providers and treatment options (e.g., smart phone applications, living documents that TGD individuals can access and edit based on their experiences with particular providers and facilities). For example, participant #005 emphasized the need for holistic, material resources: “I think free HIV and hepatitis screenings... condoms and pamphlets on mental health and substance abuse. Handing out NARCAN, stuff like that.” Participants also suggested ways to disseminate resources utilizing social media and existing community events and organizations.

#004: I like the idea of not having to search to find your things, so I think if you're gonna be offering like...We have this group, we're also going to post about it on social media, the same way that we would post about any other group so that they as an organization are not ashamed of it...Make sure that you're getting into spaces where individuals who might need your services are going to see it without having to seek them out so make sure you're going... If you are trying to do specifically transgender or queer [outreach], make sure you're going to Pride, talk to people at pride and [give] out information and resources in the spaces that the community already meets up rather than the community having to seek you out.

Respect for Identity

Given the prevalence of treatment and recovery contexts that explicitly (e.g., discrimination) or implicitly (e.g., lack of consideration) disregarded identity, it is not surprising that nine participants emphasized the need for more intentional inclusion and respect. Many participants expressed the value of identity-related understanding and respect as well as what forms it should take. This respect would include asking for and using the correct names and pronouns, staff and providers sharing their own pronouns, explicitly including representation and examples of TGD folks in advertisements and treatment materials, and meaningfully engaging with the TGD community. This also encompassed thoughtful and nuanced design and procedures that affirm gender diversity (e.g., minimizing the need for and use of legal deadnames, inclusive intakes and paperwork, gender inclusive restrooms) without overemphasizing difference, othering, or outing clients. The possibility of truly sensitive and culturally responsive care seemed to strike a chord with participants. Participant #010 expressed “...the idea that a treatment can be affirming when it comes to gender is just so exciting, even if it's not directly connected.”

#005: Having staff that understands the concept of gender diversity, having staff that doesn't refer to what you were born as or your old gender, your old name. Like I said, people sometimes think they're being inclusive by talking about it so much, and it's just very rude and clumsy.

#011: Honestly, just being more educated about what that... Not just medically what it means, or psychologically what it means, but also the lived experiences of trans people, just like... I don't know, get some experience. I know that's easier said than done, but

that's... The base of it is like, if you don't know anybody who's trans, maybe go meet some trans people, I don't know, just like... I don't know. Yeah, it's hard 'cause it's like... The basics of it is like they have to broaden their understanding of what it means to be a person and what gender is, and that's kind of a difficult blanket statement to give to like, Oh yeah, providers should just be more open-minded or should make more of an effort to understand the trans community or the queer community in general, but specifically the trans community, 'cause I feel like that's been much more central to my life.

Discussion

The goal of the present study was to elicit first-person accounts of the experiences TGD individuals have had in substance use treatment contexts as well as suggestions, informed by lived experiences, for improving care. Eleven transgender and gender diverse participants, aged 18-64, completed a brief questionnaire and an interview that explored their substance use histories and experiences seeking and engaging in treatment. As expected, each participant reported a mixture of positive and negative experiences when seeking and engaging in treatment for problematic substance use. Individuals encountered barriers to treatment (e.g., stigma and discrimination), problems within treatment (e.g., disregard for their identities), and successes related to reducing use and receiving care (e.g., supportive communities). Participants also provided suggestions to make treatment more affirming and accessible (e.g., holistic care, TGD-specific spaces).

Participants reported having difficulties accessing and benefiting from treatment that was rarely inclusive or designed with TGD folks in mind. Some of these difficulties are commonly experienced by folks of all identities who seek substance use treatment (e.g., high costs, lack of insurance coverage, limited access to treatment; Priester et al., 2016; Rapp et al., 2006). Prior

