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Experiences of Hospitalization for Suicide Ideation and Suicide Attempt in Gender Diverse Adults

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**EXPERIENCES OF HOSPITALIZATION FOR SUICIDE
IDEATION AND SUICIDE ATTEMPT IN GENDER DIVERSE
ADULTS**

A Thesis

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Masters of Arts

in

The Department of Psychology

by
Alix Aboussouan
B.S., Pennsylvania State University, 2015
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ABSTRACT

Individuals who identify as Transgender/Gender Diverse (TGD) have elevated rates of suicidal thoughts and behaviors (STBs). No studies have determined the prevalence of hospitalization for STBs in TGD adults or whether this care is viewed as helpful. Understanding hospitalization experiences may determine potential new treatment targets and training initiatives integral to developing affirming care experiences for TGD individuals. This study sought to explore the lifetime prevalence of hospitalization for suicide ideation (SI) and suicide attempt (SA) for TGD individuals, determine how helpful TGD individuals find hospitalization, and investigate demographics, gender minority stressors, or provider/hospitalization characteristics that correlate with hospitalization helpfulness ratings. Data from the 2017 Trans Lifeline Mental Health Survey, an online survey of self-identified TGD individuals, were used. The final sample was comprised of $N=3,718$ individuals, $n=1,003$ (28.4%) of which had been hospitalized; $n=328$ (31.1%) had been hospitalized for SI and $n=728$ (68.9%) had been hospitalized for SA. Generally, SI and SA hospitalization was rated as unhelpful compared to neutral and helpful options. Univariate predictors of helpful SI hospitalization experience included age, trust in providers, and voluntary status of admission, while historical avoidance of mental health institutions led to less helpful experiences. In addition to the above, pride in TGD identity had a positive relationship with SA experience, while historical need to educate providers and avoidance of coming out to providers were inversely related to SA hospitalization experience. When entered into a multivariate analysis, increased trust in providers and voluntary hospitalization had a positive relationship with SI and SA hospitalization helpfulness. Additionally, the multivariate model for SA found increased pride in TGD identity had a positive relationship with hospitalization helpfulness. Limitations and future directions are discussed.

INTRODUCTION

Brief Overview of Current Study

The term Transgender/Gender Diverse (TGD) is used to describe individuals whose gender identity differs from the sex they were assigned at birth. This includes binary transgender women and transgender men, along with people who do not identify with a single gender (e.g., non-binary or agender) or do not adhere to a societally prescribed binary notion of gender (Puckett, Cleary, Rossman, Mustanski, & Newcomb, 2018). Roughly 1.4 million adults identify as TGD within the United States (U.S.) (Flores, Herman, Gates, & Brown, 2016). Research on minority stress has been conducted to help understand mental and physical health disparities predominantly in lesbian, gay, and bisexual (LGB) populations leading to the creation of the Minority Stress Model (Meyer, 2003). However, this model only represents sexual minorities and therefore gender minorities and TGD specific concerns are largely ignored. Thus, the American Psychological Association (APA) created a task force on gender identity and gender variance in order to guide research and theory, to better understand the unique experiences and needs of TGD individuals (American Psychological Association. Task Force on Gender Identity and Gender Variance 2009).

In response to the lack of reliable and valid means of assessing minority stress in TGD individuals, research started to build models that more accurately reflect gender related minority stressors. One such measure, the Gender and Minority Stress and Resilience (GMSR) measure, included nine constructs unique to TGD individuals. These constructs included: 1) distal stress factors such as gender-related discrimination, gender-related rejection, gender-related victimization, non-affirmation of gender identity; 2) proximal stress factors such as internalized transphobia, negative experiences, and concealment; and 3) resilience factors such as community

connectedness and pride (R. J. Testa, Habarth, Peta, Balsam, & Bockting, 2015). Briefly, findings from the GMSR model showed that distal stress factors had a positive relationship with the proximal stress factors and that both distal and proximal stress factors were inversely related to mental and physical health in a sample of TGD adults (R. J. Testa et al., 2015).

These findings resonate with the well-established fact that, among the general population, discrimination is positively associated with the number of negative mental health outcomes (Pascoe & Smart Richman, 2009). Historically, 63% of TGD individuals report experiencing verbal victimization due to their gender identity, 38% have been physically abused, and 26.6% have been sexually abused (Clements-Nolle, Marx, & Katz, 2006; R. J. Testa et al., 2012). These high rates of verbal, physical, and sexual abuse are also prevalent when looking at past year occurrence at 46%, 9%, and 10% respectively (James et al., 2016).

The experience of these kinds of discrimination are related to suicide ideation (SI) and suicide attempt (SA). In the U.S, among individuals who self-identify as TGD, 45%-54% report lifetime SI (Grossman & D'augelli, 2007; Nuttbrock et al., 2010) compared to the 9.2% of the general population (Nock et al., 2008). Further, 28%-41% of TGD individuals report one or more lifetime SA (Haas, Rodgers, & Herman, 2014; Nuttbrock et al., 2010) in contrast to the 2.7% of the general populations (Nock et al., 2008). A meta-analysis by Wolford-Clevenger (2018) helps explain these high rates of SI and SA in the TGD population by exploring correlates of SI and SA among TGD individuals (Wolford-Clevenger, Frantell, Smith, Flores, & Stuart, 2018). For instance, external or distal stressors (such as actual experiences of violence, discrimination, harassment, and rejection experienced) and internal or proximal stressors (such as expectations of rejection, stress related to the concealment of one's identity, and internalized stigma or negative beliefs about one's identity), continuously correlate to both SI and SA.

For example, a positive relationship between SI and external minority stressors such as nonaffirmation, discrimination, and gender related stigma have been found in multiple samples (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Lehavot, Simpson, & Shipherd, 2016; R. J. Testa et al., 2017). Similarly, physical, sexual, and verbal abuse are related to lifetime SA (Bauer et al., 2015; Clements-Nolle et al., 2006; R. J. Testa et al., 2012). Additionally, in a sample of TGD adults proximal internal minority stressors related to increased SI include nondisclosure of identity (R. J. Testa et al., 2017), while positive self-concept and ability to express one's gender were negatively related to SI (Kuper, 2015; Moody & Smith, 2013). Finally, internal minority stressors such as internalized transphobia relate to higher rates of SA (Bauer et al., 2015) and negative self-concept and low self-esteem relate to increased history of lifetime SA (Clements-Nolle et al., 2006; Marshall, Claes, Bouman, Witcomb, & Arcelus, 2016; Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015).

Over 48,000 people died by suicide in the U.S, in the year 2018 alone (NVDRS | WISQARS | Injury Center | CDC, 2018). However, knowledge of how many TGD individuals die by suicide is lacking as gender identity is not thoroughly recorded on death certificates (Haas & Lane, 2015). Nevertheless, knowing how many individuals die by suicide is not enough. Despite 50 years of research, our knowledge of who is likely to die by suicide is no better than a chance prediction (Franklin et al., 2017). One way to further analyze suicidal thoughts and behaviors (STBs) may be to look at emergency department (ED) and hospitalization records, as many people suffering from STBs seek medical help. Rates of ED and inpatient admissions due to STBs have been steadily increasing over the past 10 years, with an estimated 10 million visits due to STBs per year (Pfunter, Wier, & Stocks, 2014; Rockville MD: Agency for Healthcare Research and Quality, 2019; Rockville MD: Agency for Healthcare Research and Quality, 2019).

One study determined that of 58.2% of individuals entering the ED for STBs, including SA, SI, self-harm, and imminent plans, were subsequently admitted to the hospital (Randall, Roos, Lix, Katz, & Bolton, 2017).

As a majority of people who visit the ED for STB concerns are put in inpatient care, it is important to understand how helpful hospitalization is. In a critical review on the efficacy of inpatient hospitalization on reducing suicide risk, results reveal evidence of iatrogenic effects of hospitalization. Immediately following hospitalization patients are at an elevated risk of suicide (Ward-Ciesielski & Rizvi, 2020). A meta-analysis showed that the suicide rate within three to 12 months of discharge from a psychiatric inpatient stay was almost 60 times that of the global suicide rate (Chung et al., 2017). A population-based control study of recently discharged psychiatric patients found that 43% of suicides occurred within a month of discharge from care. Especially high risk periods appear to be the days and weeks after discharge (Hunt et al., 2009). With these rates in mind it is important that research and clinical efforts at suicide prevention are particularly focused on hospitalized patients and that clinical research evaluates why, for some individuals, there are iatrogenic effects of psychiatric hospitalization (Chung et al., 2017; Ward-Ciesielski & Rizvi, 2020).

Although post-discharge suicide is not well understood, knowing factors that relate to helpful and unhelpful hospitalization experiences may be of use. Age is one demographic factor that plays a role in how helpful a general hospitalization is. In the general population, older adults tend to have more positive experiences with hospitalization than younger adults (Crow et al., 2002; Danielsen, Garratt, Bjertnæs, & Pettersen, 2007). Further, the voluntary/involuntary status of an admission is important. Studies have found that a majority of involuntarily committed psychiatric patients found that admission was neither justified nor beneficial and they

were generally dissatisfied with the treatment they received (Kallert, Glöckner, & Schützwahl, 2008; Katsakou & Priebe, 2006). Finally, ability to trust a provider and patient autonomy have related to experiences of hospital stay (Brännström, Strand, & Sand, 2018; Molin, Graneheim, & Lindgren, 2016).

While a few studies of hospitalization experience correlates have been done in the general population, none have addressed the TGD populations' specific experiences of hospitalization. Age, involuntary/voluntary hospitalization, and trust in a provider can be expected to extend to the TGD experience of hospitalization, but the specific external and internal minority stressors linked to SI and SA should be considered as well. Other important minority factors which must be considered include pride in transgender identity, this will help discern if internal minority stressors such as, internalized transphobia, negative self-concept, or low self-esteem, affect hospitalization experiences. Another factor to consider includes whether the TGD individual has ever been fearful of coming out to a therapist, due to fear of discrimination or mistreatment, as research has shown external discrimination has repeatedly been correlated with SI and SA. Research has shown that about 70% of TGD individuals' experience gender-related discrimination in health care (Lambda Legal, 2010). This fear and mistrust of providers is related to another important factor to examine, historical avoidance of mental health care. Avoiding healthcare is not uncommon among TGD individuals. For instance, in one report 23% of respondents did not see a doctor due to fear of being mistreated based on their gender identity (James et al., 2016). Finally, an important correlate to examine is a need to educate your therapist about TGD specific needs. Research has shown that a provider's level of comfort in working with the TGD population was positively associated with the patient's wellbeing (Stanton, Ali, & Chaudhuri, 2017).

