2020

Homelessness and HIV Risk: Experiences, Perceptions, and Beliefs of Transgender Youth

Darcia Bryden-Currie
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Darcia Bryden-Currie

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Kimberly Dixon-Lawson, Committee Chairperson, Public Health Faculty
Dr. Phuong Trang Huynh, Committee Member, Public Health Faculty
Dr. Patrick Tschida, University Reviewer, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Homelessness and HIV Risk: Experiences, Perceptions, and Beliefs of Transgender Youth

by

Darcia Bryden-Currie

MPAS, University of Nebraska, 2012

BS, Touro College, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2020

Abstract

Human ImmunodeficiencyVirus (HIV) continues to be a public health concern in the United States, with increased rates of infection among transgender youth. The phenomenon of homelessness is also a significant challenge for transgender youth. Gender expression often results in stigma, and discrimination, many trans youth experience poverty, rejection, and low self-esteem, which are precursors to homelessness. The purpose of this qualitative phenomenological study was to explore the influence that homelessness has on sexual risk associated behaviors in transgender youth. The theoretical framework that guided this study was Bandura's social cognitive theory. The research questions sought to explore how this population perceived their risk of contracting HIV. A qualitative research design with a phenomenological approach, was used to capture their lived experiences through in-depth interviews. Study participants included 10 homeless transgender youth. Data was organized using NVivo 12 software, upon data analysis 8 themes emerged: (a) knowledge of HIV, (b) risk factors, (c) experiences with homelessness, (d) challenges, (e) social network, (f) personal and cultural beliefs, (g) access to healthcare, and (h) services. Results of the study provided insight about the factors that influence the adherence and non-adherence of prevention methods. Exploring the impact of homelessness on HIV risk has implications for positive social change as results of this study could decrease housing disparities, which can further decrease risk for HIV and other sexually transmitted infections. Decreasing survival sex work, increasing adherence to prevention methods, and increasing safe housing options are all critical to influence behavior change for transgender youth.

Homelessness and HIV Risk: Experiences, Perceptions, and Beliefs of Transgender Youth

by

Darcia Bryden-Currie

MPAS, University of Nebraska, 2012

BS, Touro College, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2020

Dedication

This study is dedicated to all those who are homeless, and face stigma and discrimination that subjects them to risk. I would like to present a special dedication to the transgender youth who participated in this study for providing such detailed information on your lived experiences to help others experiencing the same phenomenon. You each exhibited such humility and resilience.

Acknowledgments

First, I must give all glory and honor to God for his grace, mercy, and provision of strength throughout this journey. “With God all things are possible.”

I would like to acknowledge and personally thank my dissertation committee: To my chair Dr. Kimberly Dixon-Lawson, Thank you so much for your commitment, dedication, and guidance throughout this process. I am truly blessed to have worked with you. To my committee member Dr. Phuong Huynh, I must express my gratitude to you for your timely responses even with the difference in time zones between us. I am grateful for your contribution to this critical body of work. To Dr. Patrick Tschida, my University research reviewer, your expert guidance has been truly appreciated.

I would like to thank the two organizations that allowed me to conduct interviews at their locations. I would like to acknowledge my colleagues and staff members who have shown genuine interest and provided motivation throughout this journey. Your support has not gone unnoticed. My advice to staff currently completing degrees; The race is not for the swift but for those who can endure.

It is with great pleasure that I introduce my dissertation partner, Dr. Tracy Jackson. Our friendship goes back to LICH and strengthened during this journey together. I am proud of you for accomplishing your goal, while consistently motivating and encouraging me to accomplish mine.

Mom, thank you for being my first role model and my biggest cheerleader. Your confidence, and faith in me provided the motivation I needed to keep going, even while you were hospitalized you ensured that I stayed on track. I hope I have made you proud.

I would like to thank my family and friends for all their support during this journey, I know I missed out on many phone conversations, events, and special occasions. I hope I have made you all proud enough to forgive my absenteeism.

To my incredible son, Dominic, you have kept me entertained during this process. Yours was the greatest sacrifice of time, as many of our lazy son and lazy mommy days were cut short so mommy could complete her homework. I will have all the time in the world to play Octonauts with you now. I am proud to be your "mommy" as this is my most important title and highest achievement.

Finally, I would like to acknowledge my husband, friend, and soulmate, Ted. His encouragement, support, gentle nudging, and motivation has carried me through this process. You have made many sacrifices and carried many burdens, so I could pursue my doctorate degree. Thank you for believing in me and in us.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

The topic of this study is homelessness and human immunodeficiency virus (HIV), the lived experiences and perceptions of transgender youth. Familial rejection, low self-esteem, behavioral health issues, stigmatization, discrimination, poverty, and education drop-out are possible experiences of transgender youth who choose to disclose their gender identity (Alegria, 2011; Grant et al., 2010). These experiences are a few of the risk factors that can lead to homelessness, which ultimately may lead to additional risk factors. According to Wilson et al. (2015), transgender people face disproportionate risk when compared to their cis-gendered peers as it relates to HIV.

Data indicates that New York ranked 4th among the top 10 states in reporting new HIV cases in 2017 (Centers for Disease Control and Prevention [CDC], 2017). Youth ages 13-24 remain at significant risk for acquiring this disease with a 22% rate of infection documented in 2015 (Gay Men's Health Crisis, 2018). It is beneficial to be conscious of the rates of HIV infection among the youth population and risk factors that contribute to the acquisition of this disease. According to the CDC (2017), individuals in age groups 20-24 and 25-29 had the highest number of HIV diagnosis in 2017. The highest category of transmission was among men who have sex with men; this category may also be inclusive of transgender individuals.

Homeless and transgender individuals are considered a double minority population. This research explored the lived experiences and perceptions of homeless transgender youth and their risk of acquiring HIV. The information in this study could

drive change related to social determinants of health that would influence homelessness and HIV risk. Another impact would be the promotion of preventative care using an integrated health approach to provide culturally competent care. Practicing the principle of harm reduction to meet the youth where they are, based on their experience, perceptions, and beliefs, will have a positive effect on their risk.

Chapter 1 covers the following topics: the background of transgender homeless youth and their risks, the theoretical framework on which the study was grounded, the problem statement, the purpose of the study, definitions of common terms, and the research questions that will assist in closing the gap. In this chapter I also review the assumptions, the scope and delimitations, limitations, the significance of the study, followed by a summary.

Background

It is essential to consider the prevalence of homelessness in the transgender population and the risk of acquiring HIV, especially in areas such as New York City (NYC), where there is a disproportionate representation of HIV (CDC, 2017). I provide an overview of articles relating to homeless transgender youth, sexual risk factors, discrimination, and stigmatization.

There is a lack of designated shelter for individuals who identify under the lesbian, gay, bisexual, transgender, and queer (LGBTQ) umbrella (Forge & Ream, 2014). According to the NYC Commission report of 2010, there were 3,800-20,000 homeless youth in NYC of whom up to 40% identified as LGBTQ (NYC Commission, 2010). The numbers seem to be skewed as there were only about 250 LGBTQ-specific beds in NYC

(Anderson-Minshall, 2012).

LGBTQ youth are at greater risk for discrimination, sexual risk behaviors, substance use, and behavioral health exacerbations including suicide (Forge & Ream, 2014). Many youth who leave home often end up in emergency shelters or the foster care system. The foster care system was designed to protect minor children who experience abuse, neglect, or cannot be with their parents or guardian for other reasons, but instead of entering a haven to shield them from domestic troubles, the system is often rife with the trauma that they were trying to escape (Forge & Ream, 2014). Youth in foster care and shelter establishments often report the theft of their belongings, drug use, and violence as some of the reasons for leaving foster care and turning to the streets (NYC Association of Homeless and Street-Involved Youth Organization, 2012). According to McKenzie-Mohr, Coates, and McLeod., (2012), life on the streets can be extremely challenging. While this experience may be traumatizing, it also builds resilience as they learn to adapt to their environment (McKenzie-Mohr et al., 2012). For many youth, the cycle of homelessness becomes difficult to break due to the lack of gainful employment. Many youth do not have the proper education or credentials to obtain sustainable positions, leading to wages that are not enough to pay for living expenses (Ehrenreich, 2014). Life necessities, regardless of how simple or routine, can turn out to become stressful ordeals.

For transgender youth to obtain an item that their cis-gendered peer may take for granted, such as a legal identification card, transgender youth may be required to undergo surgery that corresponds to their preferred gender (Poteat et al., 2015). Insurance is often needed

to undergo gender-affirming surgery as these can be costly medical procedures. However, the possibility of not having gender-affirming procedures covered by insurance companies is common in the transgender population (Poteat et al., 2015).

It is essential to understand the issue of stigma and discrimination faced by the transgender population and how it impacts their risks related to HIV and behavioral health issues (Poteat, German, & Kerrigan, 2013). Stigma and discrimination have been linked to health disparities, which place transgender youth at increased risk for physical and behavioral health conditions, for example, depression, suicide, sexually transmitted infections (STIs) and HIV (Grant et al., 2011; Poteat et al., 2013). Research conducted by Poteat et al. (2015) identified HIV risk in transgender sex workers, and the complex multifaceted barriers to prevention inclusive of stigma, discrimination, financial, and decrease in healthcare competency faced by this population. According to this research, there is a disproportionate risk of HIV in transgender women, particularly transgender women of color and those who participate in sex work. This subset of the transgender population is at higher risk due to the use of hormone injections, the need for affirmation, high-risk male partners, and violence (Poteat et al., 2015). Unprotected sex is the main risk, although research has proven that "stress, depression, low self-esteem, discrimination, and substance misuse" are additional causes of sexual risk behaviors in transgender women (Hotton, Garofalo, Kuhns, & Johnson, 2013, Shannon et al., 2009).

The gaps in the literature addressed in this study were related to the lived experiences of homeless transgender youth, and their risks for HIV, as well as decisions about prevention. Emergent themes in the literature include social support, lack of access

to services that impact health, and challenges navigating the system (Torres et al., 2015). Many transgender youth face behavioral health issues, such as depression, anxiety, posttraumatic stress disorder and suicidal behaviors, often related to a lack of acceptance (Torres et al., 2015). Housing and healthcare are interrelated; it is hard to focus on medical issues without having a safe place to lay one's head. Discrimination, violence, and lack of housing are all barriers to successful treatment. Since there is usually a lack of insurance coverage for gender-affirming health treatments (including, but not limited to, surgery and hormone therapy), transgender youth revert to illegal activity, such as sex work, to fund their treatment (Torres et al., 2015). Additional factors include lack of societal acceptance and limited employment opportunities; coupled with stigma and discrimination, these can lead to a reduction in both the physical and mental well-being (Singh, Hays, & Watson, 2011). These factors can also increase the risk of homelessness (Singh et al., 2011).

Research has been conducted to focus on policy around discrimination faced by transgender people when seeking medical care (Tagliamento & Paiva, 2016). This focus was imperative because many transgender individuals who are looking for acceptance put their health at risk by using hormones and/or silicone that are not prescribed, and thus may not be regulated or administered by a medical professional. These are all actions that place the population at risk for disease or death (Visnyei, Samuel, Heacock, & Cortes, 2014).

Different aspects of homelessness and transgender sexual risks were reviewed. Data derived from prior research provided information on the risks associated with

transgender youth and homelessness. Although there are multiple research articles on particular risk factors, there was a lack of studies that concentrated on the perceptions of the target population. The lack of perceptions from the targeted population indicated the multifactorial influences associated with homelessness and the sexual behaviors that continue to perpetuate risk for HIV and other diseases. The need for interventions to reduce sexual risk factors in the transgender population is evident. As public health practitioners, it is essential to illuminate public health issues that impact youth and to provide them with the empowerment tools they need to cope and to address social determinants of health. The perceptions of homeless transgender youth can impact change and may result in effective prevention methods that will be accepted among their peers.

Problem Statement

In the United States, individuals who identify as LGBTQ comprise approximately 40% of youth facing homelessness (Ferguson & Maccio, 2015; Shelton, 2016). The stigmatization they face leads to further oppression and marginalization. They consider disclosure of their gender identity to family members as precursors to becoming homeless (Hunter, 2008). Many fall victim to homophobic and transphobic violence, which is often overlooked by shelter staff; therefore, they feel safer on the streets (Abramovich, 2016).

The transgender population experience a disproportionate incidence of HIV risk in comparison to their cis-gendered male and female counterparts (Wilson et al., 2015). These youth are exposed to increased sexual risk behaviors (Gridley et al., 2016). Stressors in their environments often lead them to resort to behaviors that increase their

risk for HIV and other sexually transmitted diseases (Garofalo, Deleon, Osmer, Doll, & Harper, 2006). Transgender homeless youth often turn to sex work and survival sex based on their inability to gain employment due to discrimination. These are all contributing factors that increase the risk of HIV transmission among this population (Stevens, Bernadini, & Jemmott, 2013). Additional risks related to HIV include polysubstance abuse, victimization related to their chosen gender identity, intimate partner violence, stigma, discrimination, and lack of insurance or access to care (Brennan et al., 2012). Lacking in the literature was an exploration of the risks influenced by homelessness. This research study sought to discern how being homeless influenced decisions related to sexual risk behaviors in the transgender youth population. Participants' responses could help decrease sexual risk by providing an understanding of the influences that contribute to risks mitigating them.

Purpose of the Study

The purpose of this dissertation was to explore the influence of homelessness on behaviors associated with sexual risk in transgender youth and to identify effective prevention methods by using the social cognitive theory (SCT). This was achieved by obtaining the perceptions of the target population. Understanding the perceptions of homeless transgender youth is imperative to reducing risk behaviors in this marginalized group, which faces a "double minority" status that can lead to increased stigma, prejudice, violent victimization, and family disconnect (Kraft, Beeker, Stokes, & Peterson, 2000). The research method that was used to address the gap in the literature was qualitative. The theoretical framework was SCT. It was chosen because it outlines

how behaviors are stimulated by specific relationships and by environmental interactions (Bandura, 1986). Analysis of the problem statement was completed using interviews to gain a better understanding of the challenges faced by the population and their perceptions about risk.

Research Questions

1. What are the perceptions of HIV risk behaviors among the homeless transgender youth of New York City?
2. How does being homeless affect sexual risk behaviors in transgender youth?
3. What specific services are needed to combat HIV risk-related behaviors in homeless transgender youth?