literature supports the notion that marginalized communities face additional barriers to care (Priester et al., 2016). For example, in a prior study, men of color reported barriers such as a lack of culturally competent services and cultural attitudes about substance abuse, mental health difficulties, and help-seeking (Ro et al., 2006). Participants faced additional identity-specific barriers (e.g., stigma, well-founded fears of mistreatment, community norms that inhibited recovery) that further limited their ability to receive the help that they needed, which is consistent with prior literature on treatment-seeking TGD samples (e.g., Snow et al., 2019). When participants were able to access treatment, they often encountered providers, groups, and systems unequipped to meet their needs respectfully and effectively. Participants reported a range of problems including mistreatment (e.g., providers accidentally or purposely using incorrect pronouns and making offensive assumptions like claiming gender identity is a result of trauma), rigidly gendered treatment spaces, a lack of providers with shared identities (e.g., providers of color, TGD providers), and providers who did not have knowledge of or experience working with the TGD community. These findings are also consistent with the minority stress literature which emphasizes the additional stressors faced by marginalized communities (e.g., Hendricks & Testa, 2012).

However, participants reported resilience and resourcefulness in their pursuit of recovery. This often involved leaning on other TGD community members and local networks to find affirming care or forging their own affirming spaces when none existed. Given how these individuals persisted despite serious, systemic barriers and personal costs, this suggests that it is treatment efficacy might be enhanced if allies and providers worked not only to support individuals but to amplify the community voices and reimagine substance use treatment. To this end, study participants offered valuable suggestions to consider.

Several key recommendations were identified in the analytic stage that warrant further exploration given their potential impact to clinical care for this underserved community. Though the sample was not large or nationally representative, the variety of experiences and perspectives shared reiterates that the TGD community is not monolithic or stagnant. The diversity within the TGD community was discussed by participants in the present study and has been noted in other studies related to the experiences of TGD individuals (e.g., Johns et al., 2023; Kattari et al., 2020). Consequently, substance use treatment must be flexible and dynamic in content, structure, and delivery to address the diverse and evolving needs of the TGD community. Treatment should also be grounded in a more nuanced understanding of the community's context and norms related to substance use. Providers who belong to the LGBTQ+ community broadly, and the TGD and recovery communities specifically, may be especially helpful in facilitating safe and culturally responsive treatment. Wraparound services may be particularly indicated in a community in which individuals are less likely to have a college degree, have lower rates of employment, lower household incomes, and increased rates of poverty (Carpenter et al., 2020). As recovery and treatment-related resources are identified and developed, it would be beneficial to create local and national hubs for information and referrals in order to enhance the accessibility of these resources and reduce the burden on help-seeking individuals.

Additionally, the frequency with which participants discussed their apprehension about engaging with treatment providers and systems indicates a pressing need for the field to make repair and begin to build trust with the TGD community. Prior research has identified this hesitancy to seek help in other contexts including primary care settings and gender-affirming HIV care clinics (e.g., Baguso et al., 2022; Mikovits, 2022). Improving training and education is a crucial step in demonstrating both concern for and greater understanding of this unique and

diverse community. Some work has been done to improve service providers' training and sensitivity in various fields (e.g., Suesch Schwend, 2020; Yoder, 2021). Much work remains to be done in the field of substance use treatment. Prioritizing TGD experts and community stakeholders in the development and delivery of such education will likely result in more nuanced, sensitive, and affirming content and demonstrate respect for the community and their lived experiences (Moore et al., 2021). Cultural adaptations of existing interventions that engage stakeholders (e.g., local psychologists, social workers, and target community members) in the adaptation process been shown to improve acceptance and bolster outcomes (e.g., Musanje et al., 2023). Such adaptations may include changing language, integrating community practices, and updating stories and visuals to center the targeted community. A failure to engage the community in this work will likely result in further disconnect and distrust between providers and the individuals they are meant to serve. Becoming supporters and advocates for the TGD community both within and outside of treatment contexts will also be important to facilitating the development of trust and mutual respect. Given participants' experiences and feedback, the treatment community needs to embrace an intersectional and culturally humble stance in their work with this community and involve community experts with lived experiences in each step of the adaptation process. Without this foundational work, improved treatment development and delivery will likely have limited impact on these communities (e.g., Griner & Smith, 2006; Rathod et al., 2018). The present study aligns with and builds upon a body of literature that has identified barriers and problems experienced by transgender and gender diverse individuals seeking treatment. The unique contribution of the present work was a strengths-based approach in which TGD individuals were asked to utilize their lived experiences and expertise to directly

make recommendations for advancing substance use treatment for their community. Centering the