The current study aims to determine experiences of hospitalization in TGD adults for both SI and SA along with factors that correlate to helpful and unhelpful hospitalization experiences. Once correlates of hospitalization experience are determined, future clinical studies can be geared toward directly dealing with the specific concerns, thus creating a more robust and helpful hospitalization experience.

It is hypothesized that a vast majority of participants would not express hospitalization as helpful for either SI or SA. It is hypothesized that correlates of finding hospitalization unhelpful for both SI and SA will include: involuntary commitment, discrimination from providers which led to fear of coming out to therapist or avoidance of mental health care, and needing to educated therapists. On the other hand, it is hypothesized that correlates of finding hospitalization helpful for both SI and SA will include: older age, having pride in TGD identity, and having a trustworthy therapist.

Transgender/Gender Diverse Discrimination and Mental Health

Transgender/Gender Diverse (TGD) is an umbrella term for individuals whose gender identity differs from the sex they were assigned at birth. This, non-exhaustively, includes, 1) binary: natal male to female (trans women) and natal female to male (trans men); and 2) non-binary/genderqueer/agender: including individuals who do not identify with a single gender or do not prescribe to the binary notions of gender (Puckett et al., 2018). As of 2016, within the United States (U.S.) it is approximated that 0.6%, roughly 1.4 million, adults identify as TGD (Flores et al., 2016).

Discrimination among TGD individuals is reported at alarmingly high levels. In 2015 the U.S. Transgender Survey (USTS), the largest survey dedicated to examining the experiences of TGD individuals in the U.S. revealed that within the past year alone, 46% of respondents had

been verbally harassed, 9% had been physically attacked, and 10% had been sexually assaulted (James et al., 2016). Historically, 38% of TGD individuals had experienced physical violence and 26.6% had reported a history of sexual violence. Among these reports, a majority of these incidents were due specifically to gender identity or expression (R. J. Testa et al., 2012). Further, another study sampling TGD adults showed that historically 63% of individuals reported experiencing verbal victimization specifically due to the individuals' gender identity (Clements-Nolle et al., 2006). The first study to compare TGD people to cisgender siblings found TGD siblings were more likely to report having experienced harassment and discrimination than their cisgender siblings with 90% of TGD individuals reporting harassment compared to 80% of cisgendered sisters and 63% of cisgendered brothers (Factor & Rothblum, 2007). There is a positive relationship between level of discrimination and number of negative mental health outcomes (Pascoe & Smart Richman, 2009). TGD individuals are not immune to the negative health outcomes attributed to discrimination.

While research supports the fact that TGD individuals suffer from more discrimination and higher rates of psychological distress, it is important to understand the cause of this. Meyer's Minority Stress Model (2003) was created to help understand mental and physical health disparities majorly in lesbian, gay, and bisexual (LGB) populations (Meyer, 2003). Unfortunately, this model only represented sexual minorities and largely ignored gender minorities. While sexual and gender minorities are frequently clustered together under the LGBT acronym, those who identify as TGD are not always understood or included within the LGB community. Although this umbrella term is meant to be inclusive, this conflation undermines the unique experiences that differentiate sexual from gender minorities (Fassinger & Arseneau, 2007). Thus, the American Psychological Association (APA) created a task force on gender

identity and gender variance in order to guide research and theory to better understand the unique experiences and needs of TGD individuals (American Psychological Association. Task Force on Gender Identity and Gender Variance 2009).

As research on TGD specific concerns has started to grow, researchers have begun to build reliable and valid models that more accurately reflect gender related minority stress. For example, the Gender and Minority Stress and Resilience (GMSR) measure, focused on studying nine constructs unique to TGD individuals. The nine constructs included: distal stress factors such as gender-related discrimination, gender-related rejection, gender-related victimization, non-affirmation of gender identity; proximal stress factors such as internalized transphobia, negative experiences, and concealment; and resilience factors such as community connectedness and pride (R. J. Testa et al., 2015). Briefly, findings from the GMSR model showed that distal stress factors, such as gender-related discrimination, rejection, victimization, and non-affirmation had a positive relationship with the proximal stress factors of internalized transphobia, negative expectation, and gender concealment. Further, in a sample of TGD adults, both distal and proximal stress factors were inversely related to mental and physical health indicating higher levels of depressive and anxiety symptoms (R. J. Testa et al., 2015).

Suicide Ideation and Suicide Attempt in TGD Adults

A specific concern among TGD adults, beyond poor mental and physical health, is suicide ideation (SI) and suicide attempt (SA). High rates of SI and SA are reported among individuals who self-identify as TGD in the U.S. with 45%-54% reporting lifetime SI (Grossman & D'augelli, 2007; Nuttbrock et al., 2010) and 28%-41% reporting one or more lifetime SA (Haas et al., 2014; Nuttbrock et al., 2010). These rates are higher than those of the general

population, with a reported SI and SA prevalence of 9.2% and 2.7% respectively in epidemiological studies (Nock et al., 2008).

Similar to the GMSR model linking external and internal minority stressors to mental health issues, a meta-analysis conducted by Wolford-Clevenger (2018) systematically went through literature from 1991 to 2017 regarding correlates of SI and SA among TGD individuals. Correlates were split into six main categories including external minority stress, internal minority stress, psychiatric morbidity, transition and healthcare, reasons for living, and static/demographic factors. External minority, or distal stressors, relate to actual experiences of violence, discrimination, harassment, and rejection experienced. One specific distal stressor important to the TGD community is non-affirmation, this includes intentional or unintentional use of non-affirming language such as improper use of pronouns. Gender related stigma, another distal stressor, includes labeling, stereotyping, and rejecting human differences of those who do not conform to socially accepted expressions of gender. Externalized stigma is related to problems with disclosure such as worrying about telling other individuals they identify as TGD for fear of stigma related discrimination. Internal minority, or proximal stressors, include expectations of rejection, stress related to the concealment of one's identity, and internalized stigma or negative beliefs about one's identity (Meyer, 2003). Internalized stigma is the integration of negative societal attitudes toward TGD individuals within oneself. Similarly, this is related to fear of disclosure of gender identity as a way to protect the self and others (Hendricks & Testa, 2012; R. J. Testa et al., 2015).

Demographic factors seem to be inconsistently related to SI across multiple studies. For example, when considering sex assigned at birth, some studies on TGD adults linked female natal sex as being connected to a higher likelihood of experiencing lifetime SI than natal males

(Grossman, Park, & Russell, 2016; Rood, Puckett, Pantalone, & Bradford, 2015) while other studies found no connection between natal gender and past year SI (Kuper, 2015; Veale, Watson, Peter, & Saewyc, 2017). Similar discordant findings occur when studying sexual orientation and past year SI. Some studies show that sexual minority status was positively linked to past year SI (Lytle, Blosnich, & Kamen, 2016; Perez-Brumer, Day, Russell, & Hatzenbuehler, 2017) whereas another article did not (Mathy, 2003). These inconsistencies between studies were also noted in demographic variables such as age, race, and level of education (Wolford-Clevenger et al., 2018).

Dynamic factors may be more consistently related to SI. Invariably, a positive relationship between SI and external minority stressors such as nonaffirmation, discrimination, and gender related stigma exists (Bauer et al., 2015; Lehavot et al., 2016; R. J. Testa et al., 2017). Further, violence, both physical and/or sexual, was positively associated with historical SI in a sample of TGD adults (Kuper, 2015). Additionally, several studies consistently find increased social support to be negatively correlated to current, past two week, and past year SI, extending not only to friends and family (Bauer et al., 2015; Trujillo, Perrin, Sutter, Tabac, & Benotsch, 2017), but also to health providers (Kattari, Walls, Speer, & Kattari, 2016). In addition to distal factors, proximal internal minority stressors related to increased SI include internalized transphobia, expectations of rejection, and nondisclosure of identity (R. J. Testa et al., 2017), while positive self-concept and ability to express one's gender were negatively related to SI (Kuper, 2015; Moody & Smith, 2013).

When using the same framework as above to study correlates of SA similar to correlates of SI, some demographic results were inconsistent. Some studies of TGD adults found that natal female gender was associated with greater odds of historical SA than natal males (Goldblum et

al., 2012; Grossman et al., 2016; Perez-Brumer et al., 2015). However, other studies found no difference between natal male and females lifetime SA history (Clements-Nolle et al., 2006; Reisner, Vethers, et al., 2015). Findings on race were equally inconsistent, while some studies found White individuals had greater odds than people of color (POC) for a lifetime SA (Clements-Nolle et al., 2006; Grossman et al., 2016) others found POC had greater odds of a lifetime SA than White individuals (Klein & Golub, 2016; Lytle et al., 2016; Perez-Brumer et al., 2015). However, in terms of some other demographics there were more consistent findings. For example, sexual orientation does not relate to lifetime SA (Clements-Nolle et al., 2006; Mathy, 2003), age has a negative relationship with lifetime SA (Clements-Nolle et al., 2006; Klein & Golub, 2016), and education is negatively associated with lifetime SA (Klein & Golub, 2016; Perez-Brumer et al., 2015).

Findings on dynamic factors related to SA seemed to vary more than they did when looking at SI. In terms of external stressors, while physical, sexual, and verbal abuse continued to consistently relate to lifetime SA (Bauer et al., 2015; Clements-Nolle et al., 2006; R. J. Testa et al., 2012) results on discrimination were not consistent. Some studies on TGD adults found that discrimination was positively associated with lifetime SA (Clements-Nolle et al., 2006) but this relationship was not found in others (Lytle et al., 2016). Higher rates of enacted transphobia, that displayed by other people towards TGD individuals, relate to higher rates of lifetime SA (Bauer et al., 2015) Social support by friends and family inversely relates to lifetime SA (Bauer et al., 2015), while a history of rejection is positively associated with SA history (Klein & Golub, 2016). Internal minority stressors such as internalized transphobia, one's discomfort with their own TGD identity, relate to higher rates of SA (Bauer et al., 2015) and negative self-concept and

low self-esteem relate to increased history of lifetime SA (Clements-Nolle et al., 2006; Marshall et al., 2016; Perez-Brumer et al., 2015).