Theoretical Framework

The theoretical framework that guided this research study comes from the SCT developed by Albert Bandura in 1986 (Glanz, Rimer, & Viswanath, 2015). SCT is a triad model where personal, behavioral, and environmental factors contribute to an individual's behavior (Bandura, 1986). This framework is centered on how the environment can influence behaviors. Viewing the research questions through this lens allowed the researcher to understand the stigma faced by the participants, their perceptions of multiple issues, including behavioral, substance use, mental illness and the relationship between their housing status and an increase in HIV-risk-related behaviors.

Nature of the Study

According to Maxwell (2013), when determining the appropriate methodology for a research study, it is essential to take the research topic and questions into consideration.

A qualitative method of inquiry was chosen for this study. Qualitative research is investigative, interpretive, and it allows participants to provide information in their natural setting (Creswell, 2014). There are five main types of qualitative methods: ethnography, narrative, phenomenological, grounded theory, and case study. A phenomenological approach was chosen to focus on the lived experiences of individuals experiencing the phenomenon being studied: homeless transgender youth, ages 18-24 (Moustakas 1994; Stark & Trinidad, 2007). A semi structured interview tool was used for data collection. All interviews were recorded and then transcribed verbatim. Using a phenomenological approach and conducting interviews gave participants the opportunity to identify the stigma they face daily and to provide an understanding of their perceptions and the relationship between being homeless and sexual risk-related behaviors.

Definitions

Disclosure: This is the revelation to society that an individual identifies as transgender (Grant et al., 2010).

Gender: "a culturally constrained concept combining social, psychological, and emotional traits associated with masculinity or femininity" (Spicer, 2010, p. 322).

Gender expression/presentation: "The physical manifestation of one's gender identity through clothing, hairstyle, voice, body shape, etc. (typically referred to as masculine or feminine). Many transgender people seek to make their gender identity (who they are), rather than their sex assigned at birth. Someone with a gender expression may or may not be transgender" (Trans Student, n.d.).

Gender identity: "One's internal sense of being male, female, neither of these or

both, or other gender(s). For transgender people, their sex assigned at birth and their gender identity is not necessarily the same" (Trans Student, n.d.).

Homelessness: Reference to one of the following: homeless, living in a shelter, foster care, or group homes, doubled-up and staying with friends, or living with a partner (Grant et al., 2010).

HIV: Human immunodeficiency virus, commonly known as HIV is a virus that is spread through body fluids. This virus affects the body's immune system, particularly the CD4 cells which help the body fight infection. If the CD4 falls below 200, the diagnosis changes to acquired immunodeficiency syndrome (CDC, 2018). HIV can be transmitted via unprotected sex with an infected partner, sharing needles with an infected individual, as well as other ways.

Sex assigned at birth: "The assignment and classification of people as male, female, intersex, or another sex assigned at birth often based on physical anatomy at birth or karyotyping" (Trans Student, n.d.).

Sexual orientation: "A person's physical, romantic, emotional, aesthetic, and/or other form of attraction to others. In western cultures, gender identity and sexual orientation are not the same. Trans people can be straight, bisexual, lesbian, gay, asexual, pansexual, queer, etc. just like anyone else. For example, a trans woman who is exclusively attracted to other women would often identify as lesbian" (Trans Student, n.d.).

Transgender/trans: "encompassing term of many gender identities of those who do not identify or exclusively identify with their sex assigned at birth. The term

transgender is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life" (Trans Student, n.d.).

Trans woman/trans man: "Trans woman generally describes someone assigned male at birth who identifies as a woman. This individual may or may not actively identify as trans. Sometimes trans women identify as male-to-female (also MTF, M2F, or trans feminine) and sometimes trans men identify as female-to-male (also FTM, F2M, or trans masculine)" (Trans Student, n.d.).

Visual nonconformity: The ability of an individual to identify as transgender based on visual indicators (Grant et al., 2010).

Assumptions

Three assumptions guided this study: (a) I assumed that the participants would share their experiences, perceptions, and beliefs about their HIV risk (b) I assumed that the participants would provide honest answers to the open-ended questions (c) I assumed that the experiences of the participants reflected those of other homeless transgender youth.

Scope and Delimitations

The scope of this study was delimited to homeless transgender youth who are at risk of HIV transmission or acquisition. The inclusion criteria for this study was participants had to identify as transgender, therefore, additional youth in the LGBTQ subset were excluded. Participants were also required to have homeless experience. In this study, youth were defined as being between the ages of 18-24 years because youth in this age range who identify as a sexual minority comprise a disproportionate percentage

of homelessness in the United States (Shelton, 2016). The social cognitive theory was chosen to investigate the impact of learned behaviors, and the environment on the risk of homeless transgender youth. The findings of this study may not be generalizable to homeless transgender youth in other regions of the United States, as the study was specific to the NYC area.

Limitations

A qualitative design with a phenomenological approach was chosen for this study to glean the lived experiences of the participants. An interview protocol was developed to collect data from participants regarding the phenomenon being study. The validity of the study was based on the participants providing truthful accounts of their experiences.

Bias is another limitation of qualitative studies. Participants may experience recall bias, where they may provide details that they think the researcher wants to hear, rather than their actual experiences. When dealing with any marginalized population, it is important to be willing to meet participants where they are to embody the principles of harm reduction. As the principal researcher, I practiced reflexivity throughout the study to address any personal bias that arose.

According to Creswell (2014), qualitative studies allow for a smaller sample size with an average of three to ten participants for phenomenological studies. The final limitation of this study was the sample size, based on the premise that data saturation can be obtained in qualitative studies with a small sample size, the results may not represent the entire homeless transgender population.

Significance of the Study

The homeless population faces many risks, all of which are exaggerated by being transgender. This research sought to help decrease the sexual risk factors faced by the homeless transgender population, a goal missing from the literature. The significance of the study was understanding how the intersections of gender identity and housing status influence the risk of HIV in the target population. This research fills the gap in understanding how homeless transgender youth perceive their risk of HIV, and the influence of their lived experiences and social networks in their decision-making processes (Tyler, 2008).

Although there are multiple studies that outline the gaps in services available to the targeted population, including housing, access to care, and skills and knowledge to avoid risks, transgender youth still remain an understudied population (Grant et al., 2010). I was unable to identify research on the target population that used SCT as the theoretical framework. The aim was to provide a foundation to decrease homelessness and its associated risk factors, by fostering a change in policies related to shelter access and housing for transgender youth. This study addresses the paucity of studies on the perceptions of homeless transgender youth and the factors that contribute to their sexual risk. The themes that emerged is the need for specific services in order to decrease the risk factors related to HIV including sexual risk, psychiatric illnesses, and victimization (Shelton, 2016).

One of the goals of this research study was to generate positive social change by addressing risk behaviors. By identifying participants' current experiences, public health

practitioners can develop and implement more effective prevention programs for homeless transgender youth to continue the fight to decrease stigma, discrimination, and violence; and to improve housing and education that directly impact other social determinants of health.

Summary

HIV and homelessness both remain significant public health challenges in the United States. Homeless transgender youth represent a minority within the LGBTQ classification. The housing status of this population places them at significant risk of acquiring HIV. Transgender youth are stigmatized, and often face discrimination, which increases their risk of disease. The problem statement identified issues such as stigmatization, oppression, and marginalization faced by the target population that increase their risk of homelessness; also violence, substance use disorders, and inadequate access to care are some of the issues related to risk behaviors. The purpose of this research was to understand the influence of being homeless on risky behaviors for transgender youth. Research questions were created to explore the perceptions of HIV risk behaviors, determine if these behaviors are affected by homelessness, and identify services that would be beneficial in decreasing risk in the target population. The gaps in the literature that I addressed were the lived experiences of the participants, and their perceptions about their risk. Bandura's SCT, provided the framework to examine the personal, behavioral, and environmental factors that affect risk and reduction strategies of homeless transgender youth. The results of this study provided insights into the services needed to mitigate HIV risk in homeless transgender youth.

In Chapter 2, I present the literature review, which expands on the research problem, offers background on the risk factors faced by transgender youth, and expands on the theoretical framework. In Chapter 3, I provide details related to the methodology, research design, data storage, collection, and analysis. In Chapter 4, I discuss the results of the study based on the analysis and interpretation of the data. In Chapter 5, I provide a discussion of the findings, recommendations for future research, implications for social change and a conclusion of the study.

Chapter 2: Literature Review

Introduction

Homelessness remains a public health concern among transgender youth, due to myriad reasons, including but not limited to social and environmental factors (Shelton, 2016). According to the National Alliance to End Homelessness (2019), in 2018 about 36,000 youth, who were considered homeless, were counted in one night. Of those counted, 89% were 18-24 years old, and 11% were under the age of 18 years old. According to Ferguson and Maccio (2015), approximately 40% of homeless youth identify as LGBTQ. In NYC, one study indicated that 9% of unstably housed participants identified as transgender (Center for Innovation through Data Intelligence, 2015). According to the Coalition for the Homeless (2018), in April 2018, NYC reported 62,498 homeless individuals living in shelters throughout the city. NYC has approximately 250 shelter/transitional beds that are specific to LGBTQ youth (Anderson-Minshall, 2012).

Transgender youth face unique challenges such as stigma, discrimination, and rejection from friends and family members, which they consider to be precursors to homelessness (Hunter, 2008). Discrimination also plays an integral role in their ability to obtain gainful employment; such stressors often lead to behaviors that put the transgender population at risk (Garofalo et al., 2006). Many transgender individuals turn to sex work for survival (Gridley et al., 2016). The transgender population tends to experience an increased risk of HIV when compared to their cisgender peers (Wilson et al., 2015). Gender choice often leads to discrimination, polysubstance use, victimization, violence, lack of health insurance, and limited access to care (Brennan et al., 2012). When

compared to other populations, Healthy People 2020 found that, among transgender individuals, there was a higher prevalence of HIV, sexually transmitted diseases, victimization, behavioral health disorders, uninsured and underinsured, and suicide (Healthy People (2020), 2018).

When exploring the risk factors among homeless transgender youth, it is important to understand their experiences. The consensus among recent research is that this population is marginalized and this leads to several issues: homelessness, decreased employment opportunities, lack of appropriate health care, HIV, sexually transmitted diseases, victimization, stigma, discrimination, gender dysphoria, mental health issues, polysubstance abuse, and loss of foundational relationships (Algeria, 2011; Grant et al., 2010). These issues create barriers to care, which further impact risk in this population.

While there are multiple studies on transgender homelessness and associated risk factors, the research seems to show a paucity in qualitative studies related to the phenomenon. Therefore, it fails to include the perceptions of the cohort affected by the issues raised. The current literature is indicative of the lack of service availability for the transgender population (Wanta & Unger, 2017). However, there seems to be a lack of review of structural issues, as well as social and economic conditions that produce adverse health outcomes. The purpose of this study was to determine how homelessness influenced risk factors by using a different lens to focus on social and environmental factors, which will, in turn, allow public health professionals to target risk reduction strategies to alleviate negative behaviors. Perceptions are necessary to give a voice and

opinion for the homeless transgender population as it is crucial to program design, strategic planning, and implementation.

This chapter highlights the current body of literature, examining the phenomenon of homelessness and risk-related behaviors. The review explicitly emphasized the risks in the target population including, but not limited to, psychosocial, substance abuse, gender identity, and access to care. This chapter also includes reviews related to the theoretical framework and methodology.

Literature Search Strategy

The process of searching and reviewing the literature was iterative. The following databases were used to search for peer-reviewed journals for the years 2008-2018: LGBT Life with Full Text, MEDLINE with Full Text, CINAHL Plus with Full Text, and Science Direct. The following keywords were used: *homeless, transgender, risk, HIV, homelessness, stigma, substance abuse, sexual risk factors, shelters, barriers to care, LGBT,* and *social cognitive theory.* Boolean operators AND and OR were used to optimize search results.

I reviewed additional literature on the SCT as a structure for the framework that was used in the study. Literature using this theory related to transgender homelessness was limited; therefore, the literature was reviewed independently, and the search focused on the risk factors that are faced by the homeless transgender population. The search for literature specific to homelessness and transgender youth proved to be challenging; many of the topics were searched independently to gather the necessary information for this research study.

In addition to risk factors of the homeless transgender population, the methodology of the current literature was also reviewed which identified a more substantial subset of quantitative studies. The search on homeless transgender youth using the SCT provided a total of six articles, when searched separately using the SCT it yielded many results. The literature presented in this study offers an understanding of the influence of homelessness on risk factors in the transgender population.

Theoretical Framework

The theoretical framework that guided this study is SCT. The SCT originated from the observational learning theory (later renamed the social learning theory) in the 1940s by Miller and Dollard (Miller & Dollard, 1941). These fundamental theories served as the foundation for observational learning. Albert Bandura later expanded the theory to include cognitive concepts of behavioral learning. The SCT was established in 1986 by Bandura (Pajares, 2002). This theory suggests that individuals learn from experiences and observations. The SCT posits that learning is a triad that consists of the individual, their environment, and behavior. The SCT is unique because it emphasizes social influence and how it can influence internal and external social reinforcements in a reciprocal fashion (Pajares, 2002). Individuals learn from observing their surroundings, and the actions of others within those surroundings. These observations are further based on the principles of the environment, one's behavior, and cognition as evolutionary components in the theoretical development.

This theory was selected because it provided a foundation to understand the rationale of behaviors by the transgender youth population. The basic premise of this

theoretical framework is that individuals learn from their experiences, and from the experiences of other individuals that they may encounter. The SCT investigates how experiences shape reinforcements and expectations, which further determine behavioral engagement (Pajares, 2002). The moral compass of an individual may elude that unprotected sex places them at risk for HIV; however, if the inducement for sexual risk is notable, the individual may embody a differing perspective concerning their actions. According to Bandura (1986), "what people think, believe, and feel affects how they behave." The goal of the SCT is to identify how the triad interacts bidirectionally to achieve specific behaviors that can be maintained over time (Bandura, 1999).

To demonstrate that individuals learn by observation, Bandura (1986), conducted a study on aggression using a "Bobo Doll" in which he used a cohort of three groups of children. One group was exposed to aggressive behavior, the second group was exposed to non-aggressive behavior, and the third group was the control group. The outcome of this experiment was that the children that had been exposed to the aggressive behavior were the ones that exhibited this behavior with the doll. This study exemplified the SCT by exhibiting how individuals recreate observed behaviors.