Limitations

The study had several limitations that are important to consider. The present sample was predominantly young, White, and employed and their experiences may not reflect those with intersecting marginalized identities and characteristics (e.g., TGD people of color, older adults, and more economically marginalized individuals). Additionally, many identities encompassed within the transgender and gender diverse community were not represented within the present sample (e.g., agender, Two-Spirit, and androgynous individuals). Information related to participants' location within the United States (e.g., state, geographic region, rural vs. urban community) was not collected. These factors likely have a meaningful impact on the availability of treatment (e.g., physical distance to treatment facilities, number of treatment facilities/providers, insurance coverage of services, and political and legal landscape). For example, an individual located in a rural community in a Southern US state may not have the same access to affirming care centers as a similar individual in a large urban community in a Northeastern US state (e.g., Martos et al., 2017). Additionally, an individual's location may impact their perception of safety and trust in the medical and mental health system. For example, even if a state has no laws impeding substance use treatment, laws that restrict gender affirming care might lead an individual to distrust or hesitate to access services related to mental healthcare and substance use. However, there is not yet published research exploring this potential effect, likely in part due to the rapidly changing nature of the legal landscape for TGD people in the United States. Additionally, providers in smaller, more conservative, or more rural communities may have less exposure to training or experience working with TGD individuals, which may

impact access to, quality of, and trust in services for TGD people (e.g., Knutson et al., 2018). Individuals may have differential access to substances based on their location. For example, states vary in their regulation of access to and use of substances (e.g., legality of cannabis varies widely across states), and certain substances may be more commonly used and accessible in some cities and regions. Additionally, certain resources and types of treatment may be available in some states and regions but not others (e.g., safe needle exchanges, supervised consumption sites, rehabilitation centers; Nadelman & LaSalle, 2017).

Future research should target a more intersectionally representative sample of the TGD community to explore what barriers, problems, successes, and recommendations arise. Larger studies present the opportunity to examine the differential experiences of TGD individuals based on different intersecting identities and characteristics (e.g., ethnicity, age, socioeconomic status, sexual orientation, disability status).

Future Directions

Participants noted problems they experienced related to their ethnic identities, age, and sexuality. Future research may continue to explore the ways that intersecting identities shape individuals' experiences, needs, and strengths. There is a need for large, nationally representative studies of the experiences, needs, and desires of the TGD community within a substance use treatment context. Community members should be centered in the design, implementation, and interpretation of this work to increase sensitivity and effectiveness. Additionally, the feasibility and acceptability of community-specific adaptations should be assessed with stakeholders including TGD community members, LGBTQ+ resource centers, and service providers.

Conclusions

Transgender and gender diverse individuals have a broad range of experiences with and perspectives on substance use treatment. Participants described the current barriers and gaps in treatment and discussed positive experiences and a desire for greater diversity, training, and respect from treatment providers. The lived experiences of these TGD community members provide potential directions for researchers and service providers to explore in pursuit of effective, culturally humble substance use treatment (Mosher et al., 2017). While these individuals represent only a small subset of the vast and multifaceted gender diverse community, they offer an essential perspective on the current state of treatment for drug and alcohol use and imagine a better and brighter future.

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Table 1

General demographic characteristics

	<i>n</i> (%)
Age, mean (SD)	29.18 (12.27)
Gender	
Genderfluid	1 (9.1%)
Genderqueer	3 (27.3 %)
Nonbinary	2 (18.2%)
Transgender Man	3 (27.3 %)
Transgender Woman	2 (18.2%)
Race/Ethnicity	
Black or African American	1 (9.1%)
Latinx/Hispanic	2 (18.2%)
Native American	1 (9.1%)
Multiracial (self-identified “Black + White”)	1 (9.1%)
White or European American	8 (72.7%)
Relationship Status	
Single/Never Married	8 (72.7%)
Cohabiting but not married	2 (18.2%)
Married	1 (9.1%)
Education Completed	
12 th Grade or GED	1 (9.1%)
Some College	6 (54.5%)
Associate Degree	1 (9.1%)
Bachelor’s Degree	2 (18.2%)
Graduate Degree	1 (9.1%)