Why is Studying Hospitalization Experience Important?

In the U.S., over 48,000 people died by suicide in the year 2018 alone (NVDRS | WISQARS | Injury Center | CDC, 2018). However, knowledge of how many TGD individuals die by suicide is lacking as gender identity is not thoroughly or consistently recorded on death certificates (Haas & Lane, 2015). Nevertheless, knowing how many individuals die by suicide is not enough. Based on a meta-analysis that explored the past 50 years of research on risk factors for STBs, the predictors of who is likely to die by suicide do not perform better than a chance prediction (Franklin et al., 2017). One way to further analyze suicidal thoughts and behaviors (STBs) may be to look at ED and hospitalization records, as many people suffering from STBs seek medical help. Over the past 10 years, increased rates of emergency department (ED) and inpatient unit STB admissions were recorded, with an estimated 10 million STB visits per year. This figure accounts for 15% of all ED visits in the U.S. (Pfunter et al., 2014; Rockville MD: Agency for Healthcare Research and Quality, 2019; Rockville MD: Agency for Healthcare Research and Quality, 2019). One study determined that of individuals who entered the ED for STBs, including SA, SI, self-harm, and imminent plans, 58.2% of those were subsequently admitted to the hospital (Randall et al., 2017).

As a majority of people who visit the ED for STB concerns are put in inpatient care, it is important to understand how helpful hospitalization is. A meta-analysis showed that the suicide rate among patients within three to 12 months of a discharge from a psychiatric inpatient stay was almost 60 times that of the global suicide rate (Chung et al., 2017). Many SA survivors will make a subsequent attempt (Oquendo et al., 2004), often shortly after psychiatric hospitalization

(Chung et al., 2017). A population-based control study of recently discharged psychiatric patients found that 43% of suicides occurred within a month of discharge from care. Especially high risk periods appear to be during the days and weeks after discharge (Hunt et al., 2009). In a study on the effects of psychiatric crisis services on women with Borderline Personality Disorder, ED visits were the sole predictor of the number of follow-up year SAs, with individuals who had a treatment-year psychiatric ED visit experiencing a greater number of SAs (Coyle, Shaver, & Linehan, 2018). Studying hospitalization experiences while keeping in mind the possible negative outcomes of hospitalization for STBs is important.

Factors That May Affect Hospital Experiences

Although post discharge suicide is not well understood, knowing factors which relate to helpful and unhelpful hospitalization experiences may be of use. Although not specific to STBs, age is one demographic factor that plays a role in how helpful a general hospitalization is. In general, older adults tend to have more positive experiences with hospitalization than younger adults (Crow et al., 2002; Danielsen et al., 2007). Another specific hospitalization experience that appears noteworthy to study is the voluntary/involuntary nature of the admission. One international study found that the rate of involuntary hospitalization of general psychiatric patients ranged from 3%-30% (Salize & Dressing, 2004). In two separate meta-analyses of studies that included a majority of involuntarily committed patients, most found that admission was neither justified nor beneficial, and they were generally dissatisfied with the treatment they received (Kallert et al., 2008; Katsakou & Priebe, 2006). Alongside voluntary status, other hospital experiences may influence perceptions of hospitalization such as being able to trust providers and patient autonomy, which have been shown to relate to experiences of stay and

recurrent or prolonged stays with psychiatric inpatient situations (Brännström et al., 2018; Molin et al., 2016).

Expanding Hospitalization Experience Factors to TGD Populations

Since minimal research among the general population has been done to explore correlates of hospitalization experience, it is no surprise that studies have yet to look at TGD populations' specific experiences of hospitalization. The established factors in the general population that relate to hospital experience such as age, involuntary/voluntary hospitalization, and trust in provider, can be expected to extend to the TGD experience of hospitalization, however, the specific external and internal minority stressors that have been linked to SI and SA should be considered as well. Important minority factors to consider include pride in TGD identity, this will help discern if internal minority stressors such as, internalized transphobia, negative self-concept, or low self-esteem, affect hospitalization experiences.

Another factor to consider includes whether the TGD individual has ever been fearful of coming out to a therapist, due to fear of discrimination or mistreatment, as research has shown external discrimination has repeatedly been correlated with SI and SA. About 70% of TGD individuals' experience gender-related discrimination in health care. This includes being refused needed care, health care professionals refusing to touch or using excessive precautions, the use of abusive or harsh language, being blamed for health status (such as being HIV positive), being physically or sexually assaulted, and providers being physically rough or abusive (Lambda Legal, 2010). This fear and mistrust of providers is related to another important factor to examine, historical avoidance of mental health care. Avoiding healthcare is not uncommon among TGD individuals and in one report, 23% of respondents did not see a doctor due to fear of being mistreated in general in the past year (James et al., 2016).

Finally, an important correlate to examine is a TGD individual's need to educate their provider(s) about TGD healthcare needs. Research has shown that a provider's level of comfort in working with the TGD population was positively associated with the patient's wellbeing (Stanton et al., 2017). In recent years, efforts have been geared toward educating providers on how to provide gender affirming care. This can be seen in the development of Fenway Health's program on TGD healthcare, research, education, and dissemination of best practices and the World Professional Association of Transgender Health's (WPATH) development of their *Standards of Care* (Coleman et al., 2012; Reisner, Bradford, et al., 2015).

Aims and Hypotheses

The current study had four aims: (1) Explore the lifetime prevalence of hospitalization for SI and SA in TGD adults, (2) examine perceived helpfulness of hospitalization for both SI and SA, (3) examine potential correlates of hospitalization experiences for both SI and SA, and finally (4) determine which significant univariate correlates of hospitalization experiences continue to predict self-reported helpfulness when considered in tandem.

As aims (1) and (2) were exploratory in nature, no formal hypotheses were made. It was further hypothesized for aim (3) that for both SI and SA, individuals who were older, had an involuntary commitment, historically avoided coming out to a mental health provider due to fear of mistreatment or discrimination, historically avoided mental health care, or had to educate former providers about TGD healthcare issues would rate their hospital experiences as less helpful. Individuals who endorsed pride in their TGD identity and historically had providers they could trust would have more positive experiences with hospitalization. Finally, no hypotheses regarding the relative importance of each univariate correlate was made for aim (4).

METHODOLOGY

Procedure

This current project utilized archival data collected from June to October 2017 from the Trans Lifeline Mental Health Survey, a collaborative effort between the National LGBTQ Task Force and the Trans Lifeline. This online, cross-sectional survey asked questions regarding TGD experiences with and utilization of mental health services. Participant recruitment involved the utilization on listservs, PRIDE events, and social media groups related to TGD adults.

Participants in this survey included a total of $N = 4,467$ TGD identifying adults from across the U.S. Eligibility for this study included being 18 years of age or older, self-identifying as TGD, and living in the U.S. Participants were not financially compensated for their participation.

In order to determine power, aim four utilized an ordinal logistic regression. Research on minimal sample size for logistic regression based on the rule of event per variable determined the formula; $n = 100 + 50i$ where i refers to the number of independent variables is a recommended (Bujang, Sa'at, Sidik, & Joo, 2018). Assuming all 13 independent variables which were examined as univariate correlates of hospitalization experience were significant correlates and thus entered into the multivariate ordinal logistic regression, a sample size of 750 ($100 + 50*13$) was required.

Participants

In total, $N = 3,718$ participants completed the study. A majority of the sample were natal females ($n = 2,025$, 54.6%), White ($n = 2,898$, 77.9%), sexual minorities ($n = 3,437$, 92.8%), and self-identified their gender as outside the gender binary ($n = 2,207$, 59.7%). Of the sample $n = 875$ (23.7%) endorsed a masculine expression of gender identity while $n = 1,233$ (33.4%) endorsed a feminine expression. Only 374 (7.4%) participants identified as former military.

Participants ranged in age from 18 to 87 ($M = 32.08$, $SD = 12.87$). A full summary of sample demographics can be found in Table 1.

Table 1. Demographic characteristics of participants

Variable <i>n</i> (%)	No Hospitalization (<i>n</i> =2,662, 71.6%)	Hospitalization for SI (<i>n</i> =328, 8.8%)	Hospitalization for SA (<i>n</i> =728, 19.6%)	Full Sample (<i>N</i> =3,718)
Natal Sex ^a				
Female	1410 (53.0)	195 (59.8)	420 (57.9)	2025 (54.6)
Male	1250 (47.0)	131 (40.2)	305 (42.1)	1686 (45.4)
Gender Identity ^b				
Masculine Expression	572 (21.7)	87 (26.6)	216 (29.8)	875 (23.7)
Feminine Expression	902 (34.2)	96 (29.4)	235 (32.4)	1233 (33.4)
Non-Binary	1009 (38.2)	119 (36.4)	217 (29.9)	1345 (36.4)
Transgender Unspecified	29 (1.1)	7 (2.1)	11 (1.5)	47 (1.3)
Other	127 (4.8)	18 (5.5)	46 (6.3)	291 (5.2)
Binary Status ^c				
Outside Binary	1595 (60.3)	202 (62.0)	410 (56.5)	2207 (59.7)
Inside Binary	1051 (39.7)	124 (38.0)	316 (43.5)	1491 (40.3)
Sexual Orientation ^d				
Heterosexual	177 (6.7)	29 (8.9)	59 (8.1)	265 (7.2)
Other	2472 (93.3)	298 (91.1)	667 (91.9)	3437 (92.8)
Person of Color				
Yes	544 (20.4)	80 (24.4)	196 (26.9)	820 (22.1)
No	2118 (79.6)	248 (75.6)	532 (73.1)	2898 (77.9)
Veteran				
Yes	169 (6.3)	33 (10.1)	72 (9.9)	274 (7.4)
No	2493 (93.7)	295 (89.9)	656 (90.1)	3444 (92.6)

Note. SI=suicidal ideation, SA=suicide attempt

^a *n* = 3,711

^b *n* = 3,691

^c *n* = 3,698

^d *n* = 3,702

Measures

Demographics. Participants responded to general questions to assess age, sex assigned at birth (natal sex), gender identity, binary status, sexual orientation, race, and veteran status. Natal sex had options of male, female, or intersex. Current self-identified gender was assessed in an open response format which was qualitatively coded as feminine experience (e.g., “male to female”), masculine identity (e.g., “female to male”), non-binary (i.e., “outside the gender binary”), transgender unspecified (i.e., “transgender”), or other (“still working that out”). A dichotomous, yes or no, question followed asking individuals whether they viewed themselves outside of the gender binary. Sexual orientation was also asked in an open-ended format and coded by the research team as either sexual majority (straight) or sexual minority. To assess race and ethnicity a list of 28 racial categories was included and participants could check multiple answers. For the sake of statistical power, due to low numbers for some racial identities, race was further distilled down to census categories then dichotomized as majority (White) and person of color (POC) as this has previously been done in research on TGD adults (Aboussouan, Snow, Cerel, & Tucker, 2019). To assess veteran status, individuals were asked if they had ever served in the U.S. armed forces with an option for currently serving.