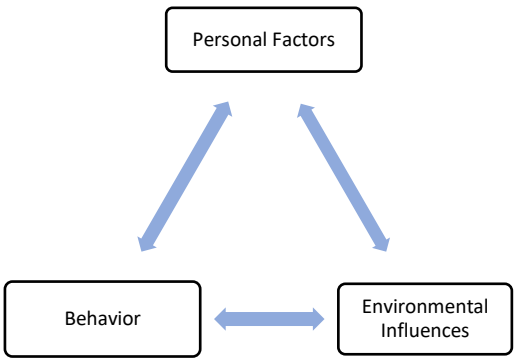

Figure 1. Diagram of social cognitive theory.

The SCT has some similarities to the social ecological model (SEM). The SEM is a theory that is widely used in research related to the transgender population. SCT addresses individual behavior change (Pajares, 2002). Bandura proposed six constructs of the SCT; the first five stages originated from the SLT; reciprocal determination, behavioral capability, observational learning, reinforcements, and expectations (Bandura 1999). The details of each construct of the SCT is as follows; reciprocal determinism describes the core of the SCT; it outlines the interaction between an individual, their environment, and their behaviors. The second construct is behavioral capability, which focuses on the individual's ability to perform a specific behavior based on prior teachings. The third construct reinforces that behaviors are learned and posits that as individuals; one can generally duplicate what they see. In the fourth construct of reinforcement, an individual's behavior can be either positive or negative and is linked to their environment. Expectations are the fifth construct of the SCT, it is subjective, but details anticipation of consequences related to specific behaviors.

It is said that every action has a reaction. Self-efficacy was added as the sixth construct and identifies an individual's confidence in their ability to perform the behavior; it is ultimately influenced by the individual and by environmental factors, these influences can be positive or negative. Self-efficacy ultimately influences the choices that an individual makes, and the pathway that they will use to accomplish the goal (Pajares, 2002). The SCT further posits that "strategies for increasing well-being can be aimed at improving emotional, cognitive, or motivational processes, increasing behavioral competencies, or altering the social conditions under which people live and work"

(Pajares, 2002). The SCT identifies three different environments: the imposed environment, the selected environment, and the constructed environment (Bandura, 1997). SCT provides a framework for understanding and changing human behavior (Green & Peil, 2009). How an individual copes in their surroundings has an impact on the level of stress they feel when in a compromising situation (Bandura, 1999). The SCT reveals the role of individual determinants that may influence behaviors amongst their peers. The SCT is relevant to the research study because transgender youth can be thrust into an environment that they did not choose, and it is their reaction to this environment that will often determine the behavior.

Review of Literature

Transgender

In the United States, societal norms support that there are two genders and two sexes and that this should align with our sex at birth (Dietert & Dentice, 2013). This lesson proves difficult for individuals who do not conform to what society considers the "norm." While often included in the common acronym "LGBTQ" which stands for lesbian, gay, bisexual, transgender, and queer people, there happens to be significant diversity within each population (Beemyn & Rankin, 2011). The Diagnostic and Statistical Manual of Mental Disorders (DSM), gives the label "gender dysphoria" formerly known as "gender identity disorder" to individuals who do not conform to societal norms (Moran, 2013). It is estimated that 0.03 – 0.05% of the population identify as transgender (Gates, 2011; Hughto, Reisner, & Pachankis, 2015), and the needs and concerns of transgender individuals are complex and distinct from their peers.

For clarity, definitions are important to provide education on some current and appropriate terms. A list of key definitions related to gender and gender identity can be found in Chapter 1. For individuals who identify as transgender, their sex assigned at birth and their gender identity are not necessarily the same (Trans Student, n.d.). Other terms frequently used by this population to express their gender include man, woman, a transgender man, a transgender woman, genderqueer, bigender, butch queen, and femme queen (Hughto et al., 2015). Gender expression may be affected by socioeconomic status, race/ ethnicity, and even residential status (Hughto et al., 2015; Valentine, 2007). Individuals that identify as transgender may or may not choose to transition and based on their decision they are often met with stigma for identifying with a gender that is discordant with what they were assigned at birth (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Dietert & Dentice, 2013; Grant et al., 2011, Hughto et al., 2015). A transgender woman was assigned male sex at birth, and a transgender man was assigned female sex at birth (CDC, 2018)

In the United States, the transgender population is considered deviant because their gender identity does not conform to their gender assigned at birth, and based on this deviation from the societal norm, the transgender population experiences widespread social stigma (Bockting et al., 2013; Hughto et al., 2015). Stigma in this population is known to be highly prevalent, and also associated with multiple adverse effects (Grant et al., 2011), including mental health disorders, suicide, substance abuse, and HIV (Grant et al., 2011; Hughto et al., 2015; Sevelius, 2013). Individuals are often ostracized, and fall

victim to derogatory remarks and insults (Sue, 2010). According to the CDC (2018), a total of 2,351 transgender individuals were diagnosed with HIV between 2009 and 2014.

Identity Disclosure

Transgender individuals are often concerned with disclosing their identity, according to Stieglitz (2010), transgender youth are most likely to disclose their identity to those close to them in the following order: friends, teachers, parents, siblings, aunts/uncles, and grandparents. Based on this disclosure, youth reported discrimination and victimization as outcomes (Stieglitz, 2010). Many individuals do not disclose their sexual identity for fear of victimization and discrimination (Swank, Fahs, & Frost, 2013). The disclosure of sexual orientation has often been identified as a significant source of homelessness in this population (Toro, Dworsky, & Fowler, 2007). Sexual minorities which are inclusive of the trans population report fear of disclosure as a significant stressor (Stieglitz, 2010; Willging, Salvadore, & Kano, 2006). Youth have also reported hiding their sexual identity while in public for fear of their safety (Leedy & Connolly, 2007). This internalized fear can have a negative impact on identity and mental health development (Rickard & Yancey, 2018). Familial rejection and peer harassment are usually consequences of identity disclosure (Dietert & Dentice, 2013). According to Dietert & Dentice (2013), lack of family acceptance increases the risk of negative behaviors such as drug abuse and unprotected sex.

Individuals who choose to disclose their gender are at risk for victimization (Grant et al., 2011). In many countries across the world, transgender individuals are unable to secure identification in their selected gender or must undergo a surgical

transition to accomplish the feat of obtaining legal identification (Poteat et al., 2015). This can prove to be an expensive form of identification as gender-affirming surgeries are generally not covered by insurances.

In the United States, physical violence is prevalent among transgender individuals. A Virginian study conducted by Xavier, Honnold, and Bradford (2007), indicated that 40% of transgender participants reported physical violence (Stotzer, 2009). In Washington, DC, another study by Valera, Sawyer, and Schiraldi (2000), reported that 65% of sex workers who identified as transgender experienced physical assault (Stotzer, 2009). In San Francisco, a cohort of 126 trans sex-workers were studied and 53% of the participants reported physical violence (Cohan et al., 2006; Stotzer, 2009). Data from the United States National Coalition of Anti-Violence Programs concluded that of the 18 anti-LGBTQ or HIV-related deaths in 2013, 72% included transgender women (Ahmed & Jindasurat, 2014). Youth who are homeless are subjected to significant trauma that can create and exacerbate existing mental health issues (Ali Forney, 2018).

Homelessness

The definition of homelessness varies depending on the resource; therefore, there is more than one official definition of this public health issue. For this study, the definition is that of the federal government Health Resources and Services Administration primarily in collaboration with the National Health Care for the Homeless Council. Homelessness is defined as “an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that

provides temporary living accommodations, and an individual who is a resident in transitional housing." (National Health Care for the Homeless Council [NHCHC], 2011). A homeless individual may live on the streets, in a shelter, in abandoned buildings, or in vehicles (NHCHC, 2011). The definition of youth homelessness also varies in definition based on the organization or study; homelessness among youth has been identified as fluid with the ability to change frequently (Tyler, 2008a).

Homelessness, in general, is often associated with challenges. Life on the street can lead to victimization in the form of robbery, physical abuse, and sexual assault (Begun & Kattari, 2016; Coates & McKenzie-Mohr, 2010). These risks are magnified for transgender individuals. Homeless individuals are exposed to significant barriers that can impact personal hygiene. Homelessness remains a serious public health concern. Prior research indicates that lack of personal hygiene can place individuals at risk for infectious diseases. Personal hygiene has a direct impact on communicable as well as non-communicable diseases (Leibler, Nguyen, Leon, Gaeta, & Perez, 2017). Homelessness is associated with an increase in substance use, risky sexual behaviors, depression, suicidal ideations, and posttraumatic stress disorder (Bender, Ferguson, Thompson, Komlo, & Pollio, 2010; Solorio et al., 2008; Warf et al., 2013). Transgender individuals experience higher levels of housing discrimination (Begun & Kattari, 2016; Bradford, Reisner, Honnold, & Xavier, 2013). According to Grant et al. (2011), 20% report experiencing homelessness directly related to their gender choice.

Transgender homeless youth are considered a double minority; first due to their homeless status, and the second is from their gender identity choice. In comparison to

their peers, transgender youth often experience transphobic discrimination when trying to access services, such as shelter and housing programs (Abramovich, 2013). Transgender youth are often left to fend for themselves in the shelter system, as their perpetrators go unpunished; they then turn to the streets where they perceive themselves as safer than in shelter (Keuroghlian, Shtasel, & Bassuk, 2014). The needs of this population are often overlooked. Most shelters are segregated by sex which creates great hardship and emotional distress for an individual who identifies as transgender (Mottett & Ohle, 2006). In 2012, there were a reported 250 LGBTQ specific shelter beds available in NYC (Anderson-Minshall, 2012; Forge & Ream, 2014). The lack of available shelter beds for this population supports the challenge of acquiring safe shelter for homeless transgender individuals (Begun & Kattari, 2016). Many find shelters to be physically unsafe, incapable of protecting their privacy, and their right to gender expression (Mottett & Ohle, 2006). In a study conducted by Begun and Kattari (2016), participants identified negative experiences related to seeking shelter. Individuals in the study referenced above were denied access, harassed, assaulted physically and sexually by staff and other residents (Begun & Kattari, 2016). Many individuals decided that it was safer to leave the shelter than to stay, and others felt that they had to represent the wrong gender to feel safe or even remain in the shelter system (Begun & Kattari, 2016; Mottett & Ohle, 2006). In 2003, the National Coalition for the Homeless adopted a non-discrimination resolution that protects individuals based on their gender identity as well as gender expression (Mottett & Ohle, 2006).

Aspects of Homelessness

Many paths lead to homelessness including poverty, mental health disorders, legal issues, and lack of support from family members (Spicer, Schwartz, & Barber, 2010). In a previous study, it was reported by sexual minority youth that the reasons for leaving home included family conflict, desire for freedom, conflict over sexual orientation, and physical abuse in their household (Cochran, Stewart, Gauzier, & Cauce, 2002; Ferguson & Maccio, 2015). In a qualitative study conducted with five transgender and gay youth in San Francisco, the participants identified family issues, poverty, and transphobia as precursors to experiencing homelessness (Reck, 2009). In San Francisco, the Castro District is a popular LGBTQ area. Advocates felt that this area would be an ideal location for homeless sexual minority youth, but this idea was rejected and became the topic of public debates (Reck, 2009). The Castro was reserved for the affluent individuals who could spend money, and not for the homeless youth (Reck, 2009). This lends credibility to the fact that racism and class division exists within cultures. Studies have also shown that trans women are at disproportionate odds for homelessness, physical, sexual, and emotional abuse than the transman population (Grant et al., 2011).

Regardless of gender identity or sexual orientation, homeless youth experience multiple challenges. Transgender youth face harassment, which for some end with them forced out of school, resulting in lack of gainful employment due to inadequate education (Mottett & Ohle, 2006). The perception is that individuals who identify under the LGBTQ umbrella have an increased risk of homelessness and discrimination affecting their ability to secure employment which ultimately affects the ability to secure stable

housing (Keuroghlian et al., 2014). Inherently, the assumption is also that identifying as transgender increases the risk of homelessness, employment discrimination, and housing discrimination; it also hinders any attempts to secure housing (Keuroghlian et al., 2014). For youth that can obtain employment, the positions tend to be "physically demanding, have unpredictable schedules, and pay so meagerly that workers can't save enough to move on" (Ehrenreich, 2014). Homelessness in the transgender population can be attributed to employment discrimination and unemployment; this leads to instability of financial resources which makes acquiring stable housing difficult (Begun & Kattari, 2016). There are limited shelters that serve transgender individuals which further perpetuates sexual risk, violence, and exploitation (Abramovich, 2016). Transgender youth can become homeless for many different reasons. Some of these youth become homeless after entering the state system (foster-care); others experience family conflict and rejection based on their gender identity and sexual orientation (Castellanos, 2016). While foster care should provide a haven for youth, they often report that it is "rife with theft, drug use and abuse, and violence" (NYC Association of Homeless and Street-Involved Youth Organizations, 2012). There is also the concept of "hidden homelessness," which refers to "doubling up" with someone for the night, or couch surfing (Canadian Observatory on Homelessness, 2012). This concept applies to many who are unable to maintain their own housing, and stay with friends or family (NHCHC, 2011).

While homelessness is historically viewed as an adverse event, in a qualitative study conducted by Shelton (2016), participants reported that being homeless saved their

lives. Participants stated that if they were still residing in their family homes that they would have probably committed suicide, so they attribute homelessness to saving their lives. Other participants identified that having a transgender community provided them a sense of belonging, the peace of mind that other individuals were like them, and to whom they could relate. They identified with networks that could provide them with protection and support around their gender choice, but also where they could receive resources from those with experience (Stieglitz, 2010). Some of the participants identified their newly developed network as "surrogate families or gay families" (Shelton, 2016). Individuals in this study were able to address the negatives of homelessness and identify the positive experiences that for some were life-saving events. Street life can be traumatizing to the youth, but it also builds resilience and coping mechanisms that they would not have ordinarily developed to adapt to their environment (McKenzie-Mohr et al., 2012).