Table 1

General demographic characteristics

Employed	
Yes	7 (63.6%)
No	4 (36.4%)
Disability	
No	3 (27.3%)
Yes	7 (63.6%)
Prefer not to respond	1 (9.1%)
Annual Household Income	
Less than \$10,000 per year	2 (18.2%)
\$10,000 to \$19,999 per year	1 (9.1%)
\$20,000 to \$29,999 per year	2 (18.2%)
\$30,000 to \$39,999 per year	1 (9.1%)
\$40,000 to \$49,999 per year	1 (9.1%)
\$50,000 to \$59,999 per year	1 (9.1%)
\$70,000 to \$79,999 per year	2 (18.2%)
\$90,000 to \$99,999 per year	1 (9.1%)

Note: Participants were allowed to select multiple racial and ethnic identities, so these percentages do not sum to 100%.

Table 2

Substance Use

	<i>n</i> (%)
Past or Current Use	
Alcohol	10 (90.9%)
Cannabis	11 (100%)
Amphetamines	8 (72.7%)
Cocaine	6 (54.5%)
Opiates	1 (9.1%)
Hallucinogens	6 (54.5%)
Solvents/Inhalants	3 (27.3%)
GHB and others	4 (36.4%)
Sleeping/sedatives not as prescribed	6 (54.5%)
Painkillers not as prescribed	6 (54.5%)
Risk Indicators	
Polysubstance use	9 (81.8%)
Negative consequences	10 (90.9%)
Injury to self or others	4 (36.4%)
Expressed Concern	8 (72.7%)
Attempts to cutback	10 (90.9%)

Table 3

Frequency of Current Substance Use

	<i>n (%)</i>
Alcohol	
Daily	2 (18.2%)
5-6 times per week	1 (9.1%)
3-4 times per week	1 (9.1%)
1 time per week	1 (9.1%)
2-3 times per month	1 (9.1%)
3-11 times per year	1 (9.1%)
No longer use	3 (27.3%)
Cannabis	
Daily	5 (45.5%)
5-6 times per week	1 (9.1%)
3-4 times per week	1 (9.1%)
1 time per week	1 (9.1%)
No longer use	3 (27.3%)
Amphetamines	
Daily	1 (9.1%)
1 time per month	1 (9.1%)
3-11 times per year	2 (18.2%)
No longer use	4 (36.4%)
Cocaine	
3-11 times per year	1 (9.1%)
1-2 times per year	1 (9.1%)
No longer use	4 (36.4%)
Opiates	
No longer use	1 (9.1%)

Table 3

Frequency of Current Substance Use

Hallucinogens		
1-2 times per year		3 (27.3%)
No longer use		3 (27.3%)
Solvents/Inhalants		
1-2 times per year		1 (9.1%)
No longer use		2 (18.2%)
GHB and others		
3-4 times per week		1 (9.1%)
1 time per week		1 (9.1%)
1-2 times per year		1 (9.1%)
No longer use		1 (9.1%)
Sleeping/sedatives not as prescribed		
2-3 times per month		1 (9.1%)
1-2 times per year		2 (18.2%)
No longer use		3 (27.3%)
Painkillers not as prescribed		
1 time per month		1 (9.1%)
No longer use		5 (45.5%)

Note: Percentages reflect the percentage of the total sample.