Hospitalization for STBs. The following single items with a yes/no answer format were asked to assess history of hospitalization: “Were you ever hospitalized because of an attempt to end your life?” and “Were you ever hospitalized for thinking about ending your life?” Participants who answered yes to either/both items were asked about their experience(s) with hospitalization with the following item: “How would you describe your experience in the hospital?” The item included a seven-point Likert-type answer format that ranged from 0 (very unhelpful) to 7 (very helpful) with 4 (neutral).

Historical Interactions with Mental Health Providers. As the 2017 Trans Lifeline data set was composed to assess TGD experiences with mental health providers, items that assessed quality of historical interactions with therapists and psychiatric facilities were included. One question assessed history of “hospitalization or placement in a psychiatric inpatient care (psych ward, psychiatric hospital, etc.) due to mental health reasons” with a follow-up question that asked, “Would you describe your hospitalizations as overall voluntary or not?” with the following response options, “voluntary,” “voluntary but I felt coerced,” or “involuntary.” Participants also indicated yes/no to the following question regarding avoidance of mental healthcare, “Have you ever avoided a mental health institution (inpatient, outpatient, psychiatry, psychology, other)?” A similar yes/no question was asked regarding disclosure of TGD identity to therapists, “Have you avoided coming out to your therapist(s), current or in the past, due to fear of mistreatment or discrimination?” Another yes/no question was asked regarding pride in TGD identity “Would you say that you have pride in your transgender identity?”. History of needing to educate therapists on TGD healthcare issues was assessed with the following question and yes/no answer format, “Have you had to educate your therapist(s), past or current, about transgender issues?” Participants who endorsed a history of seeing a therapist were asked, “Do you feel that you can trust therapist(s)?” with response options ranging from 0 (never) to 5 (always). This question was treated as a continuous variable.

Analytical Strategy

Prior to conducting any statistical analysis, data from individuals who did not complete the study were excluded. Additionally, due to the U.S. Department of Defense (DOD) Directive-type Memorandum (DTM)-19-004, banning TGD individuals from serving in the military (U.S Department of Defense, 2019), active military individuals were removed to further protect their

anonymity. Data from those missing hospitalization experience data, the primary outcome measure, were excluded. As missing data still existed for demographics and univariate correlates of hospital experience, further missing data were handled via listwise deletion within each analysis completed to preserve power to detect small effects. If respondents indicated hospitalization for SI and SA, only their SA data was analyzed. This was done to eliminate possible conflation between both experiences. For example, someone hospitalized for a SA would also be hospitalized for SI in that same hospital experience and thus reference this event when answering questions about SI hospitalization and SA hospitalization. The individuals who indicated having a hospitalization for SA only had their SA hospitalization considered and SI hospitalization experiences were composed of ratings from only those who indicated SI but not SA hospitalization.

Aim One: Lifetime Prevalence of Hospitalization for SI and SA. The first aim of the study explored the lifetime prevalence of hospitalization for SI and SA in TGD adults. To do so descriptive statistics were computed to determine the frequency of no historical hospitalization for STBs, hospitalization for SI but not SA, and hospitalization for SA. Chi-square tests were used to assess if there were any significant differences between the demographic categories and the hospitalization groups.

Aim Two: Helpfulness of Hospitalization. The second aim of the study was to examine experiences of hospitalization for both SI and SA. Aim two only included those who reported that they had been hospitalized for either SI or SA. Percentages were calculated for each of seven options of hospitalization experience and reported. For further analyses this was distilled down to a general unhelpful category for people who rated their experience between somewhat unhelpful to very unhelpful, a neutral category, and a general helpful category for people who rated their

experience between somewhat helpful to very helpful. This decision was made as very few respondents reported very helpful experiences ($n = 16$ (4.9%) for SI and $n = 26$ (3.6%) for SA) as shown in Figures 1 and 2. Clinically, the distinction between a response that is “unhelpful” versus “somewhat unhelpful” may not be the same as the “distance” between “very unhelpful” and “unhelpful” ratings. With these considerations in mind, the experiences variables (SI and SA) were collapsed.

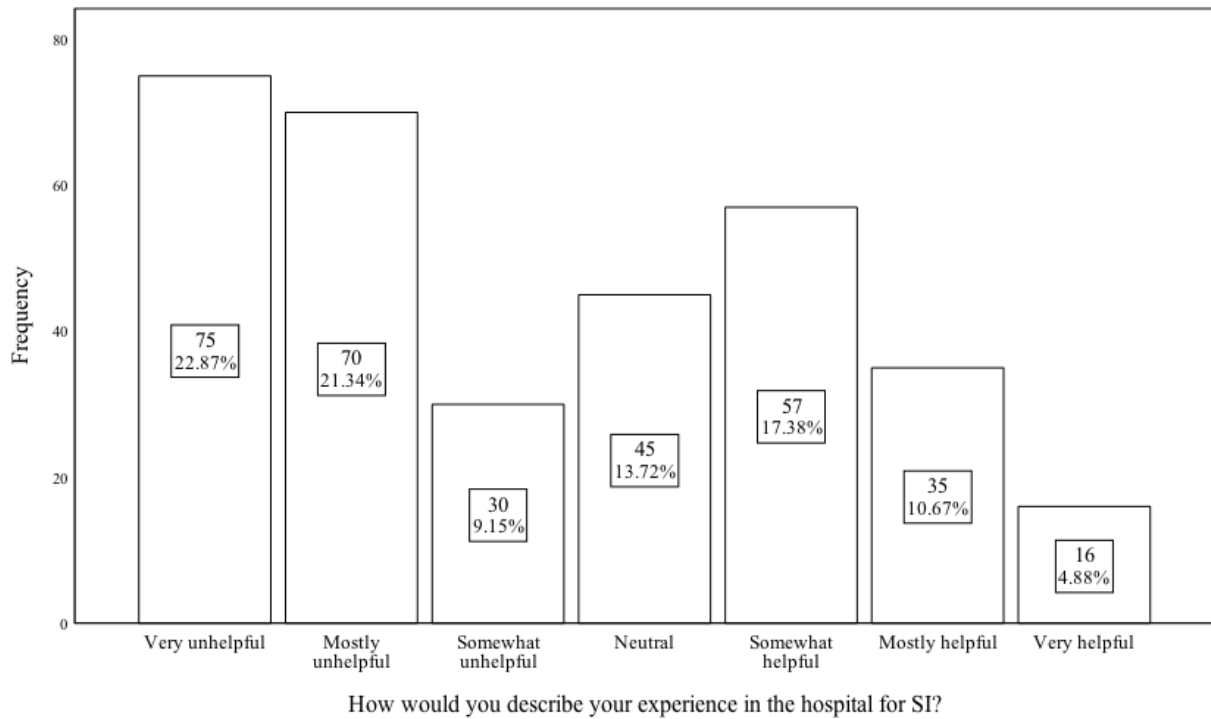


Figure 1. Experiences of Hospitalization for SI

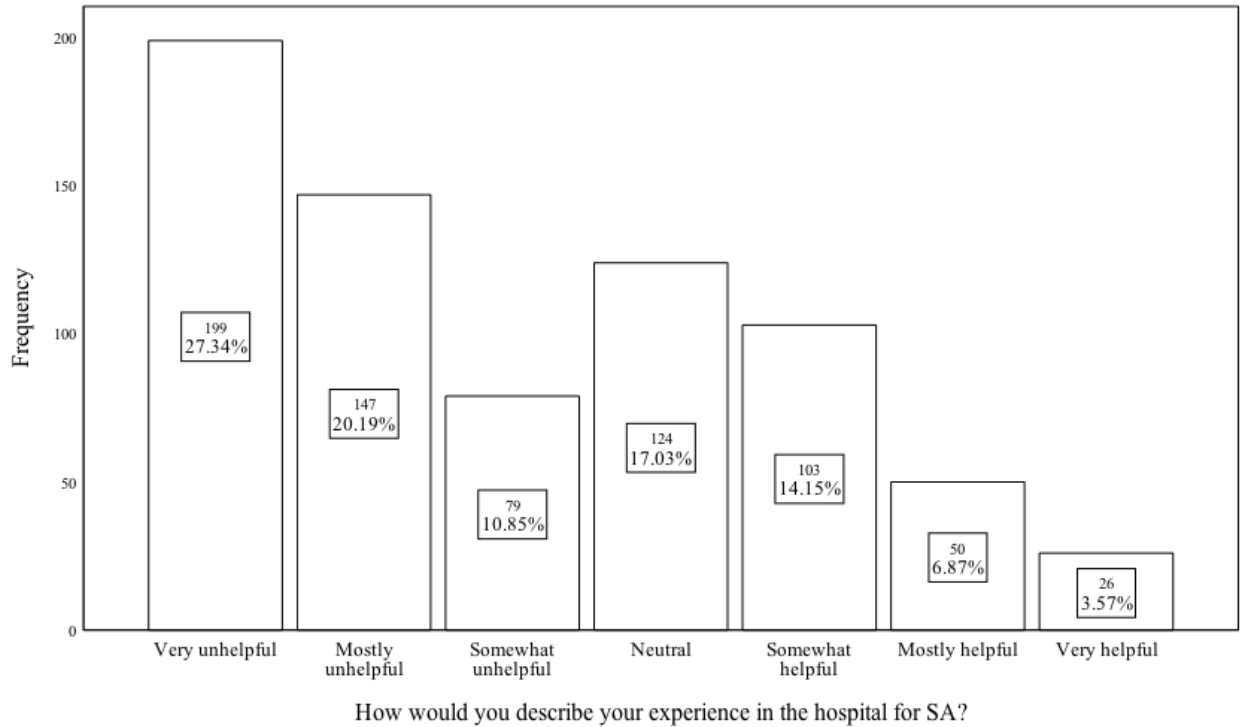


Figure 2. Experiences of Hospitalization for SA

Aim Three: Univariate Correlates of Helpfulness. To determine aim three, which univariate correlates relate to both helpful and unhelpful hospitalization experiences for both SI and SA, various univariate analyses were run. Ordinal logistic regressions were run for each of the potential correlates individually. Model fit was represented by χ^2 and associated p-value. Both Cox & Snell R^2 and Nagelkerke R^2 values were presented as some scholars argue that the former statistic is a too conservative estimate of predicted variance while the latter is too liberal (Smith & McKenna, 2013). To determine the influence of the different levels of the independent variables and the outcome of helpfulness, $\text{Exp}(B)$, and the 95% confidence interval (CI) were reported.