Substance Use

Substance use remains a public health concern in the United States (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018), and has been associated with adverse health outcomes and consequences (Bowers, Branson, Fletcher, & Reback, 2011; Garofalo et al., 2006). There are different classifications of substances that can put individuals at risk for contracting HIV and other illnesses, such as hepatitis C. Alcohol is considered a drug, and when ingested in excessive quantities it can alter judgment. Alcohol has been shown to be linked to risky sexual behaviors which can lead to increased risk for HIV. This drug can also alter treatment for people living with HIV (CDC, 2018). Substance use poses a challenge for individuals who are already infected

by HIV because they are less likely to take their antiretroviral therapy (CDC, 2018).

Opioids are another classification of substances that are often prescribed for pain relief. This drug class also includes heroin, which is an illegal drug. Heroin is often injected intravenously, which increases the risk of HIV through sharing needles with an individual that may be infected (CDC, 2018). Another class of drugs is methamphetamines, or "meth" as it is commonly referred to on the streets; this drug can be injected which also increases the risk of HIV transmission through shared needles (CDC, 2018). Crack cocaine is another class of drugs that is considered a stimulant; it poses a risk because individuals continuously seek ways to acquire the drug, including trading sex for money or additional drugs, which increases the risk of disease (CDC, 2018). Lastly, inhalants, otherwise known as "poppers," are another class of drug associated with risky sexual behaviors in sexual minorities (CDC, 2018). In 2016, 66% of drug overdoses involved the use of an opioid. Opioid use has become an epidemic with an estimated 115 Americans dying daily due to opioid overdose (SAMHSA, 2018).

Substance abuse includes illicit drugs as well as the non-medical use of prescription drugs. Prescription medications that are used for "pain management, anxiety, attention-deficit/hyperactivity disorder, and insomnia are being used recreationally" (Benotsch et al., 2013). Marijuana is usually the first drug used during the initiation of drugs in the youth population, followed by prescription drugs (SAMSHA, 2010). Studies have identified a higher rate of child abuse in LGBTQ youth when compared to their heterosexual peers as a precursor to prescription drug abuse (Friedman et al., 2011). According to the Substance Abuse and Mental Health Services Administration, in 2016

there were 11.8 million individuals that were misusing opioids (SAMHSA, 2018).

Studies show that comorbid disorders are inherently linked to substance use in the transgender population, including discrimination, victimization, traumatic experiences, and depression (Booth et al., 2010, Clark, 2014; Rowe, Santos, McFarland, & Wilson, 2015). Substance use remains disproportionately higher in transgender youth when compared to their cisgender counterparts (Green & Feinstein, 2012; Herbst et al., 2008). Factors related to substance abuse in the transgender population include hostile school environments, victimization in their school environment to include bias-based bullying and or harassment based on perceptions surrounding their sexual identity (Day, Fish, Perez-Brumer, Hatzenbuehler, & Russell, 2017; Kosciw, Greytak, & Diaz, 2009). An additional risk associated with substance abuse in the transgender population is the internal battle of "coming out" about one's sexual orientation or gender identity (Livingston, 2017). Substance use has been identified as a means of coping with gender identity in the transgender population (Garland, Pettus-Davis & Howard, 2013). Another risk related to substance abuse among transgender individuals includes learned behaviors from parents (Yule, Wilens, Martelon, Simon & Biederman, 2013). These behaviors have been identified as a predictor of alcohol and substance abuse in the adolescent population (Patrick, Maggs, Greene, Morgan & Schulenberg, 2014; Yule et al., 2013).

Substance abuse has been associated with additional risk factors such as sexual risk, behavioral health disorders, and increased rates of suicide in the transgender population (Friedman et al., 2014; Johnson et al., 2013; Mustanski, Andrews, Herrick, Stall, & Schnarrs, 2014). This behavior leads to adverse health outcomes and

consequences. Injection drug use is a prominent risk factor for HIV, hepatitis and other bloodborne diseases, but additional drugs that can alter behaviors and impair judgment inherently lead to risky sexual behavior (CDC, 2018; Christopoulos, Das, & Colfax, 2011; Meade et al., 2016). A study conducted of a trans-female sample in the United States showed a prevalence of illicit drug use as approximately 30%, marijuana at 20%, and alcohol and other drugs at approximately 14% (Herbst et al., 2008), and has been identified as a means of coping with gender identity in the transgender population (Garland et al., 2013).

A qualitative study was conducted that identified the experiences of transgender individuals' in residential addiction treatment, and it concluded that these individuals have difficulty accessing addiction treatment programs (Lyons et al., 2015). Discrimination and marginalization are often linked to drug use, and while substance use disorder is considered a health issue, this behavior is associated with criminal activity. Substance use disorder should be considered a treatable disorder for which individuals should receive rehabilitation or medication-assisted treatment (SAMHSA, 2018).

Homelessness can lead to the initiation or exacerbation of substance use in the homeless transgender youth population (Cochran et al., 2002; Motett & Ohle, 2006). Substance use is linked to HIV-related sexual risk behavior and HIV infection among transgender youth (Rowe et al., 2015). Trans females have a 34% greater chance of contracting HIV than the general adult population (Baral et al., 2013; Santos et al., 2014).

Barriers to Care

The transgender population faces multiple barriers to care. Eliminating these

Barriers are pertinent to the transgender population leading healthy lives. The transgender population often face homelessness, lack of medical and psychiatric services (Spicer et al., 2010). These conditions are exacerbated by societal stigma and denial of their human rights (Healthy People, 2018). Appropriate health care is beneficial and can impact disease prevention, mental health services, health care costs. Transgender individuals frequently do not engage in care due to barriers such as provider insensitivity related to their gender or socioeconomic status of homelessness (Spicer et al., 2010). When seeking medical or mental health care, homeless LGBTQ youth identify feelings of internal oppression and discrimination as additional barriers (Gattis, 2013).

Poverty is identified as a barrier to care because many cannot afford transgender reaffirming care such as hormones or sex reassignment surgery (Mottett & Ohle, 2006). Many transgender individuals lack access to care due to lack of health insurance coverage. It has been speculated that a lack of employment in comparison to their cisgender peers may be responsible for this lack of coverage (Conron, Scott, Stowell, & Landers, 2012; Grant et al., 2011). There are policies in place that prevent access to care. Insurance companies have been known to restrict coverage and deem procedures that are gender affirming as pre-existing, cosmetic, or medically unnecessary (Khan, 2013). which excludes them from coverage. This barrier to care can lead to increased risk in the transgender population, as individuals may resort to the use of street hormones. The use of hormones obtained on the street poses a problem because it can be detrimental to one's health if taken in inappropriate doses. Individual's using street hormones are at risk of contracting HIV and other diseases if they use a syringe that is contaminated to inject the

contracting HIV and other diseases if they use a syringe that is contaminated to inject the hormone therapy (Hughto et al., 2015, Quintana, Rosenthal, & Krehely, 2010).

According to Spicer (2010), individuals who lack access to care are at increased risk for depression, suicidal thoughts, self- injury, and even suicide. Another barrier to care is the lack of trained professionals to administer care to this population (Khan, 2013; Mottett & Ohle, 2006). This perceived risk by the transgender youth population of the lack of knowledge or sensitivity to their health care needs further estrange them from accessing or using prevention services (Garofalo et al., 2006). In 2011, a study was conducted that identified that medical providers received an average of five hours of training related to transgender care (Obedin-Maliver et al., 2011). Access to care may also be impacted by previous experiences, such as extensive history taking involving questions surrounding sexual behaviors and substance use, transgender individuals may be uncomfortable with the questions asked, and not seek follow-up care (CDC, 2018). Studies have indicated that if a transgender individual can pass for a cisgender individual their risk of experiencing discrimination when seeking healthcare is decreased (Kattari & Hasche, 2015).

Risk Behaviors

While challenging for many youth, the “street life” instills resilience because it pressures them to adapt for survival (McKenzie-Mohr et al., 2012). Unfortunately, the street life often equates to interaction with law enforcement. Trans-youth are inherently associated with sex-work and profiled because of this behavior (Amnesty International, 2005). They are also profiled for substance use, which equates to higher criminal records

than their heterosexual homeless peers (Ferguson & Maccio, 2015). Transgender youth reportedly have higher rates of criminal records when compared to their heterosexual homeless peers (Ferguson & Maccio, 2015). Interactions with the law have resulted in an unwillingness to carry condoms, as this practice has been used against trans-youth by law enforcement as evidence of performing sex-work (Wurth, Schleifer, Mc Lemore, Todrys, & Amon, 2014).

In a 2004 study, transgender female participants identified the need for acceptance as motivation for engaging in unprotected sex to validate their identity (Crosby & Pitts (2007). The participants in this study also identified substance use to cope with stress related to stigma, sex work, and economic oppression. Crosby and Pitts (2007) conducted a qualitative study using the grounded theory, 17 transgender females enrolled. The study participants identified acceptance as a "girl" as a reason to endure abusive relationships or to engage in riskier behavior. One participant stated that she had an unprotected sexual encounter with a male partner whom she later found out was HIV positive because "he treated me like a lady" (Crosby & Pitts, 2007 p. 45). Fourteen of the participants stated that they used hormone therapy to maintain femininity. They reportedly obtained hormones from friends, online, as well as street vendors.

This practice of non-medical acquisition of the hormones often involved sharing needles, leading to the risk of HIV and other bloodborne infections (Crosby & Pitts, 2007). Participants reported knowledge of their risks however, some choose to engage in sex work at the expense of acquiring hormones that will allow them to increase the possibility of acceptance in society. When engaging in street sex, there is often increased

earnings for not using a condom (Huschke & Coetzee, 2019; Selvey et al., 2018). Some participants stated that “drugs make sex work tolerable” (Crosby & Pitts, 2007, p. 45). In an additional study conducted by Stevens et al. (2013), the ecological systems theory was used to provide a framework for the study. A consistent theme among the participants was that of “transactional sex” to purchase daily wants or needs. Study participants reported that younger individuals were more likely to participate in riskier sexual behaviors when coming out (Stevens et al., 2013). The rationale for this behavior is that youth are happy to find others who are like them and are not focused on protection, but rather on acceptance (Stevens et al., 2013).

In a study conducted in 2006 by Garofalo, 61% of the transgender youth sampled indicated lack of employment as a primary source of participating in sex work; others cited unstable housing and economic instability as additional factors. Study participants who identified sex work as a source of income were associated with lower education, increased levels of homelessness, and a higher likelihood of incarceration than their peers without a sex work history (Wilson et al., 2009).

The subset of the population that identify as transgender is subjected to a higher prevalence of sexual assault with data ranging from 13-86% (Stotzer, 2009). Individuals who engage in sex work, those who are incarcerated, and transgender women of color seem to be more susceptible to this type of victimization (Ahmed & Jindasurat, 2014; Hughto et al., 2015; Stotzer, 2009). The current literature indicates an increase in sexual risk behavior, commercial sex work, substance use, homelessness, and mental health issues in transgender youth (Garofalo et al., 2006). In a study conducted by Hotton et al.

(2013), researchers hypothesized that exposure to stress is impacted by using alcohol and illicit substances which ultimately increases sexual risk. Individuals who engage in alcohol abuse or the use of illicit substances have other complex health, social and psychological needs (CDC, 2018). It is evident from the literature that transgender youth have increased vulnerability when compared to their cisgender counterparts (Walls, Hancock, & Wisneski, 2007).

Intimate partner violence also impacts an individual's power related to barrier protection and increases the risk of depression, substance use, lack of access to medical care (CDC, 2016). Lack of education, employment, and housing based on transphobia and discrimination contribute to elevated rates of substance abuse, sex work, incarceration, homelessness, depression, suicide, and unemployment (CDC, 2016). The stigma associated with name changes can further complicate access to care due to insurance discrepancies (CDC, 2016). Transgender individuals experience social rejection which creates barriers in daily tasks.

HIV Risk

HIV risk remains a public health issue regardless of an individuals' sexual orientation or gender identity. Rates of HIV and sexually transmitted infections tend to be increased in the transgender population due to engagement in survival sex; which is defined as "trading sex for food, a place to sleep, or other basic needs" (Ferguson & Maccio, 2015, p. 661; Gangamma, Slesnick, Toviessi, & Serovich, 2008). An increase in the number of sexual partners, and greater risk-taking during sexual activity, inclusive of illegal substances (Wilson et al., 2009). Historically, HIV risk is lower in the trans-male

population compared to a trans-female, but the risk should not be ignored (Bockting, Robinson, Forberg, & Scheltema, 2005). In a mixed-methods study conducted with a sample of 122 transmen in San Francisco, 81.9% of the participants reported taking hormones, 69% attributed the use of testosterone to new sexual behaviors, 72% reported an increase in their sexual behavior, while 49% identified a change in who they were sexually attracted to (Dadasovich et al., 2017). Prior to testosterone therapy, 3.3% of study participants reported sexual intercourse with cisgender men who have sex with men; this number increased to 25.4% after starting testosterone (Dadasovich et al., 2017). While studies that focus on the FTM trans population is not as common, these individuals are at increased risk for HIV based on their high-risk sexual behaviors, and relationships with cisgender gay men (Dadasovich et al., 2017; Kenagy & Hsieh, 2005).

Individuals who engage in this risk-related behavior are more prone to engaging in sexual intercourse without barrier protection and may have multiple sexual partners (CDC, 2016a). Transgender youth often are in situations where they may exchange sex for money or non-monetary items such as food, drugs, clothing, or a place to sleep (CDC, 2016a). These individuals are prone to sexual assault and victimization once homeless in comparison to their cisgender peers (Tyler, 2008a). Use of illegal substances increases an individuals' risk for contracting HIV and has a significant impact on the outcome of the disease (CDC, 2018).

Substance use impairs judgment which can increase risk by engagement in anal sex, or lack of barrier protection, or the ability to negotiate protection (CDC, 2016a). Transgender individuals may not know their HIV status due to lack of access to testing,

or access to healthcare. An estimated 3 million individuals in NYC were tested for HIV in 2015, and a diagnosis of HIV was three times the national average (CDC, 2018a). Unprotected anal receptive sexual contact has been cited as a primary driver in the transmission of HIV as well as multiple sexual partners (Baral et al., 2013). Transgender sex workers have a 27% worldwide prevalence of HIV (Poteat et al., 2015). This number is based on laboratory-confirmed HIV results from 15 countries, including the United States (Poteat et al., 2015).