Table 4

Themes and frequencies

	<i>n of participants (%)</i>
Barriers	11 (100%)
Lack of Support	7 (63.6%)
Stigma & Discrimination	9 (81.8%)
Cost & Lack of Insurance Coverage	9 (81.8%)
Well-founded Apprehension	9 (81.8%)
Limited Treatment Access	7 (63.6%)
Community Norms	9 (81.8%)
Problems	11 (100%)
Disregard for Identity	5 (45.5%)
Lack of Training & Knowledge	7 (63.6%)
Predominantly White & Cisgender Spaces	8 (72.7%)
Inappropriate Assumptions	7 (63.6%)
Rigid & Unnecessary Gendering of Treatment	4 (36.4%)
Successes	11 (100%)
Positive and/or Affirming Providers & Groups	11 (100%)
Good Resources (If you can find & access them)	9 (81.8%)
Supportive Relationships & Communities	11 (100%)
Successful Reductions Without Treatment	6 (54.5%)
Recommendations	11 (100%)
Diverse, Flexible, & Accessible Treatment Options	8 (72.7%)
LGBTQ+ Providers	9 (81.8%)
Improved Training & Education	11 (100%)
Specific Transgender and Gender Diverse Spaces	7 (63.6%)
Holistic Care	10 (90.9%)
Community Context	4 (36.4%)

Table 4

Themes and frequencies

Thorough & Accessible Resources	11 (100%)
Respect for Identity	9 (81.8%)

Appendix

Eligibility Screening Questionnaire

- What is your age?
- What sex were you assigned at birth (i.e., what is on your original birth certificate)?
 - Male
 - Female
 - Intersex
- What is your gender identity? Cisgender means you identify with the sex you were assigned at birth.
 - Transgender Woman
 - Cisgender Woman
 - Cisgender Man
 - Transgender Man
 - Nonbinary
 - Genderqueer
 - Agender
 - Genderfluid
 - A gender not listed above (please write in)
- Please check all that apply.
 - I have never thought about or sought treatment for my drug and/or alcohol use.
 - I have thought about participating in treatment for my drug and/or alcohol use.
 - I am currently exploring treatment options for my drug and/or alcohol use.
 - I am currently in treatment for my drug and/or alcohol use.
 - In the past, I have participated in treatment for my drug and/or alcohol use.
- What is a good phone number for you?
- Do you consent to being contacted by the study team to complete the questionnaire and interview?
 - Yes
 - No
- How did you hear about the study?
 - Social media
 - Local organization
 - Physical flyer
 - Friend, family member, or acquaintance
 - Please enter their phone number so that we can compensate them for referring you.

Participant History Questionnaire

Demographics

- What are your pronouns?
 - She/her
 - He/him
 - They/them
 - Ze/zir
 - Pronouns not listed above (please write in)
- Are you of Spanish, Hispanic, or Latinx origin?
 - Yes
 - No
 - Unsure
- How do you describe your race?
 - Black or African American
 - White or European American
 - Asian or Asian American
 - Alaskan Native
 - Pacific Islander
 - Native American
 - Multiracial (please write in)
 - Not listed above (please write in)
- What is your marital status?
 - Single/Never married
 - Married or cohabitating
 - Separated or divorced
 - Widowed
- What is the highest level of education you've completed?
 - Less than 12th grade
 - 12th grade or GED
 - Some college
 - Associate degree
 - Bachelor's degree
 - Graduate degree
- What is the highest level of education completed by a parent/primary caregiver?
 - Less than 12th grade
 - 12th grade or GED
 - Some college
 - Associate degree
 - Bachelor's degree
 - Graduate degree
 - Not sure
- Do you currently have a job?
 - Yes

- No
- What is your estimated annual household income?
 - Less than \$10,000 per year
 - \$10,000 to \$19,999 per year
 - \$20,000 to \$29,999 per year
 - \$30,000 to \$39,999 per year
 - \$40,000 to \$49,999 per year
 - \$50,000 to \$59,999 per year
 - \$60,000 to \$69,999 per year
 - \$70,000 to \$79,999 per year
 - \$80,000 to \$89,999 per year
 - \$90,000 to \$99,999 per year
 - \$100,000 or higher per year
- Do you identify as having a disability?
 - Yes
 - No
 - Prefer not to respond
- Do you receive disability income?
 - Yes
 - No
- It's important to us to be inclusive. Is there any aspect of your identity or background that would be useful for us to know? This could be the communities you belong to, the languages you speak, where you or your family are from, your sexual orientation, or your faith or religion.

Substance Use

The following are questions about your use of alcohol and drugs. Please remember that your responses are confidential, and you will not get in trouble for how you respond.