Aim Four: Relative Importance of Hospitalization Correlates. Finally, two ordinal logistic regression models were run to test aim four. This was run to further investigate correlates of helpfulness of hospitalization - for SI in model 1 and SA in model 2 – when all significant

univariate correlates were entered in the same model to determine relative importance. Results were reported the same as above including χ^2 , associated p-values, both Cox & Snell R^2 and Nagelkerke R^2 values, Exp(B), and the 95% confidence intervals.

RESULTS

Data Cleaning

In total, $n = 7,671$ individuals provided informed consent to begin the study. Of those, $n = 4,350$ completed the study to the end, $n = 83$ were removed for being under 18. Further, $n = 19$ active military individuals were removed and $n = 24$ were removed for endorsing a natal sex of intersex. Of the remaining $n = 4,224$, $n = 506$ individuals were removed for missing hospitalization data. The final data set was comprised of $N = 3,718$ individuals. Full demographic information of the sample is reported above in the participants section and in Table 1.

Aim One: Lifetime Prevalence of Hospitalization for SI and SA

Of the $N = 3,718$ individuals, a majority of the individuals had never been hospitalized for either SI or SA ($n = 2,715$, 71.6%). Of those with a history of hospitalization, 31.1% ($n = 328$) had only been hospitalized for SI and not a SA, these data points were used to create the SI group. Individuals who had been hospitalized for both an SI and SA or a SA only comprised the SA group ($n = 728$, 68.9%). A complete summary of demographic characteristics by hospitalization grouping can be found in Table 1.

There were differing prevalence of hospitalization for STBs based on natal sex ($\chi^2(2, N = 3,711) = 9.54, p = .008$), race ($\chi^2(2, N = 3,718) = 15.14, p = .001$), and veteran status ($\chi^2(2, N = 3,718) = 14.32, p = .001$). Specifically, natal females were more likely to be hospitalized for both SI and SA than natal males. Further, those who identify as POC and veterans were more likely to be hospitalized for SA compared to White individuals and non-veterans respectively. However, those who self-identified as POC ($n = 80$, 9.8%) were equally as likely as White individuals ($n = 248$, 8.6%) to be hospitalized for SI. Similarly, veterans were equally as likely as non-veterans to be hospitalized for SI ($n = 33$, 12.0% and $n = 295$, 8.6%, respectively).

Aim Two: Helpfulness of Hospitalization

Figures and 1 and 2 depict helpfulness ratings of hospitalization for SI only and hospitalization for SA. For SI only, most participants found hospitalization to be very unhelpful ($n = 75, 22.9\%$) or mostly unhelpful ($n = 70, 21.3\%$), with the fewest number of participants denoting a very helpful SI hospitalization experience ($n = 16, 4.9\%$). When condensed, a majority of participants found hospitalization for SI to be some form of unhelpful ($n = 175, 53.4\%$), while $n = 45 (13.7\%)$ remained neutral about their hospitalization experience, and $n = 108 (32.9\%)$ felt their hospitalization experience was some degree of helpful. Similar trends were seen when looking at experiences of hospitalization for SA, $n = 425 (58.4\%)$ found hospitalization to be some form of unhelpful, $n = 124 (17.0\%)$ felt neutrally about their experience, and $n = 179 (24.6\%)$ found it to be a helpful at some level.

Aim Three: Univariate Correlates of Helpfulness

In addition to demographic variables, specific gender minority variables and provider/hospitalization characteristics were examined as possible correlates of hospitalization helpfulness (Table 2). For perceived helpfulness of SI hospitalization, the only significant demographic correlate was age. The model was significant, ($\chi^2(1) = 7.26, p = .007$), predicting between 2.2% and 2.6% of variance in hospitalization helpfulness. The estimated odds ratio favored a positive relationship, $\text{Exp}(B) = 1.02$ 95%, 95% CI [1.01, 1.04]. As age increased, hospitalization was viewed as more helpful. Natal sex was unrelated to SI hospitalization experience ($\chi^2(1) = .28, p = .598$), as was gender identity ($\chi^2(4) = .51, p = .972$), binary status ($\chi^2(1) = 2.23, p = .072$), sexual orientation ($\chi^2(1) = 1.59, p = .207$), race ($\chi^2(1) = 1.23, p = .267$), and veteran status ($\chi^2(1) = 1.40, p = .237$).

Table 2. Gender Minority Stress Characteristics of Participants

Variable <i>n</i> (%)	No Hospitalization (<i>n</i> =2,662, 71.6%)	Hospitalization for SI (<i>n</i> =328, 8.8%)	Hospitalization for SA (<i>n</i> =728, 19.6%)	Full Sample (<i>N</i> =3,718)
Pride in TGD Identity ^a				
Yes	2065 (77.9)	249 (76.4)	567 (78.0)	2881 (77.8)
No	585 (22.1)	77 (23.6)	160 (22.0)	822 (22.2)
Trust in Psych Providers ^b				
Always	112 (9.1)	13 (5.3)	40 (7.4)	165 (8.2)
Most of the times	360 (29.3)	63 (25.9)	111 (20.5)	534 (26.6)
Sometimes	468 (38.1)	89 (36.6)	195 (36.0)	752 (37.4)
Not most of the time	232 (18.9)	62 (25.5)	147 (27.2)	441 (21.9)
Never	55 (2.1)	16 (6.6)	48 (8.9)	119 (3.2)
Historical Need to Educate Psychiatric Providers ^c				
Yes	576 (47.6)	145 (60.2)	307 (57.4)	1028 (51.7)
No	635 (52.4)	96 (39.8)	228 (42.6)	959 (48.3)
Avoided Coming Out Due to Fear ^d				
Yes	487 (39.8)	115 (47.1)	270 (50.3)	872 (43.5)
No	738 (60.2)	129 (52.9)	267 (49.7)	1134 (56.5)
Avoided a Mental Health Institution ^e				
Yes	1318 (49.9)	227 (69.8)	537 (74.1)	2082 (56.4)
No	1324 (50.1)	98 (30.2)	188 (25.9)	1610 (43.6)
Voluntary Hospitalization or Not ^f				
Mostly voluntary	-	146 (49.2)	213 (31.6)	421 (36.7)
Voluntary, but felt coerced	-	85 (28.6)	169 (25.1)	294 (25.6)
Mostly involuntary	-	66 (22.2)	292 (43.4)	433 (37.7)

Note. SI=suicidal ideation, SA=suicide attempt

^a *n* = 3,703

^b *n* = 2,011

^c *n* = 1,987

^d *n* = 2,006

^e *n* = 3,692

^f *n* = 1,14

Beyond demographic correlates, the model for trust in providers was related to SI hospitalization helpfulness ($\chi^2(1) = 28.47, p < .001$), predicting between 11.1% and 13.0% of variance in SI hospitalization helpfulness. The estimated odds ratio favored a positive relationship, $\text{Exp}(B) = .49$, 95% CI [.37, .65]. As levels of trust increased, helpfulness ratings of hospitalization increased. A history of avoiding mental health care was also related to SI hospitalization helpfulness ($\chi^2(1) = 20.81, p < .001$) predicting between 6.2% and 7.2% of variance in SI hospitalization helpfulness. Avoiding mental health institutions had an inverse relationship with having a more helpful SI hospitalization experience, $\text{Exp}(B) = .35$, 95% CI [.22, .55]. Voluntary versus involuntary hospitalization was related to SI hospitalization helpfulness ($\chi^2(2) = 48.84, p < .001$) predicting between 15.2% and 17.7% of variance. Voluntary hospitalization had a positive relationship with having a more helpful SI hospitalization experience, $\text{Exp}(B) = 5.88$, 95% CI [3.11, 11.14], compared to an involuntary hospitalization. However, in this model voluntary status failed the test of parallel lines ($\chi^2(2) = 6.06, p < .05$), an analysis ran to determine if the assumption of proportional odds was met. Thus, results need to be interpreted with caution. Pride in transgender identity was unrelated to SI hospitalization experience ($\chi^2(1) = 3.19, p = .074$), along with a historical need to educate providers about TGD specific issues ($\chi^2(1) = 1.42, p = .234$), and historical avoidance of coming out to psychiatric providers due to fear of mistreatment or discrimination ($\chi^2(1) = 1.95, p = .163$).

Similar to its relationship to SI hospitalization helpfulness ratings, age was related to SA hospitalization helpfulness, ($\chi^2(1) = 9.23, p = .002$), predicting between 1.3% and 1.5% of variance. The estimated odds ratio favored a positive relationship, $\text{Exp}(B) = 1.02$, 95% CI [1.01, 1.03]. As age increased, hospitalization was viewed as more helpful. Natal sex was unrelated to

SA hospitalization experience ($\chi^2(1) = 1.55, p = .213$), as was gender identity ($\chi^2(4) = 8.28, p = .082$), binary status ($\chi^2(1) = 1.08, p = .30$), sexual orientation ($\chi^2(1) = 1.35, p = .246$), race ($\chi^2(1) = .18, p = .673$), and veteran status ($\chi^2(1) = .37, p = .545$).