Tyler and Melander (2012), cited the social norms theory in their research which posits that the network of people that transgender youth spend time with influence their behaviors. Therefore, if transgender youth believe that their social network is not engaging in safe sex practices, they are unlikely to engage in safe sex practices themselves. Transgender youth are prone to disease; however, there are prevention methods available such as condoms which are a barrier method that protects individuals from contracting or transmitting HIV and other sexually transmitted infections. HIV negative individuals can also remain negative by engaging in pre-exposure prophylaxis (PrEP), which involves taking a daily pill to prevent HIV disease (CDC, 2016a). Behavior associated with risk magnifies the potential for disease transmission such as lack of safe sex practices during sex work as well as exposure from contaminated needles from hormone injection or substance use (Crosby & Pitts, 2007).

Psychosocial Risk

Individuals who are experiencing housing instability are more prone to physical and mental health challenges. Factors such as social oppression, stigma, transphobia,

psychosocial stress, and increased risk behaviors lead to poor health outcomes (SAMHSA, 2018). Adverse familial experiences and homelessness often exacerbate mental health challenges, and suicide attempts, which can trigger substance use as a coping mechanism (Moskowitz, Stein, & Lightfoot, 2012; Zhao, Montoro, Igartua, & Thombs, 2010). Life stressors such as "depression, low self-esteem, discrimination, and substance misuse" have been associated with greater risk-taking in transgender women (Poteat et al., 2015, p. 276).

Summary

HIV is a public health emergency among trasngender youth. The transgender population is marginalized and continue to be negatively impacted by the disease. Transgender youth are discriminated against, and are often victims of physical or sexual abuse, and continue to be negatively impacted by this disease. Previeous studies provided an understanding of the challenges faced by transgender youth, however there was a lack of studies that focused on the perceptions of homeless transgender youth and their risk risks of HIV.

This chapter provided a comprehensive review of the literature on homelessness, transgender risk factors, access to service, and use of services among homeless, transgender youth. There is significant literature available about homelessness, but there is much less literature on the experiences of transgender youth. Since transgender youth represent an increasing portion of homeless youth, it is imperative to understand their unique experiences relating to risk factors associated with a predominance for contracting HIV. Identifying and mitigating risk in this population is critical to reducing transgender

homelessness, but also to decreasing their risk of HIV and other sexually transmitted infections.

In Chapter 3, I discuss the methodology in detail, which includes areas such as recruitment, participant selection, data collection and storage, data analysis, and ethical concerns.

Chapter 3: Research Method

Introduction

The purpose of this research study was to (a) understand the lived experience of transgender youth and (b) the influence of homelessness on behaviors associated with sexual risk and (c) identify effective prevention methods. Information on the lived experiences of homeless transgender youth in NYC, along with their perception of risk related to their environment and learned behaviors, is lacking in the literature. The SCT provided greater insight into their risk behaviors. An in-depth understanding of how the target population viewed their risk may be beneficial in preventing sexually transmitted diseases and assisting with the governor's plan to end the HIV epidemic. In this chapter I cover the research design and rationale, the role of the researcher, the methodology, and issues of trustworthiness.

Research Design and Rationale

A qualitative research design was chosen for this study with a phenomenological approach as the specific aim was to understand the influence of homelessness on sexual risk. Qualitative research is defined as "a situated activity that locates the observer in the world; it consists of a set of interpretive, material practices that make the world visible" (Denzin & Lincoln, 2011, p. 3). As a researcher conducting a qualitative study, theoretical frameworks are often used to inform our study (Creswell & Poth, 2018). A qualitative study can be symbolically compared to an intricate piece of artwork and is usually conducted to explore a particular problem, a specific group or population, or give a voice to those individuals who have been silenced and unable to tell their stories

(Creswell & Poth, 2018).

The concept of phenomenology was established by Husserl and focused on detailing a specific phenomenon based on a personal perspective (Burkholder, Cox & Crawford, 2016). To understand the lived experience of the target population, it was vital that participants could articulate their perceptions, beliefs, and experiences. A phenomenological perspective examines human behavior through the eyes of the individual experiencing it (Simon & Goes, 2012).

Moustakas (1994) posits that experience and behavior are inseparable to the individual experiencing a phenomenon. A phenomenological approach was selected for this study because it focused on the lived experience of human beings (Salazar, Crosby, & DiClemente, 2015). This approach was the only approach that allowed me to obtain a better understanding of the influence of homelessness on risk associated behaviors in the target population, as only the individual with direct experience can detail the specific phenomenon related to their situation. The research entailed collecting detailed information from the participants regarding their experiences with risk associated behaviors while homeless. Interviews were utilized, as it is the most common form of data collection in phenomenological studies and allowed the participants to provide the researcher with detailed descriptions of their experiences (Smith & Goes, 2011).

Research Questions

The research questions that guided the study were as follows:

- What are the perceptions of HIV risk behaviors among the homeless transgender youth of New York City?

- How does being homeless affect sexual risk behaviors in transgender youth?
- What specific services are needed to combat HIV risk-related behaviors in homeless transgender youth?

Role of the Researcher

According to Patton (2015), the researcher is considered the main instrument for collecting data, this individual is vital to the study because their views and opinions help to shape the structure of the study. It is essential to any study that researchers are aware of personal biases. As a researcher, it is necessary to listen empathetically and interpret accurately when conducting interviews (Miner-Romanoff, 2012). According to Merriam (2009), as researchers, it may be impossible to eliminate bias, but we must be cognizant of our biases to monitor it and shape our research studies. As the primary collector of data, during the interview process, it was important not only to listen keenly to what the participants stated but also to what they expressed via nonverbal cues. As a researcher, it is essential to listen empathetically and interpret accurately when conducting interviews (Miner-Romanoff, 2012). A critical facet of the role of a researcher is to remain free of bias; this concept of epoché is the process of recognizing bias and remaining free of judgment or personal assumptions (Yűksel & Ylidirim, 2015). My role as the primary data collector and organizer was to collect and analyze data from transgender youth who have experienced homelessness (Burkholder et al., 2016). It was essential to curtail bias as bias can influence the responses of the participants. Another role as the researcher was to ensure the participants that I would maintain their confidentiality and foster an environment of trust.

According to Poggenpoel and Myburgh (2005), the researcher becomes a facilitator for data collection by ensuring that participants are comfortable in sharing their lived experiences while paying attention to additional cues that the participant may give. As the primary data collector and data analyzer, I conducted semi structured interviews with the participants individually. I used a recording device during the interview process to ensure that data was accurately captured. The data was transcribed verbatim, and then I used a qualitative coding software to identify new themes that emerged from the data.

According to Miller and Glassner (2004), a researchers approach to their research is governed by their own experiences that pertain to the phenomenon being studied; therefore it was important to remain subjective. As a medical provider, I have extensive experience providing medical care to the underserved communities in NYC. I have extensive experience working with individuals experiencing homelessness, mental health, and substance use challenges. While primarily a provider of medical services, my focus on my patients has always been holistic. I have similarly focused on the social determinants of health particularly but not limited to housing. I have had limited interactions with patients who identify as transgender and fit the definition of homeless. My professional experiences and lack thereof have piqued my interest for a better understanding of this population and the experiences they face.

As the primary researcher, the concept of bracketing is fundamental in research. Bracketing is a method used in qualitative research to reduce harmful bias that may be introduced to the study by the researcher (Tufford & Newman, 2010). Bracketing is an awareness of your preconceptions towards the phenomenon of study and not ignoring that

they exist (Moustakas, 1994; Ravitch & Carl, 2016). This method is necessary to facilitate the accuracy of the data that is collected (Tufford & Newman, 2010).

A possible ethical concern that could be raised is that I have worked with homeless men, women, and children of NYC. I have not, however, worked with homeless transgender youth. Another issue that may raise ethical concerns is the use of incentives. As a researcher, I ensured that the participants are treated with beneficence. There has been controversy about whether the use of incentives in research can be considered coercion (Groth, 2010). In a study conducted by Halpern, Karlawish, Cassarett, Berlin, & Asch (2004), the researchers suggested that financial compensation can be given to minority participants without being considered coercion. There seems to be minimal federal guidance on the matter of compensating participants, and the role of guidance seems to be placed on local institutional review boards (IRBs) (Dickert, Emanuel, & Grady, 2002). It is my responsibility to confirm that all participants received and signed an informed consent. IRB guidance was respected regarding safeguarding participant information and compensation.

Methodology

A qualitative method was selected for this study. Semi structured interviews were used, along with purposive sampling for youth who are homeless and identified as transgender. To explore the lived experiences of the target population, it was necessary to conduct this study using a qualitative approach. There are five main qualitative approaches ethnographic, narrative, case study, phenomenological and grounded theory. The research considered the lived experiences of the study participants; therefore, a

phenomenological approach was chosen. The focus of this qualitative study was to explore the perceptions, lived experience and beliefs of transgender youth in NYC who are currently homeless or have experienced homelessness. Secondarily, this research study determined the target populations perceptions related to barriers influencing testing, support services, and healthcare access.

Participant Selection Logic

The population studied was homeless transgender youth. According to Yűksel and Ylidirim (2015), participants selected for the study should have experience with the same phenomenon. The definition of transgender refers to individuals who do not exclusively identify with their sex assigned at birth (Trans Student, n.d.). There are many definitions of homeless, however for this study the federal definition was used and can be found below. Participants were chosen using a purposive sampling technique. This method of participant selection is frequently used in qualitative studies and indicates that participants are specifically chosen because they have experience and understanding of the phenomenon being studied (Creswell, 2014). This sampling method allowed for a focus on specific characteristics in the target population (Salazar et al., 2015). Since the research specifies homeless transgender youth as the target population, this sampling method was ideal for this study.

Participant selection was based on two main criteria. According to Yűksel and Ylidirim (2015), participants selected for the study should have experience with the same phenomenon. The selected participants were required to identify as transgender and currently be experiencing homelessness or have recently been homeless within the past

three years. The criteria for homelessness was measured using the federal definition. “Homelessness is defined as any individual that lacks stable or permanent housing; inclusive of individuals that reside on the street, in abandoned establishments or shelters” (NHCHC, 2018.). In addition the federal statute for youth experiencing homelessness further states there is a separate definition that applies to the youth population. Youth who are unaccompanied are considered homeless if they have not independently resided in permanent housing for an extended period of time, or if they experience unstable housing due to frequent moves, especially if the following factors play a role; physical disability, chronic physical or mental health condition, substance use disorder, child abuse, or multiple barriers to employment (NHCHC, 2018).

IRB approval was obtained from Walden University before commencing data collection. I identified organizations in NYC that provide services to homeless transgender youth. Once I received IRB approval number 09-12-19-0370149, a letter of request for participant recruitment was submitted to the identified establishments. Participants were selected from NYC and completed a demographic questionnaire (Appendix A), to determine if they met the required criteria. Participants of the study were required to meet the following inclusion criteria:

- identify as transgender
- be homeless or have a recent history of homelessness
- be between the ages of 18-24.

I worked in conjunction with social service agencies that provide services to the target population. Once the identified agencies granted permission for participant

recruitment; flyers were posted at these facilities and included information regarding participation and how to contact the researcher. Participants were required to be 18 years old at the time that the study was being conducted. Once contact was initiated, participants received additional information regarding the study. A questionnaire was issued and completed to identify demographic information that was necessary for study selection. Once participants verbally agreed to study participation, they were provided with an informed consent form. Before obtaining written consents, participants were informed that their participation in the study is entirely voluntary and that they could withdraw their participation at any time during the process.

According to Creswell (2014), while there is no set sample size in a qualitative study, participant numbers often range from 1 to 25 depending on the qualitative design that is utilized. For phenomenological studies, the specific number ranges from three to ten (Creswell, 2014). The sample was chosen from organizations within NYC that provide services to transgender youth. Flyers were distributed at select organizations within the community. According to Morse (2000), while multiple factors are considered for data saturation, in a phenomenological study, the researcher can reach data saturation with a minimum of six to ten participants. To reach saturation interviews were conducted until there was no new information obtained (Creswell, 2014).

Instrumentation

Interviews are considered an effective way of collecting information in qualitative studies. Interviews distinguish information based on questions that are asked of the participants. It allows participants to respond to questions based on their own experiences

and perceptions as it relates to homelessness in this population. According to Patton (2015), it is essential to guide the interview to ensure that participants remain focused on the current topic.

The first data collection instrument that was used was a face-sheet that provides demographic information (Appendix A). Completion of this document identified whether the perspective participants met the eligibility criteria for study inclusion. The second data collection instrument that was used was the semi structured interview guide (Appendix D). I created this tool which provided me with a foundation for exploring the experiences of the transgender youth. As the target population can be considered transient, I engaged them immediately after obtaining necessary consents. Establishments that conduct programs for the target population were contacted; I used their group rooms or therapy/case management rooms to conduct the interview process.

Once consent was obtained, interviews were initiated. Interviews were recorded using a recording device that only the researcher had access to. During the interview process, notes were taken by the researcher to capture nonverbal cues. After each interview, the data was transcribed verbatim. All data collected for this study was secured on a password protected computer, a back-up was stored on an encrypted external hard drive. All paper documentation was scanned to a folder on the external hard drive. Once this process was completed, all paper documentation including but not limited to notes, and consents were stored in a locked file cabinet in my home office. The recording device that was used during the interview process was also placed in this locked filing cabinet.

Preliminary Road Test of Interview Questions

There are four key reasons to conduct a road-test in phenomenological qualitative research: the ability to identify any problems that may arise during participant recruitment; the ability to bracket bias; practicing the principle of epoche; and being able to adjust your research questions as needed (Kim, 2011). Interview questions were reviewed by two of my colleagues who are also health care professionals, both of whom have prior experience working with marginalized populations. I contacted my colleagues, and provided a brief description of the research study, and invited their input in reviewing the interview questions that. The first road test was conducted with the assistance of a family nurse practitioner. This individual was selected based on their experience working with homeless families in the NYC shelter system. The second individual is a licensed clinical social worker, and she was chosen due to her extensive work with teens in an opioid treatment program. My colleagues both recommended noteworthy changes to the number of questions, partially due to repetition. They also referenced the appropriateness of the sub questions to the main research questions. The original research study was not initiated until approval was received from the Walden University IRB.