Here is a list of substances you may have used. Please select all substances you have used in your lifetime.

- Alcohol



- When we say one drink, we mean 12 oz. of beer, 5 oz. of wine, or 1.5 oz. of hard liquor (see picture above). Malt liquor is stronger than regular beer, so one 40 oz. Malt Liquor beverage such as Colt 45 counts as 5 standard drinks.
- How often do you have a drink containing alcohol?
 - Every day
 - 5-6 times a week
 - 3-4 times a week
 - Twice a week
 - Once a week
 - 2-3 times a month
 - Once a month
 - 3-11 times a year
 - 1-2 times a year
 - I no longer drink alcohol
- On a typical day when you're drinking, how many drinks containing alcohol do you drink?
- How often do you have five or more drinks on one occasion?
 - Every day
 - 5-6 times a week
 - 3-4 times a week
 - Twice a week
 - Once a week
 - 2-3 times a month

- Once a month
- 3-11 times a year
- 1-2 times a year
- Cannabis (i.e., marijuana, weed, pot, etc.)
- Amphetamines (i.e., meth/methamphetamines, khat, Ritalin, Adderall, etc.)
- Cocaine (i.e., crack, freebase, coca leaves, etc.)
- Opiates (i.e., smoked heroin, heroin, opium, etc.)
- Hallucinogens (i.e., ecstasy, LSD, mescaline, peyote, PCP, angel dust, psilocybin, mushrooms, DMT, etc.)
- Solvents/Inhalants (i.e., thinner, gas, glue, solution, trichloroethylene, whippits, etc.)
- GHB and others (i.e., GHB, anabolic steroids, laughing gas [halothane], amyl nitrate [poppers], etc.)
- Sleeping/Sedative Pills not as prescribed (i.e., Xanax/alprazolam, Valium/diazepam, pentobarbital, phenobarbital, triazolam, butalbital, Ambien/zolpidem, Lunesta/eszopiclone, etc.)
- Painkillers not as prescribed (i.e., Fentanyl, codeine, morphine, tramadol, oxycodone, Norco, hydrocodone, Oxycontin, Vicodin, Percocet, methadone, Demerol, etc.)

(If substance endorsed)

- How often do you use [drug]?
 - Every day
 - 5-6 times a week
 - 3-4 times a week
 - Twice a week
 - Once a week
 - 2-3 times a month
 - Once a month
 - 3-11 times a year
 - 1-2 times a year
 - I no longer use []

- How many times do you use [drug] on a typical day when you use [drug]?

Thinking back on your drinking and drug use....

- Do you use more than one type of drug (including alcohol) on the same occasion?
 - Yes
 - No
- Have you ever experienced negative or unpleasant consequences as a result of your drinking and/or drug use?
 - Yes
 - No
- Have you or someone else been injured because of your drinking and/or drug use?
 - Yes
 - No

- Has anyone ever expressed concern about your drinking and/or drug use or suggested that you cut back?
 - Yes
 - No
- Have you ever tried to cut back on your drinking and/or drug use?
 - Yes
 - No
- Often, people look for help from many different sources, including different kinds of counselors, doctors, or mutual help groups (in person or virtual). Are you currently in treatment or receiving help?
 - Yes
 - No
- Have you ever been in treatment or received help?
 - Yes
 - No
- [GATED] Why did you choose that form of treatment?
- [GATED] In the past, what kinds of treatment, help, advice, or healing have you sought for your drug and/or alcohol use?
- [GATED] What [other] forms of treatment have you heard about?
- What [other] kinds of treatment, help, advice, or healing have you thought about seeking for your drug and/or alcohol use?
- [GATED] What kinds of informal help have you received for your drug or alcohol use? This can include sources of help and support like family members, friends, and religious communities.
- [GATED] How would you rate the helpfulness of the treatment you're receiving/have received?
 - Very unhelpful
 - Unhelpful
 - Somewhat unhelpful
 - Neither unhelpful nor helpful
 - Somewhat helpful
 - Helpful
 - Very helpful
- [GATED] How affirming do you consider the treatment you're receiving/have received?
 - Very unaffirming
 - Unaffirming
 - Somewhat unaffirming
 - Neither unaffirming nor affirming
 - Somewhat affirming
 - Affirming
 - Very affirming

Interview Script

“I have now started recording. I’m going to ask you a series of questions about your thoughts and experiences related to alcohol and drug use and treatment for alcohol and drug use. Our goal is to learn more about the experiences of trans and gender diverse people who are interested in or have participated in treatment and how we might be able to improve treatment for the gender diverse community. Do you have any questions before we get started?”