Pride in TGD identity also had a significant model ($\chi^2(1) = 10.40, p = .001$) predicting between 1.4% and 1.7% of variance in SA hospitalization helpfulness. Pride in TGD identity had a positive relationship with having a more helpful SA hospitalization experience, $\text{Exp}(B) = 1.78$, 95% CI [1.24, 2.57]. However, in this model pride in TGD identity failed the test of parallel lines ($\chi^2(2) = 4.05, p < .05$), therefore results need to be interpreted with caution. Further the model for trust in providers was related to SA hospitalization helpfulness ($\chi^2(1) = 45.08, p < .001$), predicting between 8.0% and 9.4% of variance in SA hospitalization helpfulness. The estimated odds ratio favored a positive relationship, $\text{Exp}(B) = .5895$, 95% CI [.49, .68]. As levels of trust increased, helpfulness ratings of hospitalization increased. Additionally, the need to educate providers about TGD specific issues was related to SA hospitalization helpfulness ($\chi^2(1) = 11.74, p = .001$) predicting between 2.2% and 2.5% of variance in SA hospitalization helpfulness. Needing to educate a psychiatric provider about TGD specific issues had an inverse relationship with having a more helpful SA hospitalization experience, $\text{Exp}(B) = .56$, 95% CI [.40, .78]. Avoiding coming out to a provider due to fear of discrimination or mistreatment was also related to SA hospitalization helpfulness ($\chi^2(1) = 21.40, p < .001$) predicting between 3.9% and 4.6% of variance. Avoiding coming out due to fear had an inverse relationship with having a more helpful SA hospitalization experience, $\text{Exp}(B) = .45$, 95% CI [.32, .64]. A history of avoiding mental health institutions was also related to SA hospitalization helpfulness ($\chi^2(1) = 28.38, p < .001$) predicting between 3.8% and 4.5% of variance in SA hospitalization helpfulness. Avoiding mental health institutions had an inverse relationship with having a more helpful SA

hospitalization experience, $\text{Exp(B)} = .42$, 95% CI [.31, .58]. Voluntary hospitalization was also related to SA hospitalization helpfulness ($\chi^2(2) = 60.23$, $p < .001$) predicting between 8.5% and 10.0% of variance in SA hospitalization helpfulness. Voluntary hospitalization had a positive relationship with having a more helpful SA hospitalization experience, $\text{Exp(B)} = 3.81$, 95% CI [2.67, 5.43], compared to an involuntary hospitalization.

Aim Four: Relative Importance of Hospitalization Correlates.

For perceived helpfulness of hospitalization for SI, the multivariate ordinal regression (Table 3) included the significant univariate correlates of age, level of trust in psychiatric providers, historical avoidance of mental health institutions, and voluntary status of SI hospitalization. The entire model was significant ($\chi^2(8) = 53.32$, $p < .001$), predicting between 21.1% and 24.8% of variance in SI hospitalization helpfulness. Level of trust in psychiatric providers had a positive relationship with having a more helpful SI hospitalization experience, $\text{Exp(B)} = .59$, 95% CI [.43, .80]. Individuals who had higher levels of trust in providers had a more helpful hospitalization experience. Additionally, voluntary hospitalization had a positive relationship with having a more helpful SI hospitalization experience, $\text{Exp(B)} = 4.72$, 95% CI [2.13, 10.48], compared to an involuntary hospitalization.

Table 3. Multivariate Ordinal Regression Predicting SI Hospitalization Helpfulness Ratings

Level	Estimate	S.E	Wald	df	p	Exp(B)	95% CI
Age	.007	.011	.379	1	.538	1.007	.985, 1.029
Trust in Providers	-.533	1.57	11.615	1	.001	.587	.432, .797
Avoid Institutions							
Yes	-.543	.334	2.638	1	.104	.581	.302, 1.119
No	0 ^a						
Voluntary Status							
Mostly Voluntary	1.552	.407	14.528	1	.000	4.720	2.125, 10.483
Voluntary, but Coerced	.403	.459	.776	1	.378	1.496	.610, 3.670
Mostly Involuntary	0 ^a						

^a This parameter is set to zero because it is redundant.

For perceived helpfulness of hospitalization for SA, the multivariate ordinal regression (Table 4) included the significant univariate correlates of age, pride in TGD identity, level of trust in psychiatric providers, historical need to educate providers, historical avoidance of coming out to providers due to fear of discrimination or mistreatment, historical avoidance of mental health institutions, and voluntary status of SA hospitalization. The entire model was significant ($\chi^2(8) = 97.02, p < .001$), predicting between 18.0% and 21.1% of variance in SA hospitalization helpfulness. Pride in TGD identity had a positive relationship with having a more helpful SA hospitalization experience, $\text{Exp}(B) = 1.77, 95\% \text{ CI } [1.08, 2.92]$. Individuals who had pride in their TGD identity had a more helpful SA hospitalization experience. Level of trust in psychiatric providers had a positive relationship with having a more helpful SA hospitalization experience, $\text{Exp}(B) = .71, 95\% \text{ CI } [.58, .87]$. Individuals who had higher levels of trust in providers had a more helpful hospitalization experience. Additionally, voluntary hospitalization had a positive relationship with having a more helpful SA hospitalization experience, $\text{Exp}(B) = 3.59, 95\% \text{ CI } [2.33, 5.54]$, compared to an involuntary hospitalization.

Table 4. Multivariate Ordinal Regression Predicting SA Hospitalization Helpfulness Ratings

Level	Estimate	S.E	Wald	df	p	Exp(B)	95% CI
Age	.004	.007	.235	1	.628	1.004	.989, 1.018
Trust in Providers	-.346	.103	.103	1	.001	.707	.578, .866
Pride in TGD Identity							
Yes	.573	.254	5.085	1	.024	1.773	1.078, 2.916
No	0 ^a						
Educate Provider							
Yes	-.263	.195	1.813	1	.178	.769	.525, 1.127
No	0 ^a						
Fear							
Yes	-.308	.204	2.288	1	.130	.738	.493, 1.095
No	0 ^a						
Avoid Institutions							
Yes	-.380	.233	2.662	1	.103	.684	.433, 1.079
No	0 ^a						
Voluntary Status							
Mostly Voluntary	1.278	.221	33.43	1	.000	3.589	2.327, 5.536
Voluntary, but Coerced	.447	.246	3.308	1	.069	1.564	.966, 2.533
Mostly Involuntary	0 ^a						

^a This parameter is set to zero because it is redundant.

DISCUSSION

According to the World Health Organization, 800,000 individuals die by suicide every year. Furthermore, for each suicide there are approximately 20 additional suicide attempts (World Health Organization 2019). Suicide is projected to increase to the 12th leading cause of death globally by 2030 from the 14th leading cause of death in 2002 (Mathers & Loncar, 2006). Within the U.S. specifically, suicide was the 10th leading cause of death in 2018 with over 48,000 suicide related deaths, (NVDRS | WISQARS | Injury Center | CDC, 2018; Xu, Murphy, Kochanek, & Arias, 2020). The TGD community is considered to be a particularly vulnerable population with a high SA rate (Clements-Nolle et al., 2006; Mathy, 2003; World Health Organization 2019). However, although TGD individuals experience STBs at a higher rate than the general population, a more precise determination of suicide rates in this population is hard to ascertain as gender identity is not thoroughly recorded on death certificates (Haas & Lane, 2015).

Psychiatric hospitalization is a common medical strategy to increase patient stability and safety (Randall et al., 2017). However, little is known about how often psychiatric hospitalizations occur for TGD adults and how they perceive these hospitalization experiences. This is especially important as patients hospitalized for STBs are at an elevated risk of suicide days to months after their discharge from hospitalization (Chung et al., 2017; Hunt et al., 2009; Ward-Ciesielski & Rizvi, 2020). In the general population, certain variables such as age (Crow et al., 2002; Danielsen et al., 2007) and voluntary/involuntary status of admission (Kallert et al., 2008; Katsakou & Priebe, 2006) relate to general hospitalization experiences, and trust in providers correlates specifically to psychiatric hospitalization experiences (Brännström et al., 2018; Molin et al., 2016). However, proximal (i.e., internalized transphobia, negative experiences, and concealment) and distal (gender-related discrimination, gender-related

rejection, gender-related victimization, non-affirmation of gender identity) minority stress factors unique to TGD individuals must also be explored (R. J. Testa et al., 2015). To add to the existing literature on understanding hospitalization for STBs among the TGD population, the current study had four aims: (1) Explore the lifetime prevalence of hospitalization for SI and SA in TGD adults, (2) examine the reported helpfulness of the hospitalization experience for both SI and SA, (3) determine univariate correlates that relate to both positive and negative hospitalization experiences for both SI and SA, and finally (4) determine the relative importance of each significant univariate correlate.

Results regarding prevalence of hospitalization for STBs in the TGD population are difficult to place in context as few population U.S. studies have determined the hospitalization rate for either SI or SA in adults. In a sample of adult patients who had an ICD-9-CM diagnoses code for either attempted suicide or self-inflicted injury an overall prevalence rate of about 168-299 per 100,000 hospitalizations was found (Oladunjoye et al., 2020). In one study of hospital records of children's hospitals examining emergency department encounters and inpatient hospitalizations of children and adolescents across the years from 2008 to 2015, 1.21% of all hospital encounters were classified as for either SI or SA (Plemmons et al., 2018). Results from the current study, although done in an adult sample, seem to indicate much higher rates of hospitalization for SI and SA among the TGD population versus the general population as 28.4% of the sample indicated previous hospitalization for STBs: 8.8% for SI only and 19.6% for one or more SAs. This could simply be an artifact of higher rates of STBs among the TGD community compared to the general population. In the U.S, lifetime SI and SA in the TGD population is 45%-54% (Grossman & D'augelli, 2007; Nuttbrock et al., 2010) and 28%-41% (Haas et al., 2014; Nuttbrock et al., 2010) respectively, compared to 9.2% and 2.7% in the general population

(Nock et al., 2008). Future work should look to explicitly compare rates of hospitalization for STBs in a stratified sample of TGD adults and their cisgender peers to further explore the potential disparity between gender majority versus minority individuals.