Procedures for Recruitment, Participation, and Data Collection

To recruit participants for this study, I identified several organizations in NYC that directly provide services for homeless transgender youth. Once IRB approval was obtained, I submitted letters of request to previously identified organizations. The letter was sent to the leadership of the organizations, requesting the use of their facility for recruiting study participants as well as the ability to conduct interviews on site. I

conducted all recruitment efforts by posting flyers in the facility to foster an environment of inclusivity. The flyer consisted of a phone number as well as email to contact me for individuals who were interested in participating in the study. The modes of contact listed on the flyer was used for study participants only.

Once participants expressed their interest in the study, their demographic information was requested to verify eligibility; if they were eligible, they were given an invitation to participate. After verbal consent was obtained, the researcher scheduled a meeting with participants to secure written consent and provided them with detailed information on the study. The participants were given the opportunity to schedule an appointment that was mutually convenient for the participant and researcher. Interviews were scheduled in 1-hour increments, with the ability to extend, as necessary. While I requested space from the organizations, I also performed interviews in a safe space of the participants choosing to ensure that they were comfortable. The interviews were conducted in English. In phenomenological research, multiple interviews with the participants are suggested to create an environment of trust between the researcher and participant (Moustakas, 1994). Participants were encouraged to share in-depth data related to their personal experiences.

As an additional layer of identity protection and protection of confidentiality, demographic data was de-identified. To maintain participant confidentiality, a number was assigned to individual participants to prevent the use of their name. Data was collected by asking open-ended questions during the interview to capture rich, meaningful data; all interviews were recorded for verbatim transcription. After data was

collected, it was imperative that I completed the transcription notes shortly after to avoid losing the significance of the information collected (University of Kansas, 2017). Participants were asked to attend a debriefing session. In this session, they were asked to validate the data that was transcribed from their interview. If no additions were required, the participant were offered a draft.

Data Analysis Plan

When conducting research, it is essential to have a blueprint on how you plan to get to the end, which is analyzing the data. Data analysis starts with the organization of the data that is collected; this can be done by reviewing interview transcripts, notes, and creating categories for coding the data (Ravitch & Carl, 2016). Data analysis is integral to data credibility (Smith & Firth, 2011). When evaluating data, it is necessary to consider the research questions and methodology that will be used (Ravitch & Carl, 2016). Data collected from the interviews were transcribed verbatim to maintain the credibility of the data, this information was then coded using a software system, and these codes were subsequently grouped into themes. The themes gathered can produce greater insight to the phenomenon being studied (Smith & Firth, 2011).

Coding is instrumental in qualitative analysis. NVivo was the software used for coding the data. This data analysis software is capable of coding large quantities of data; it also has a memo feature where additional notes can be documented. Coding captures themes, concepts, and examples from the data (Soriano, 2013). Themes are considered "summary statements, causal explanations, or conclusions from the data (Rubin & Rubin, 2012). When analyzing data, it is recommended that the analysis takes place promptly,

which prevents clouding of impressions from the interview process (Miner-Romanoff, 2012). It is crucial to review notes and make changes to documentation after each subsequent interview process.

Issues of Trustworthiness

When conducting a qualitative study, it is crucial to obtain and maintain trustworthiness. While there are many aspects involved in conducting a qualitative study, securing the trust of the participants is paramount to a successful study. The process of qualitative data collection and analysis often provide a detailed understanding of the researched phenomenon as it relates to participant experiences in different social, cultural, and emotional facets (Smith, Flowers, & Larkin., 2009). According to Creswell (2014), when building trust with participants, it is essential to know the topic as well as the research questions to appropriately engage them. Maintaining eye contact has been reported as a way for the researcher to show genuine interest.

Trustworthiness encompasses credibility, transferability, dependability, and confirmability. Validity in research depicts the quality of work produced and has been defined in multiple ways. Validity has been defined as “the best approximation of the truth” (Trochim & Donnelly, 2007, p. 56). One method that may be used to establish trustworthiness is purposeful sampling (Miner-Romanoff, 2012). Triangulation is a second method that may be used for the establishment of trustworthiness. Use of interview technique and protocols are beneficial to establishing trustworthiness as it provides a guide thereby decreasing the need for a deviation between participants.

Credibility is a significant aspect of qualitative studies. It is crucial to reach data saturation in order to maintain credibility in a study (Fusch & Ness, 2015). Saturation is equivalent to having enough depth related to the phenomenon being studied with the inability of the researcher to glean new information (Dworkin, 2012). Triangulation is a method that can strengthen the credibility of a study, by using different sources of information to identify relevant themes from the data (Creswell, 2014). Member checking is another method which includes having participants review the data for accuracy. Transferability in qualitative research can be captured using purposeful sampling to ensure that the data that is collected is a rich description and representation of the target population by reaching data saturation (Cypress, 2017). Dependability is captured by using another individual such as a peer to validate the information provided (Creswell, 2014; Cypress, 2017). According to Gibbs (2007), there are specific processes that a researcher can implement to increase the reliability of a study. These procedures include double-checking the document to ensure that no errors were made during the transcription of data; ensure that data coding is consistent. Confirmability can be met by maintaining a journal and creating an audit of activities related to data collection. It is also vital to bracket biases and be cognizant of how one's background may affect the study (Creswell, 2014; Cypress, 2017).

Researcher bias is exceptionally influential to qualitative studies. It is critical that the researcher recognizes their biases, limits them, and remains capable of appreciating the phenomenon based on the participant's experiences (Starks & Trinidad, 2007). A researcher can use the concept of bracketing to ensure that their self-reflections are not

overpowering the interview process (Starks & Trinidad, 2007). To ensure the credibility and reliability of information; all participants were asked to give consent to have the interviews recorded. Notes were also used as a secondary method of data collection, to capture non-verbal cues. All data was stored on a password protected device, and notes and consents were scanned to this device, and stored in a locked file cabinet in my home office.

Ethical Procedures

When conducting research that involves human participants, the participant is a priority. It can be a very delicate situation; hence Walden University offered a course on ethics in conjunction with the National Institute of Health to prepare future researchers. The course included information on the protection of human participants in research. Since homeless transgender youth are considered a marginalized population high priority is given to protect this population from harm when participating in research studies. My responsibility as the principal researcher was to ensure that participants are not harmed; their participation and the information that they provided is kept confidential, and that they can make informed decisions related to their participation in the study. The Walden IRB was instrumental in this process as it served to ensure that all necessary protections/requirements were in order before the research study was approved.

Protecting participants by maintaining the confidentiality of their responses is instrumental in the deferment of harm. The process of confidentiality was instituted from participant recruitment through data analysis. Participants were informed that participation in the study was voluntary and that they could withdraw at any time. They

were also reminded that they did not have to answer any questions that were uncomfortable for them. Before engaging in the interview, participants signed a consent form, and were reassured that participation in the study was voluntary and that their information would remain confidential.

Summary

This study was conducted to aggregate information on how homeless transgender youth elucidate their social risk, their perception of their sexual risk, and how being homeless affects their risk behaviors. A phenomenological approach was chosen using open-ended semi structured interview questions. This study explored the phenomena of homelessness among transgender individuals. In this chapter I detailed the methodology and phenomenological approach of this study; an outline of the sample, data collection, and data analysis was provided. The purpose of this phenomenological study was to explore how transgender youth perceived the impact of homelessness on their sexual risk behaviors. The experiences of the transgender homeless youth may allocate interventions that will decrease homelessness in this population, which ultimately decreases risk.

In Chapter 4, the results of the research study are provided in detail.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological study was to explore the lived experience of HIV risk among homeless transgender youth. An objective of this study was to provide a platform where homeless transgender youth would be able to use their voices to describe their lived experiences as it relates to the risks that they encounter. In-depth interviews were used to collect data for this study. The following research questions guided the study:

1. What are the perceptions of HIV risk behaviors among the homeless transgender youth of New York City?
2. How does being homeless affect sexual risk behaviors in transgender youth?
3. What specific services are needed to combat HIV risk-related behaviors in homeless transgender youth?

Chapter 4 covers the following topics: the setting where data was collected, participant demographics, data collection and analysis, emergent themes, a descriptive account of the experiences of the participants, and evidence of trustworthiness.

Setting

This study was conducted in NYC and provides data collected from 10 transgender youth using in-depth face-to-face interviews. Participants were given a choice of where the interviews would be conducted. One participant was not available to travel to the designated interview locations and was willing to participate if the interview could be conducted in a specific borough. A room was reserved at the public library to

accommodate the interview of this participant. All other interviews were conducted at two approved locations. The space provided by these locations was private and confidential.

Participant Selection

The candidates viewed flyers that were placed in social service organizations that provide services to transgender youth throughout NYC. The participants self-selected by responding to these flyers. Six participants responded to the research flyer via email, three responded via telephone, and one participant responded via word of mouth.

Interviews were scheduled immediately after being contacted and completing a brief questionnaire to ensure that the inclusion criteria was met. I arrived for each interview approximately 15-30 minutes before the scheduled time in order to respect the participants' time. Arriving early allowed me to ensure that a designated space was available at the approved sites, as well as set up the audio recorder and prepare myself to begin. Prior to the start of each interview, I formally introduced myself, verified eligibility using the demographic questionnaire (Appendix A), and reviewed the consent form with each participant. I reviewed the purpose of the study, confidentiality of information, collection, and storage of data, as well as the anticipated length of the interview. Participants were notified of the risks and benefits of participating in the study, and the voluntary nature of the study was reiterated. If the participants had any questions, they were addressed prior to the signing of the consent form and beginning of the interview. Participants were also notified that if they had questions they could be asked during or after the interview.

To ensure confidentiality, I assigned a unique numerical identifier to each participant. This number was attached to the transcript and field notes of each participant. At the end of the interview, each participant was given a $25.00 gift card. The space that was provided by both partner organizations was safe and comfortable. Regarding personal conditions that may have affected the participants at the time of this study, the participant interviewed at the library expressed concerns about whether the room was soundproof or not at the end of the interview. Based on feedback that was received, I am not aware of any conditions that affected data collection or analysis of this research study.

Demographics

Ten transgender youth from NYC with a history of homelessness participated in this study. The information provided in Table 1 depicts the demographic characteristics of the interviewed participants. Participants experienced homelessness with varying timeframes ranging from 5 weeks to 8 years. Four of the participants were currently residing in homeless shelters, and based on the federal definition, the remaining six participants were considered homeless as they are “doubling-up” and did not have a lease in their own name. There was an equal distribution in the number of participants who identified as transman and transwoman. While the inclusion criteria were 18-24 years of age, the participants ranged in age from 21 to 24 years old. To maintain anonymity, all participants were assigned a numerical value from (P005 - P014) that was used throughout the study.

Table 1

Participant Demographics

Identifier	Age	Gender	Housing status
P005	23	FTM	Doubled-up
P006	22	FTM	Doubled-up
P007	21	FTM	Doubled-up
P008	24	FTM	Doubled-up
P009	24	MTF	Shelter
P010	24	MTF	Shelter
P011	23	MTF	Doubled-up
P012	23	MTF	Shelter
P013	21	MTF	Shelter
P014	24	FTM	Doubled-up

Data Collection

The data collection method for this phenomenological study was face-to-face interviews with 10 participants, deemed eligible after completion of the demographic questionnaire that was used as a screening tool for inclusion criteria. Gentles, Charles, Ploeg and McKibbon (2015), noted that the intention of research interviews is to collect adequate data from a sufficient number of distinct individuals experiencing a similar phenomenon. Data was collected for this study from December 2019 to March 2020. Interviews were scheduled based on participant availability, and at a location that was mutually agreed to by each participant. During the initial meeting for data collection participants were thanked for opting to participate in the study. The voluntary nature of the study was reviewed before commencement of the study. Participants were also informed that the interview was being audio-recorded using a zoom digital recorder.

Reflective journaling was used to document my feelings, experiences, and opinions. Field notes were taken during the interview on a participation observation form that I created, to document non-verbal cues for each participant. There were times during the participant interviews where I had to conduct further exploration of the answers provided to the research questions by asking the participants “Can you expand on that”, or “Can you explain in a bit more detail.” The interviews varied between 24 to 54 minutes in length, with an average of approximately 37 minutes (see Table 2). After transcription of the interviews, participants received a copy of the interview transcript via email or in-person as determined during the interview process. This process of member checking ensured that participants reviewed their stated accounts for accuracy and trustworthiness. The initial sampling method for this study was purposeful sampling; however, participants were also obtained by snowball sampling. This method was the only variation from the data collection process presented in Chapter 3. An unusual circumstance related to the collection of data was that one of the participants (P008), inquired whether the room where the interview was conducted was soundproof at the completion of the interview. The participant was not interested in withdrawing the consent to participate.

Table 2

Interview Details

Identifier	Interview date	Interview location	Interview length (min)
P005	12/31/2019	Site 1	31
P006	01/11/2020	Site 1	54
P007	01/15/2020	Site 2	33
P008	01/25/2020	Library	30
P009	01/30/2020	Site 1	48
P010	02/28/2020	Site 1	24
P011	02/28/2020	Site 1	40
P012	03/08/2020	Site 1	27
P013	03/08/2020	Site 1	41
P014	03/10/2020	Site 1	42

Data Analysis

Data analysis commences with the initiation of each interview process. According to Creswell (2014), it is important to practice epoche or bracketing when conducting phenomenological studies. The practice of epoche or bracketing is the method of eliminating the imposition of the researchers' personal feelings, assumptions, or biases. The researcher has a due diligence to the participants of the research study to provide accurate accounts of their lived experiences as they have described it. A rich thick description of the data was gained by conducting semi structured interviews, transcriptions were completed from the accounts of the 10 eligible research participants, and subsequently the data was coded, and further reduced into themes.

NVivo 12 by QSR international was the qualitative data analysis tool used to organize data into codes. To begin the process of analysis audio files were transcribed; each transcript was repeatedly reviewed to develop a complete sense of the content

presented. Initially, the coding strategy included labeling units as they related to the interview questions; this method was further expanded to the three research questions.

According to Thomas (2006), inductive coding affords the researcher the ability to identify themes from the raw data. The five-step methodology to inductive coding was used for the analysis of data:

1. Multiple readings and interpretation of raw data
2. Develop categories from the raw data
3. Creation of categories
4. Identify overlapping codes
5. Refine categories and identify subcategories

Codes were divided into categories, which led to the development of themes. Once primary themes where developed, the focus was on identifying additional themes and any possible association between multiple themes. The identified categories and themes changed multiple times based on the continuous review of the data. Discrepant cases are perceptions from participants in the study that relates to the theme but may not align with the information presented. According to Creswell (2014), it is important to the credibility of a study for a researcher to include discrepant information as it provides a rich precise study.