Substances

- How do you view drugs and alcohol as fitting into the trans and gender diverse community?

Treatment Experiences

“Now I’m going to ask you some questions about your thoughts about and experiences with treatment for alcohol and drug use.”

- “What barriers were there to you getting the help that you were looking for?”
 - If they needed prompting, “This can include money or insurance issues, work or family commitments, stigma or discrimination, or lack of services that understand your language or background.”
- “What aspects of treatment made you want to stay in treatment?”
 - Clarify which treatment context(s) this applies to
- “What aspects of treatment that made you want to discontinue treatment?”
 - Clarify which treatment context(s) this applies to
- “What were some things your provider/help group didn’t do well?”
 - If prompting needed, “Some people have said that when they came to treatment, they were misgendered or deadnamed or otherwise made to feel uncomfortable. Have you had any experiences like this?”
 - “Can you tell me about that?”
 - “How could they have done better in that situation?”
- “How did concerns about gender identity stigma or discrimination affect your willingness to seek treatment for your alcohol and/or drug use?”
- “How did gender identity bias or discrimination affect your ability to get help or treatment for your alcohol or drug use?”
- “Were any other patients or members of your group or treatment team trans or gender diverse?”
 - “How does this affect your feelings about the help/treatment?”
- “Do you believe that your treatment providers treated you negatively because of your gender identity?”
 - If yes, “Tell me more about that.”
- If relevant: “Do you believe the mutual help group members treated you negatively because of your gender identity?”
 - If yes, “Tell me more about that.”
- How do you feel other aspects of your identity shaped your treatment experience(s)?

- E.g., racial identity, gender presentation, religion/spirituality, sexuality, etc.
- “Did you successfully make changes in your alcohol or drug use without treatment?”
 - If yes, “How?”
- “If someone in the gender diverse community asked you for advice about treatment for drug/alcohol use, what would you say?”
- “How do you suggest people support individuals to pursue alcohol or drug treatment?”
- “What else about these topics would you like to say?”

Suggestions for Improving Care

- “One of the goals of our study is to find out how we can make treatment feel safer and more affirming for trans and gender diverse people. We’d like to hear what suggestions you might have to help us with this goal.”
- “Did you have someone you were close to that strongly supported you in your effort to get help or treatment?”
 - If yes, “What is your relationship to this person?” “How did they help you in your recovery?” “What specifically was helpful?”
 - “What types of services would be appealing?”
 - How should those services be promoted?”
 - “In what ways can providers help encourage trans and gender diverse people during their first treatment visit?”
 - “What things did you experience in treatment that you wish were more common in treatment experiences?”
 - “What things did providers do right?”
 - Clarify the setting of this experience. Many people will have had multiple treatment experiences so need to keep those distinct and be sure we can match feedback to the treatment modality.
 - “What steps could providers take to make you feel safer or more supported in treatment?”
 - “What do you wish providers knew before you entered treatment with them?”
 - “Can you tell me about the most positive and affirming treatment experience you’ve ever had?”
 - “If you were going to design a center for trans and gender diverse people to get help with their drug and alcohol use, what three things would be most important for you to include in your design?”
 - If they need prompting, “These could include something about the building itself, the providers and their training, or center policies?”
 - “What else you like to add to what we talked about today regarding providers and treatment?”

Closing Interview

“I really appreciate you taking the time to speak with me today and share your experiences and expertise.”

“Before we wrap up, do you have any questions for me? Is there anything else you’d like to share with me today?”

“Okay, please feel free to reach out if anything [else] comes up.”