Results showing that natal females are more likely to be hospitalized for both SI and SA than natal men are interesting as existing literature in the general population has shown that female sex compared to male sex is associated with higher rates of SI, SA, and suicide planning but men die by suicide more (Kessler, Borges, & Walters, 1999; Nock et al., 2008). However, this might not necessarily align with gender identity as natal females may be masculine identifying, non-binary, agender, etc. One study among TGD individuals found that there were no significant differences in SI between gender identities (R. J. Testa et al., 2017). However, a meta-analysis of 42 TGD studies reported that SI occurs more often in male to female, or natal male participants, than natal females (Adams, Hitomi, & Moody, 2017). It may be that, like cisgender females, TGD individuals who were assigned a female sex at birth also use less lethal methods when attempting suicide and thus are more likely to have experienced a hospitalization for SA than natal men who could select more lethal methods and die on first attempt (Anestis, Khazem, & Anestis, 2017). This interpretation should be made with caution as it attributes method of SA chosen to one's natal sex but could also be influenced more by gender identity and cultural scripts related to gender (Canetto, 2017).

Study results indicating that TGD POC are hospitalized for SAs at higher rates than White participants do not align with an existing study in the general population that indicate lower odds of being a POC among individuals who had been hospitalized for an SA or a self-inflicted injury (Oladunjoye et al., 2020). However, as there are few studies who have examined the correlation between race and STB hospitalization the current study's findings are hard to put

in context. As little is known about the relationship between race and the prevalence of hospitalization for STBs in the general population comparisons are mostly made based on rates of STBs, not hospitalization prevalence. In this frame of reference, findings that TGD POC had higher rates of hospitalization for STBs are not in concordance with research supporting that White adults have a higher rate of SAs than POC (Oladunjoye et al., 2020; Olfson et al., 2017). However, findings on race and STBs specifically within the TGD community are mixed. One study with seven categories for race (i.e., White, American Indian, Asian, Biracial, Black, Latino, Middle Eastern) found no association between race and past year SI among TGD individuals except for a lower prevalence of past year SI in Asian TGD individuals relative to White individuals (Yockey, King, & Vidourek, 2020). Alternatively, some studies concord to the current study and show higher rates of STBs in TGD POC compared to White TGD individuals (Lytle et al., 2016; Seelman, 2016), while others found higher rates of STBs in White TGD individuals compared to POC (Clements-Nolle et al., 2006). These results need to be taken into the context that the 22.1% of TGD POC in this sample were well representative of the population at large as the U.S census reported 23.7% of respondents identified as a race or ethnicity other than White (U.S Census Bureau, 2019). Further, consideration must be given to help seeking behaviors between races. In the general population, male and female POC had a lower propensity to seek psychiatric help (Narendorf, Munson, Ben-David, Cole, & Scott Jr, 2018). Future research should investigate whether this trend is also seen in TGD POC. To better understand these discrepancies a study built to directly test these potential racial differences is needed.

About 7.4% of this current sample identified as veterans which is quite representative of the proportion of veterans in the population at large which is about 7% of the adult population (U.S Census Bureau, 2019). Study results indicating that TGD veterans are hospitalized for SAs

at a higher rate than TGD non-veterans are also difficult to put in context as although TGD veterans endorse higher rates of lifetime SAs than TGD non-veterans (Lehavot et al., 2016; Nuttbrock et al., 2010), research in the general population has found that there is no significant difference in mental health treatment utilization between veterans and non-veterans (De Luca, Blosnich, Hentschel, King, & Amen, 2016). However, in a sample of TGD veterans who had utilized Veteran Health Administration (VHA) mental health care, a majority reported that they were satisfied with the care they received (Lehavot, Katon, Simpson, & Shipherd, 2017). If TGD veterans are highly satisfied with the care they receive specifically at VHAs, they may be less reticent to seek mental health care than TGD non-veterans who seek care from other hospitals. Additionally, if TGD veterans are more willing to seek help than gender majority veterans, taken in context with the fact that there are higher rates of STBs in veteran populations, this may help explain why TGD veterans in this sample were more likely to be hospitalized for STBs than TGD non-veterans while in the general population veterans and non-veterans have the same rates of healthcare utilization. Future research should be designed to investigate whether TGD veterans are more likely to seek help for STBs than gender majority veterans and whether TGD veterans are specifically utilizing VHA mental health resources.

Perceived Helpfulness of Hospitalization for STBs

There was variability in ratings of hospitalization helpfulness for both SI and SA. However, over 50% of respondents reported that their hospitalization was somewhere between “very unhelpful” to “somewhat unhelpful” for both SI and SA. There is a dearth of research on hospitalization experiences for STBs in the general population; however, results of previous work show mixed results. A study looking at emergency department visits and other mental health services, such as inpatient stays, found that a majority of patients were somewhat or

totally satisfied with the care they received (Fleury, Grenier, & Farand, 2019). On the other hand, one study, which did not delineate between emergency department or inpatient psychiatric experience, found that a majority of patients had negative experiences/relationships with staff (e.g., feeling they were not treated with respect, not being listened to), negative experiences with restraints (e.g., not feeling restraints were justified, being restrained for too long), and negative experiences with seclusion (e.g., not feeling seclusion was justified, not being checked on often enough while secluded (Allen, Carpenter, Sheets, Miccio, & Ross, 2003). Many of these negative experiences made patients report that they would be unwilling to seek out psychiatric care in the future. However, when analyzing negative experiences with psychiatric emergency department visits, research has found common themes, such as the environment being unwelcoming, staff treating patients as if they were crazy, and patients being committed against their will (Harris, Beurmann, Fagien, & Shattell, 2016). Although this research has not been conducted in the TGD population, it may be expected that these concerns persist for TGD individuals. Future research and clinical interventions should focus on these thematic elements in terms of hospitalization for STBs in general and TGD populations.

At the univariate level the only demographic variable that was significant was older age as it was related to more helpful hospitalization experiences for both SI and SA. Although not specific to STBs, age is one demographic factor that appears to be consistently related to how helpful a general hospitalization experience is rated. Congruent with results from the current study, in general, older adults tend to have more positive experiences with hospitalization than younger adults (Crow et al., 2002; Danielsen et al., 2007). It is important to understand why the other demographic characteristics (i.e., natal sex, gender identity, binary status, sexual orientation, race, and veteran status) were not related to perceived helpfulness of hospitalization

experiences. Gender identity and sexual orientation had low response rates in some of their options which may have made the tests too underpowered to detect any significant results. For example, gender identity consisted of five options, one of which, “Transgender Unspecified”, was endorsed in only $n = 47$ (1.3%) of participants, and another, “Other”, was endorsed in only $n = 291$ (5.2%). Similarly, only $n = 265$ (7.2%) of respondents endorsed a sexual orientation of heterosexual.

Results that natal sex and race were not significant predictors of perceived helpfulness of hospitalization experience are interesting as general population women (Teunissen, Rotink, & Lagro-Janssen, 2016) and POC (Mead & Roland, 2009) hospitalized for various medical conditions are less satisfied with the care received than men and White individuals respectively. In terms of non-significant results within natal sex, similar to the interpretation of natal females being hospitalized at higher rates, the current study did not control for gender identity, so it was impossible to know whether the natal female respondent was masculine identifying, non-binary, agender, etc., and these results should be interpreted with caution. Additionally, for gender identity, one of the response categories, “Transgender Unspecified”, was endorsed in only $n = 47$ (1.3%) of participants, so some identities are not well-represented in this study. Further, results that race was not related to hospitalization experience were unexpected as research has shown that TGD POC often believe that they would be treated better if they were White (Howard et al., 2019). Future case-controlled studies should be designed to investigate the compounding effect of multiple minority statuses to better understand this discrepancy. Additionally, few studies have been done comparing binary to non-binary TGD individuals, making it difficult to put nonsignificant results for binary status and hospitalization experience in context. Although there have been no studies on hospitalization experience for binary vs non-binary TGD individuals, in

general, non-binary individuals have significantly worse self-reported health and general well-being than binary TGD individuals (Burgwal et al., 2019). Future research should be geared towards conducting case-controlled studies to explore the relationship between binary status and hospitalization experiences. Similarly, no studies have looked at the effects of sexual orientation in TGD individuals on hospitalization experience. As research has found different levels of psychological distress among different sexual minorities (e.g., bisexual, gay/lesbian, queer) (Puckett, Maroney, Levitt, & Horne, 2016), future research should, again, use case-controlled studies to investigate this disparity.

Finally, one surprising non-significant finding was that veteran status did not relate to hospitalization helpfulness experience although veterans were hospitalized at significantly higher rates. An explanation for this could be VHAs establishment of LGBTQ care coordinators who aim to increase culturally sound care for gender and sexually diverse veterans (Ruben et al., 2017). Further, VHAs have implemented many policies and programs to address TGD disparities in health care, such as The Office of Healthy Equity (Lange-Altman, 2021) which has included gender identity and expression in VHA nondiscrimination policies and a Transgender Education Workgroup which has created toolkits of key resources for VA providers on TGD specific health care issues (U.S. Department of Veterans Affairs, 2021). Since the implementation of these programs, TGD veterans who seek psychiatric services through VHAs specifically may receive culturally competent care, thus various gender related stressors were not compounded with their veteran status making their hospitalization experiences similar to TGD non-veterans.

Although historical need to educate providers, historical avoidance of coming out to a provider due to fear of discrimination or mistreatment, and historical avoidance of psychiatric providers were significant univariate predictors for SA hospitalization experience, they did not

explain any variance in hospitalization experience in the multivariate model. A possible explanation for this is that trust in psychiatric providers may underlie this relationship (e.g., a lack of trust increases avoidance). Logically, if an individual trusts their provider to deliver competent and unprejudiced care, they should not feel the need to hide their identity or avoid healthcare in general. Further, in one study, transaffirmative counselling was shown to help increase therapeutic alignment which increased the participant's feelings of trust (McCullough et al., 2017). Participants in this study reported that they felt more trusting of their providers when the provider used affirming language that showed that they understood and were educated about TGD issues. When providers took time to educate themselves about TGD issues, respondents felt a greater sense of advocacy from the provider (McCullough et al., 2017).