Evidence of Trustworthiness

Bias is often prevalent in qualitative studies and can occur at any time during the research process; therefore, it is important to establish trustworthiness to validate the results of the research study. To establish trustworthiness, it is important to

consider the following: credibility, transferability dependability, and confirmability.

Credibility

Credibility is the assurance that you have conducted an ethical research study that results in data saturation. Data credibility was ensured by following the indicated data analysis guideline presented in Chapter 3. Study participants were informed of the purpose of the study, asked to sign an informed consent form, and reminded of the voluntary nature of the study. Triangulation was another method used to ensure the credibility of the study. Data was collected using audio recordings, which were later transcribed, in conjunction with field notes and reflexive journaling. Member checking was conducted; participants were given a copy of the transcribed interviews to verify the accuracy of their reported experiences. In the analysis of the data, I immersed myself in the lived experiences of the participants by reading the transcripts multiple times.

Transferability

Transferability in qualitative research refers to the external validity of a study. Purposeful sampling was maintained, while one participant was included as a result of snowball sampling, all participants met the inclusion criteria for participation. In order to accomplish transferability an accurate account of the participants' data was provided. Verbatim transcriptions allowed for a precise depiction of their experiences. I detailed information related to participant selection, setting, demographics, sampling, data collection, and data analysis to have the process replicated by other researchers who are interested in the same phenomena.

Dependability

Dependability in qualitative research refers to the reliability of the study. Dependability was obtained by using audio recordings to ensure an accurate capture of each participant's statements during the interview. Permission to record each participant was obtained as part of the informed consent process prior to starting the interview.

Confirmability

In order to provide confirmability of this study, data rich descriptions were obtained from the research participants by transforming audio-recordings into verbatim transcription of their accounts. In addition, reflexivity was conducted. Notes were taken during the interview to capture non-verbal cues. I used the concept of bracketing to suspend any assumptions that I had related to the phenomena being studied. This allowed the description provided to be a representation of the perceptions of the participants rather than my own views (Korstjens & Moser, 2017).

Results

The research questions and emergent themes guided the study findings. Themes that emerged from the data answered the three main research questions, which encompassed the what and the how of the phenomenon. While each participant described a unique experience, the eight emergent themes depicted the quintessence of their experiences. I gained an understanding of the lived experiences of homeless transgender youth in NYC as it relates to their risk of HIV based on the accounts of their experiences. The following section presents the statements from the participants to support each theme.

Table 3

Research Questions and Corresponding Themes

Research questions	Themes
What are the perceptions of HIV risk behaviors among the homeless transgender youth of NYC?	Knowledge of HIV Risk factors
How does being homeless affect sexual risk behaviors in transgender youth?	Experiences with homelessness Challenges Social network Personal and cultural beliefs
What specific services are needed to combat HIV risk-related behaviors in homeless transgender youth?	Access to healthcare Services

Theme 1: Knowledge of HIV

The interview started by asking the participants what they knew about HIV. All the interviewed participants had some knowledge of the disease. The responses varied from "sometimes a baby can get it through breast milk" to a more definitive answer: "it stands for human immune deficiency virus." The participants were aware that the virus affects the immune system. P006 stated, "I know that HIV is a virus that attacks the immune system." P010 commented, "The disease is sexually transmitted and is very risky to all people in the community." The participant eluded to the fact that HIV has no name, it can be contracted by transgender people, those who are gay, and even those who are heterosexual.

The participants also provided their own personal beliefs of how the disease could be contracted, P009 mentioned, “You just ain’t getting no HIV from fucking in the ass. You’re not getting HIV from fucking…. Well, that’s the thing; again, I’m a Trans, so I don’t know about the female side of things.” Another participant felt that while HIV was not a disease that one would wish for; there have been many advances in medicine that affected how the disease was treated when compared to past treatment of the disease, P007 explained, “So if you do get HIV, it’s not a death sentence, and there’s so many options out there on how to control it and to become undetectable. Undetectable people aren’t transmittable.”

In relation to available resources, condoms were considered a readily available resource, and while all the participants were educated on PrEP and its use in HIV prevention, there were different opinions regarding the medication. The following outlines some of the experiences described by the participants. While the participants were aware of the need for prevention practices to decrease their risk, barrier protection was not always an option P012 was in a long term relationship, and the notion of not using barrier protection had become habitual. This participant was aware of the fact that using condoms may not be the best method and that provided her rationale for the use of PrEP. P012 noted the following in relation to the personal barrier to using condoms,

> I would say now, today, yeah, because we just recently broke up, and like I said, it was six years. And it's like, you never use condoms when you go back to it. But me knowing that, that's why I got on PrEP. So, it's like, if you're not going to practice safe sex; at least you can take this pill to take extra measures of

protecting ourselves.

Additional participants provided their concept and beliefs related to PrEP. Participants mentioned awareness of how the medication worked P005 added, “I know that PrEP if taken consistently, it can keep you HIV negative.” Truvada is the medication used as PrEP for HIV prevention; this prescription drug can be expensive for someone without medical insurance; one study participant who is currently using this method of prevention detailed barriers to consistently taking it as prescribed. P011 stated, “Currently, I am taking PrEP it has been a little hard for me to find organizations where I can get it for free. I do have access to condoms.” Another participant worried about the side effects of taking medication, and preferred to utilize condoms, P008 mentioned, “I have condoms and I have been offered PrEP, but I don't want to be on too many medications.”

There was one discrepant case, P013 stated that HIV did not exist. P013 was asked the same question as the other participants in an effort to explore this participants knowledge of the disease and her perceived risks about contracting HIV. The participant felt that she was not at risk for any disease because her partner was the “Lord”, she further elaborated as follows “I heard that there are diseases out there and that people are dying from them, and they come through sexual relations like man with man or sleeping unprotected and stuff like that.”

Theme 2: Risk Factors

Eight of the ten participants discussed vulnerability as a critical factor in the contribution to their risk for HIV. Many of the participants detailed their experiences with sex work in order to make ends meet. P005 noted the following,

> It just makes it more difficult because you might want to do like sex work or so, and being Trans, kind of like...just the way being Trans is kind of fetishized in general, it could just make it... Yeah. I guess from what I've seen is that a lot of people that I see on Grindr that are Trans women, they're also sex workers. Well, some of them, not everyone, but so it just seems like sex work and then not having a home kind of goes, can go hand in hand in terms of survival for people.

P008 discussed how being vulnerable can lead to HIV risks. “I did survival sex work and I also was raped multiple times while being homeless because it made me much more vulnerable. I depended on people for housing, and they wanted sex in return for me to stay there.” P007 mentioned, that the need for shelter played a significant role in his risk for HIV. He stated,

> Well, while I was trying to find places to stay, it wasn't always people I knew. Some of the situations didn't go so greatly. When it started turning sour, I had to leave so that led a lot to HIV risk. And also, a lot of people who I didn't know, and random people that I met on the street were like, "Oh, so you're Trans. What do you have underneath?" That was just the issues that I faced before.

The need for basic necessities such as food and shelter placed the participants at risk. P010 stated, “I sometimes have to be a sex worker in exchange for food because sometimes I don’t even have anything to eat.” Another participant described the severity of the problem, P007 mentioned that a friend was hospitalized for malnourishment while homeless and stated, “people were prostituting themselves out literally to get food and that was a huge problem.”

A few of the participants alluded to the fact that their peers were at increased risk when compared to themselves because they engaged in sex work practices. According to P014, “Well, I definitely ended up in a lot of risky situations. Not myself, but I know other transgenders that practice in sex work to feed themselves on the street.”

P006 identified [race] as another risk factor that relates to homelessness and HIV risk. He stated the following:

> What we do know is that it's compounding and that it is a lot more of a chance... there is a lot more of a chance for someone who is not only just trans but a person of color to contract this. And also, the fact that the data doesn't collect it... They don't collect data in the way that is representative of who we actually are and the ways that we actually have sex, to even understand how bad it is. Yeah.

In relation to safe sex practices six out of ten participants stated that it was difficult for them to insist on protection prior to engaging in sexual intercourse. P005 mentioned, “Sometimes it is. I would, no actually, I would say yes. It definitely is.” P006 stated,

> In the beginning, …, of having sex that required the use of condoms, it [was]. It was difficult because of the assumption of what masculinity and being a man is and having unprotected sex should be and feel like. So, it was hard to enforce that, yeah.”

Participants’ accounts of having unprotected sexual intercourse varied from never to always. P007 noted, “I never have unprotected sex”, while P011 mentioned, “I was having unprotected sex a lot, but after getting the diagnosis of syphilis, I stopped.” P006

commented “Often” and the rationale was “Well, like I know that I can shower somewhere. I know that I can sleep somewhere. There might be food. This person may not be so bad.” P009 shared, “Girl, I done had unprotected sex…every time for the most part.” Another participant identified unprotected sex as a means of survival. According to P011,

> Sometimes, things have to be done to survive. As I mentioned, sex work, even being exposed to get any sexually transmitted disease for not having safe sex, because some they don't want to pay you because you want to protect yourself. Perhaps, because you are in need, you have to agree, even if you are at risk.

Participants outlined additional factors that compounded their risks for contracting the disease. P014 and P012 included drug use as a compounding risk factor concerning HIV. Another risk factor mentioned relates to the HIV status of the participants' partner; one participant consciously engaged in unprotected sex with a partner who was known to have a positive status. Two of the participants identified with being “a top,” which refers to the individual penetrating, as a protective mechanism against HIV risk.

There was one discrepant case: P008 noted that societal circumstances place people at risk, the participant provided detail on the negative view of the shelter system by stating that some youth would rather be HIV positive as a way out of the shelter system. P008 stated the following,

> Like, people, other youth that I met in the homeless system were kind of happy to get HIV, sometimes because it meant that they could get more services and that

> they could get a home and that they wouldn't have to be in the shelter system for a long time.
>
> This comment conflicted with the other participants' beliefs.

Many of the participants were cognizant of their risk factors for HIV, and conveyed strategies they have used to minimize their risk of infection. Measures such as abstaining from illegal substance use, safe sex practices such as condoms, and awareness of their surroundings by being able to identify risky situations. P012 stated, "For one, I don't do drugs anymore. I don't do crystal meth. I don't do cocaine, molly, or ecstasy anymore. I smoke weed. I listen to the doctors." In reference to the use of condoms for safe sex practices, one participant was adamant about using this barrier protection method. P010, stated "No, I wear them, whether they want them or not." One participant identified advocacy as a risk prevention method. This was important as most participant identified their need for shelter as precursors to their risk behaviors. P008 mentioned political advocacy as a measure to combat risk:

> So some of the things that we advocated for was GENDA, which just got passed, which is an anti-discrimination law for transgender, nonconforming people, and other things that we advocated for is for employment, resources for employment programs specific to transgender, nonconforming people, and there are people doing great grassroots work. Black Trans Media has a mutual aid fund for Trans sex workers to get $500 every month to help towards their rent so they don't have to worry about their rent.

Theme 3: Experiences with Homelessness

Among the ten participants interviewed, the length of homelessness ranged from 5 weeks to 8 years. The participants had varying degrees of homeless experience. Four participants acknowledged less than a one-year history of homelessness, and four participants were currently residing in the shelter system. Some of the precursors to homelessness included being kicked out, family conflicts, and leaving due to the need for freedom of identity as some of their pathways to becoming homeless.

Participants expressed that they were forced into homelessness for various reasons. Age played a factor for one participant, P008 stated:

> My mother had told me that when I turned 18, I had to find somewhere else to live. So, she woke me up in the morning, we got into an argument, and she told me that I had to leave

Family rejection related to gender was also identified as a precursor to homelessness. P007 stated, “So, the entire reason why I became homeless was because I am transgender. I came home one day, and my parents saw my binder in my packer and my dad said, "Get the hell out." So, I did.” Others expressed making a personal choice whether for independence or for peace of mind and safety. P011 mentioned, “I was fleeing from my country because of situations that threatened my life because of my sexuality and because I’m a transgender person.” Another participant explained that while he felt supported by some family members, he felt stifled by others and needed his independence. P006 explained,

> The easiest way to explain it is family rejection. It was a need to... because it was ultimately, I didn't have a choice. And that's what people don't understand is that just because you have a choice doesn't mean you have to withstand certain kinds of abuse and down-talk, and I don't know, invisibility.

P009 mentioned stealing from the one person who always supported and protected her as the precursor to becoming homeless. P009 stated "Well, to be honest, my original homeless situation? Doing my grandmother dirty. You know what I'm saying. That's when she washed her hands of me and that's when at that point, I had no fucking home." Participants also identified multifactorial reasons that led to their homeless situation. P014 stated,

> I ended up being homeless around the age of 19. A few factors contributed to that. One was an unstable family life. Another was lack of ability to continue college. I wasn't able to have anywhere to go home to once I left college, so I ended up on my own very suddenly.

Participants were asked to provide their own personal definition of homelessness; loneliness was a reoccurring theme. P010 stated, "Homeless is not having employment, homeless is not having a home, and being alone." P014 stated, "It means, it means, loneliness. It means feeling lost. It means losing your identity." P007 stated, "Homelessness to me was the fact that I was kicked out of my home and I had to basically fend for myself." A few participants identified the phenomenon of homelessness as a lack. P009 stated, "I got nowhere to go, no roof, no key." P012 added, "I just feel like homeless, being homeless is like... I guess not having any stability, or

having shelter, or a roof over their head. it's just a different lifestyle." P008 added, "Homelessness means that you're unstably housed. You're couch surfing, you're staying in shelters, you're staying with friends or random family members, stuff like that."

One participant described the emotional feeling of homelessness. P011 added, "It causes a bad appearance. It creates a lousy appearance, lousy appearance, because if you don't have clothes or you are dirty, or you are in a bad situation, people start to look down on you." One discrepant case noted by P013 in response to the definition of homelessness, was the notion that once she had a roof over her head, she did not consider herself to be homeless. P013 noted the following,

> I'm not homeless because being in the shelter is not homeless. I believe if I was outside, out on the street, I would be homeless. I don't believe that us in the shelters are being homeless…How could we be homeless if we have a roof over our head?