Higher levels of trust and a voluntary commitment both remained significantly related to hospitalization helpfulness for SI and SA in the multivariate analysis. Findings that increased trust is related to a more helpful hospitalization experience are consistent with existing research in the general population that has shown inpatient psychiatric patients who had a lack of trust in hospital staff reported they felt like they were wasting their time in the hospital (Molin et al., 2016). This extends beyond psychiatric hospitals to general inpatient hospitalization where trust between patients and doctors were associated with greater patient satisfaction (Shan et al., 2016).

The ethics of involuntary commitment have been heavily debated by U.S. scholars (M. Testa & West, 2010). Many providers civilly commit patients after a brief assessment in order to ensure stability and safety of the patient, however the question remains, whether involuntary commitment in the patient's best interest (Christensen & Richard, 1993). Extant research has suggested that individuals who perceive that their admission to a psychiatric hospital was coercive were more likely to make a post discharge SA (Jordan & McNiel, 2020). As there is

growing evidence that taking away patient autonomy may be harmful (Borecky, Thomsen, & Dubov, 2019) more research needs to be geared toward understanding if involuntary hospitalization is beneficial. Results from the current study that involuntary commitment is related to less helpful hospitalization experiences are congruent with some existing literature which has reported less satisfaction in treatment when patients reported they did not find their admission to be justified (Kallert et al., 2008). However, a literature review of studies on involuntary hospitalization found that retrospectively 39-75% of patients believed their commitment was justified while 10-47% stated that it remained unjustified. Further, the study concluded that the length of time since hospitalization was positively correlated with patient's views of hospitalization as a higher proportion of patients reported the hospitalization was helpful when more time had elapsed from their admission (Katsakou & Priebe, 2006). It appears that time since discharge is an important factor in determining helpfulness of hospitalization which the current study did not include. However, since many suicide attempts occur days to months after discharge (Chung et al., 2017), learning about what contributes to a helpful hospitalization experience is especially important.

Overall, the final multivariate models for SI and SA did not differentiate from each other very much. Both models explained around the same amount of variance in helpfulness ratings, and further, they both shared trust in providers and voluntary status of hospitalization as significant predictors. However, the only discrepancy was that unlike the model predicting SI hospitalization helpfulness, the SA model showed that increased TGD pride was additionally related to higher levels of helpfulness. This additional significant correlate is an important distinction. Much research has been conducted to explain the differences between SI and SA. There are two to three individuals who have experiences SI for every one person who has a SA

(Nock et al., 2008). Leading theories in the field of suicidology that explain the transition from SI into SA, or “Ideation-to-Action” frameworks, include The Interpersonal-Psychological Theory of Suicide (Joiner, 2005) and the Three-Step Theory (Klonsky & May, 2015). Both theories posit that there are separate processes, with unique explanations and risk factors, between SI and SA. Although the current study did not find many discrepancies between correlates of hospitalization helpfulness for SI and SA, increased pride in TGD identity significantly improved ratings of hospitalization helpfulness in those hospitalized for a SA but not SI. In the Three-Step Theory of suicide the second step focuses on a lack of connectedness turning moderate ideation to strong ideation. Broadly, connectedness can include any sense of perceived purpose or an attachment to a role an individual plays (Klonsky & May, 2015). A lack of connectedness is often found in individuals who have made an attempt. In terms of pride in TGD identity, it is possible that the connectedness aspect is present in individuals who have pride in their TGD identity as they believe they play a greater role in a specific community as a whole.

However, the three-step theory varies from the interpersonal-psychological theory of suicide and the subsequent gender minority and resilience model (R. J. Testa et al., 2015) as the latter two believe that internal stressors and interpersonal factors must be present to turn feelings of pain and hopelessness into SI in the first place. In the interpersonal theory of suicide the concept of perceived burdensomeness is important when discussing pride in TGD identity as perceived burdensomeness is a construct of self-hate which is associated with low self-esteem and shame (Van Orden et al., 2010). It can be assumed that individuals who lack pride in their TGD identity also experience perceived burdensomeness. Within the gender minority and resilience stress scale the concept of internalized transphobia is integral to lower rates of pride in

TGD identity (R. J. Testa et al., 2015). Tying the two theories together, research found that perceived burdensomeness mediated the relationship between internalized transphobia and SI (R. J. Testa et al., 2017). Following these models, this would negate the current study's findings that pride in TGD identity may not be as important for SI as it is for SA when increasing hospitalization helpfulness. Despite these discordant findings, it is clear that pride in TGD identity is an important factor in STBs. As research has found that having pride in one's gender identity is an important resilience factor that is significantly related to lower rates of depression and social anxiety in TGD individuals (R. J. Testa et al., 2015), future research should investigate specific therapies and methods of increasing these resilience factors. Further, research among TGD individuals needs to include "Ideation-to-Action" frameworks to better understand what gender minority factors can be protective in preventing SI turning into a SA.

Limitations

The current study has sample limitations that should be considered when interpreting results. The dichotomization of racial categories into POC and racial majority was not ideal but made due to concerns related to low endorsement of some identities. This dichotomization prevents generalizability as the prevalence of STBs vary across racial groups for the general population (Wong, Maffini, & Shin, 2014) and the TGD population (Blosnich, 2018). Sexual minority representation was low in the sample and thus it is unsure if study results represent the experience of those with a minority representation. The mean age of the sample was 32.08 and few older adults participated. Results may not be applicable to older adults which is a concern as the rate of fatal suicide is highest among individuals 65 and over (Canner, Giuliano, Selvarajah, Hammond, & Schneider, 2018). Further, as this study was only conducted in an adult sample, results may not be applicable to TGD youth. When looking at emergency department visits for

STBs between 2006 and 2013 there is a peak in visits among individuals aged 15-19 (Canner et al., 2018). Again, unique factors that correlate to this peak were not explored in the current study.

There are methodological limitations to the study that should be considered as well. First, a single, dichotomous, self-report measure was used to assess lifetime hospitalization for SI and SA. This prevents knowledge about where the hospitalization occurred, for how long, and the nature of the STB that preceded it (e.g., a four-hour assessment and discharge in an emergency room, a three day stay in a psychiatric inpatient unit due to severe SI, a two-week stay on a medical floor following a SA). Future research would benefit by connecting these data to medical records to depict characteristics of hospitalization that could influence perceived effectiveness (e.g., number of group/individual therapy sessions, medications prescribed, etc.). Although voluntary versus involuntary status was assessed, it is unknown whether hospitalization was based on medical necessity (e.g., a near-lethal suicide attempt) or was the result of help seeking following STBs. Thus, future research would benefit from understanding many factors related to the nature of admission for SI/SA not assessed in this study to better understand what predicts helpful hospitalization experiences. Further, the single item response for helpfulness precluded assessment of what was inherently helpful or not helpful about the hospitalization or whether this care reduced eventual STBs. Future research would benefit from longitudinal studies which allow for causal interpretations of the relationships between correlates of experiences of hospitalization for STBs in TGD individuals.

Finally, although the results were significant, the multivariate models that considered the impact of all univariate correlates explained less than 25% of the variance in perceived hospitalization experience. This may mean that there are many more factors that were not

assessed in the study that relate to hospitalization experience. An example of this would be type of care received while hospitalized. It is important to differentiate between suicide specific care and treatment as usual (TAU), for example a “no-harm” contract, a medication-only approach, or an evidence-based clinical intervention such as the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2016). In the general population there is mounting evidence on the efficacy of CAMS over TAU (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005), in contrast there is building evidence that treatments such as no-harm contracts are not effective methods for preventing suicide (Lewis, 2007). Future research should explore whether a treatment like CAMS, which focuses on increasing therapeutic alliance and treatment motivation (Jobes, 2012), leads to a more helpful hospitalization experience than various other treatments.

The study also does not investigate characteristics of the providers during the hospitalization, for example was the treatment team affirming of the patient’s gender identity or were they discriminatory. A survey conducted by Lambda Legal (2010) found that when looking at TGD individuals seeking health care broadly, 70% of individuals experienced some type of discrimination in care (e.g. providers using harsh or abusive language, providers being physically rough or abusive). Additionally, the survey revealed that 90% of TGD individuals reported that they believed that there are not enough medical providers who are properly trained to care for them (Lambda Legal, 2010). Future research should assess the relationship between providers’ attitudes towards the TGD population and how helpful TGD individuals viewed their hospitalization experience.

Implications

For both SI and SA, over 50% of respondents indicated that their hospitalization experiences were unhelpful. This could indicate that the guidelines of care for those working

with TGD individuals (American Psychological Association, 2015; Coleman et al., 2012) may not be influencing care as desired. As these guidelines are revised, the specific experiences regarding care for STBs should be considered. Standards of care for suicide prevention (Jobes, 2020), as well as affirming practices should be highlighted. The current study provides some evidence that involuntary admission for STBs should be scrutinized and only considered as a means of crisis stabilization, not treatment. As these guidelines provide a clear standard of care, new training practices will be needed to help providers reach these standards. Luckily, training programs have budding promise. In response to the rising number of TGD veterans (Kauth et al., 2014) the VHA created the Specialty Care Access Network-Extension of Community Healthcare Outcomes (SCAN-ECHO) program to educate providers on culturally competent care for TGD individuals. Providers who completed to program believed the entire program was useful and reported their confidence in treating TGD veterans increased. Participants reported that the program increased their empathy and understanding of TGD veterans (Shipherd et al., 2016). This type of training may be particularly important for providers to form trust with their TGD patients, a factor that showed particular relevance for potentially increasing perceived helpfulness of a hospitalization.

Although there is a considerable gap in research regarding the hospitalization experiences for SI and SA in TGD individuals, the current study cements the need for several adjustments in current care practices. In summary, (1) TGD patients should be able to trust their providers, this can be achieved by increasing education to providers by supplying guidelines of care for treating TGD populations in order to enhance their cultural competence in working with minority populations, (2) therapies during hospitalization should focus on resilience factors to help increase community connectedness and pride, and (3) if involuntary hospitalization is necessary,

more care should be paid to increasing the patients autonomy by keeping them informed and involved in their treatment process.

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VITA

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