To cope with HIV risk while homeless, the participants share their experiences related to survival mechanisms that they used in their current situations. P008 shared the following, "I didn't want to have unprotected sex that I was
having for survival, so I made a plan to find another place to live and continued to have sex with the person until I left." P014 added,

> I coped with it mostly by trying to partake in prevention of things as much as I could when I was using intravenously, I was pretty good. I was pretty good about sticking with only me. When I did share, it was like I said, at very extreme moments, not things I'm proud of but overall, I did try to always be responsible.

Theme 4: Challenges

Eight of the ten participants noted challenges to homelessness. Half of these participants specified lack of education, discrimination, and financial related barriers when describing challenges faced during periods of homelessness. P008 noted the following,

> Income, having a decent credit score, having a co-signer, not being discriminated against for looking for housing. So, those are the barriers, and those are huge hurdles. It was also hard to save money, and I also gained a minor criminal record for being caught not paying the bus often, like hopping the bus or hopping the train.

P014 mentioned "hunger" as a major challenge of being homeless. He mentioned the vulnerability faced by being in the streets. P014 stated "assault, not just sexual obviously. I had two sexual assaults, but I have many physical assaults." Financial barriers were identified as the most prominent challenge. P011 stated, "Not having money. Many issues can be listed." This participant also discussed the challenge of relocating from another country, navigating the system, and lack of documentation to work legally in the United States. P011 stated the following, "First, not having documents, that is a big problem" and also mentioned "not knowing the city or how to move around is another huge problem." Participants detailed how a lack of financial resources made them feel. P010 stated, "I go out as little as possible, so I don't feel bad, it feels ugly to be just like not having money. I'm a Trans girl of the community, and people discriminate against you because you're Latina and Trans."

Another challenge expressed by participants' is the need for allowing the essence of their own experience, which can lead to a lack of adherence to treatment regimens provided by healthcare professionals. P006 stated the following,

> So, I would say a lot of doctors and professionals out there need to maybe adopt the whole expert of your own experiencing thing from the people who are in nonprofit worlds with people experiencing homelessness. And so that's where a lot of issues happen, where a lot of people are not in care, and would rather go get a shot from like Sally down the block, because well, Sally's not going to question what I've been doing and tell me that if I've been smoking I can't have my hormones.

P012 stated,

> Like I said, me being vulnerable, I see this guy, and he gives me money. But he also just has sex with a lot of random people, and that's a major turnoff for me. But I'm in a desperate situation where I need money, and he could provide that. That's why I say a lot of people are vulnerable and in certain situations, they get taken advantage of.

Financial barriers were also noted as a restriction to observance of religious practices. P007 mentioned,

> So, my family is observant Jews. So even though I am much less [observant] than my family there was no way I was able to keep kosher or anything like that while I was homeless because I couldn't afford it. I literally had to go to the local McDonald's and order off the dollar menu.

Lack of education credentials was mentioned in the context of being able to find stable employment to be able to sustain the cost of living in NYC. P006 mentioned, “Not having a degree” as a challenge. Two of the participants described having to make choices between their physical and mental health care as an additional challenge. P014 stated,

> Health care, you start to neglect your health care for other priorities. Like, Oh, I’m Not feeling well, but I have to get X, Y, and Z for today or I’m not going to eat or I don't feel good, but I'll go to the doctor some other day.

There were no discrepant cases.

Theme 5: Social Network

To understand the impact of social support on risk behaviors, the study participants were asked to define social support and identify who they considered included in their social network. Seven of the ten participants identified friends as a part of their network. P008 mentioned the following, “Social support means friends, and family, and lovers who are there for you emotionally and who can also help you with resources. That's important. Oh, and also your social community, yeah.” Likewise, P007 stated, “my social support is the second family that I've made when I wasn't accepted in my own and the people that went out of their way to help me.” P012 also stated, “Social support means to me that people actually care, genuinely care, and basically they care, and they want to see you do better.” P005 noted, “That means having people that know how to help you navigate out of bad situations.”

P006 stated,

> Social support looks like maybe not someone who you know, but someone who is willing to be there, whether that be a youth counselor or a peer in an internship or someone on the street who just says, "Good morning" So yeah, it's anybody inside of my circle or even outside of my circle who is willing to understand we're all human.

While not all participants felt that they had a solid support system, they all agreed that social support was an important resource. Some participants mentioned friends and family being a large part of their network, while many also perceived their professional circle to encompass their social and support networks. P011 mentioned, “I guess that social support is lawyers, physicians, psychiatrists, psychologists.” P013 stated,

> No, I don't have a good support system. I am my support system.” The participant further noted, “I don't have a social network because the things that I want, they don't want for me. The things that I want, they want other things for me. And that's not good. So, I don't have a social network.

P012 also stated, “No, I barely have support from people. A lot of people aren't really relatable or can't stay on topic for me to socialize.”

All of the participants discussed the expectations of their social network. Participant 011 explained,

> Sometimes, I have a lot of problems with the people around me because they judge me; I always introduce myself as… [Name]. It does affect a lot because they tell me, "What is your name?" "My name is [Name]." It is a female name, and you look masculine.

P010 expressed, “People here live with a lot of appearances and if you have money, that you can use to buy things, you can look nice, but if you don't have any money you can’t afford to buy nice things.” The participant further stated, “I try to avoid those people. I can't change; I can't be somebody else for other people.

Although not all participants felt that they had a good social network, the participants were clear about the importance of a need to have mutual support and trust from those individuals who they considered to be included in their social network. Trust was a concept that did not come easy to all the participants. P006 mentioned the importance of trust by stating,

> Oh yeah, definitely. Yeah. I mean I have friends that like we've learned to ask each other... that we are in the same position and with people who expect certain things from us too. And we check in with each other and it's like, "Hey, do you want me to listen right now? Do you need advice right now? Do you need me to just be here right now?" The participant also mentioned that this type of

support and trust was not available from family. Trust was important among the participants. P011 expressed, “It is beneficial to have good support and someone you can trust for emotional support is needed.” P012 further explained, “Yeah, it is beneficial. But like I said, it's hard to trust people, because not everyone is genuine.”

More than half of the participants recognized their social network for providing positive influential health related behaviors. The participants were transparent in articulating the fact that they were not always compliant with the advice that they were given by their social networks. P006 mentioned the following,

> In a lot of ways, I'm a lot more timed, and in a lot of ways I don't have time for certain things, for certain people that I know are trying to cause certain reactions out of me. Because before I was not, I guess I would say trained, to understand when someone is trying to lower your vibration.

One of the participants contributed another positive learned behavior from their social network. P010 stated, “I always use protections when I do sex work” in response to the adaptation of behaviors from their social network. P005 added,

> I do have good friends and they do always tell me about making sure to use protection. Even though I don't always listen all the time, they're not like out here saying for me to just do things without condoms. They're always advocating for me to be safe.

P014 noted the following,

> I guess we'll go back to my best friend again. She actually always emphasizes like cleanliness. She's a clean freak but in a way like about health. So, she taught me things about like STDs I didn't know, she's very well educated on things like that.

Not all of the participants expressed positive learned behaviors from their social networks. P007 stated, “I did become rather less religious over this entire thing.”

P011 stated,

> I have had a hard time because it is a very different system from the system used in my country. Here there is a kind of open mind, a bit more freedom that there was not in my country. More than anything, I had to readjust myself to the new system to adapt to my new street life.

There were no discrepant cases.

Theme 6: Personal and Cultural Beliefs

Many of the study participants identified personal or cultural beliefs that affected their risk for contracting the HIV virus. P012 stated “The fact that I believe that I'm a top and I'm untouchable, and it's crazy for me to think that, but it's the truth.” Similarly, P009 stated, “Again, it doesn't really affect my risk because, again, I'm a top.” P005 explained, “I sometimes feel like when I started PrEP, I started to feel like, oh well I can't get anything.” P014 mentioned, “My past personal belief was that I was indomitable to any drug and that belief probably really put me at risk.” One of the participants identified that pride of being raised in a specific culture as a factor that influenced his behaviors. P006 mentioned,

> Oh yeah. I mean I was raised a Dominican Catholic, a Roman Catholic, and very much in the hood, and around a lot of gang stuff and all that…But unfortunately there were things that stuck, like pride and ego and not being able to ask for help the way that I should, because of cultural, definitely Dominican...My personal belief is that I'm working on a lot of these things that have continuously limited me and still are limiting me today, because homelessness is still embarrassing in my mind.

P013 detailed religious beliefs and stated the following,

> I want God to accept me for who he created me as. And I want... Because I didn't like the fact that the Bible says that homosexuality is an abomination to God and everything he created. But how could he say we are an abomination when he

> created us? And that's what hurts me. So, I want God to love us and accept us for who we are and not throw us away, cast us out, and to put us in hell for who he created us. That hurts me. Some belief systems, their people are trying to tell me that God said we're going to go to hell for how he created us. That is so hurtful. And knowing every single day that God created us this way, who else did? … And that's why I used to be so scary about messing with men when I was coming up, going through this, in my teens and stuff because I knew that God said that we would go to hell if we didn't stop messing with men. And that scared me.
>
> There were no discrepant cases.

Theme 7: Access to Healthcare

Overall, the participants noted that they had positive experiences accessing the healthcare system. Some participants accessed healthcare more frequently than others. P010 stated, “It's a good experience because you learn new things for your health, and the doctors help you.” P012 mentioned, “In a lot of different states, believe it or not, as far as the LGBT community, there are a lot of helpful doctors who are willing to be resourceful to your needs.”

Participants explained that they were issues related to gender discrimination that was faced when accessing care. P013 stated “I be having... I have to tell them to call me ma'am because they go by what my gender says on the papers. So, if it says male, they say sir.” P007 shared,

> I wish that they would be more free clinics for people who are homeless because my friends were scared that I had the flu. I was not functioning at all because I

couldn’t go to a doctor because I couldn't afford one.

P008 stated, “I go to an LGBTQ specific health clinic”, and also stated, “It's because I go to a specific clinic that understands my needs. If I wasn't, I wouldn't feel affirmed. Participants also identified that the lack of medical insurance impacted their ability to seek care, and for fear of a medical bill that they did not have resources to pay, many chose not to seek care. In reference to accessing healthcare once health insurance was obtained P006 stated,

> Often now. Actually, I got to go soon, but yeah, I go often. I'm like current on my labs and yeah, I go often. And by often, I mean like every month I go to some sort of doctor's appointment. I do acupuncture, I do all kinds of stuff. But that's... And my insurance covers it.

P007 explained that having an HIV positive partner required increased testing.

> I was getting tested regularly every three months. After I started dating my ex fiancé, I was getting tested once a month even though she was undetectable, it was still a little bit of a scare for me. So, for me I got tested more often.

Participants discussed the varying frequency in which they sought medical care. P009 mentioned seeking healthcare only “When I really feel something is wrong.” P013 stated, “I don't really go to the doctor. Because I never get sick.” P011 mentioned, “In my organization, if I want, I can have a medical check every week, but I do it every two months.” P012 stated,

> For a while I didn't have Medicaid, but now I do, I haven't had a primary doctor in so long, I used to pay this guy, the only time I would see the doctor is when I'd get

my hormones. P005 expressed the flexibility provided by medical coverage in his decision to seek care. P005 expressed, “I seek medical care pretty often because I'm on Medicaid, so medical care is very easy for me right now.” P005 further expressed the following,

> If I wasn’t a part of a transgender health clinic, I don’t think I’d be as on it about my healthcare because I honestly don't really like going to doctors, especially outside of …[transgender health clinic], because I'm either mis-gendered by providers that know that I am transgender or people just glaze over it even though on my IDs it will say male.

Theme 8: Services

The participants were asked what was needed to decrease homeless and HIV risk. Participants noted that they needed safer housing options, whether through safe shelter, their own apartment or sharing an apartment with other individuals. Participants offered advice to others who are currently homeless and identified current shelter options that are available.

> P007 stated, I knew deep down that shelters were a thing. We volunteered at a few soup kitchens with my high school and everything like that. I know it existed, but I am not seeing about how to get to one, what happens when you're or anything about that. I knew nothing but besides the few friends that I talk to, but I had no idea.

P011, also commented that “shelters are sometimes unsafe” indicating that one would then end up on the street.

In recommending services that could decrease the risk of HIV in homeless transgender youth many of the participants had multiple suggestions and responded as follows,

> P006 mentioned, “Make it work how they can. Use your network, use social media. I really think anyone; all people who are experiencing homelessness should have access points where they can be trained in proficiency on the internet, because they can find help on the internet. In addition, P006 added,
>
> Well, to help better, well, we need to have people who truly are there for the right reasons. And de-stigmatization is a lovely word, but is it true? Does it exist? I don't know. I don't know if we can poop-poop, test empathy or whatever. But we need people in the field who have no ulterior motives or who have a certain view of people. Because when I hear out of a provider's mouth, "Oh yeah, well, we want the best for them, or blah, blah, blah, blah, blah, blah. That's the classist." I feel like understanding that we're all just people and your situation can change tomorrow.

P012 mentioned, “I just think Trans women should read a lot more, get very informative information. Probably should have more classes. Sex ed classes.” P012 also mentioned,

> I would recommend that you find, especially Trans women, find some Trans group that you can go to. Find some hobbies that make you happy, because a lot of people, with boredom and depression and anxiety or whatever, emotion that you're going through, you can revert to doing things that aren't good for you.”

P007 mentioned,

> And for HIV practices, not even just for homeless people but in high schools, actually teaching what that meant. I went to a private school and my health class was basically non-existent. So, for me, I didn't even know HIV was a thing until I got into college.

P007 also mentioned that for individuals experiencing homelessness they should "find someone and somewhere safe." P007 continued:

> I wouldn't have been able to figure out the list of shelters without contacting…because they're not really so publicized. I feel like due to the fact that I am trans and the fact that if I was seeking out shelters, creating more shelters that are more inclusive or safe for people who are trans so that they wouldn't have to be basically scared for their lives, going into a shelter and hiding and just the fact that there are LGBTQ shelters is an amazing thing and so you can have more of that because a lot of the LGBT shelters are younger than 21. So, I wouldn't even be able to technically go in. So, needing more like that is safer.

Participants detailed services that they considered lacking based on their own personal experiences. Seminars to provide homeless youth with educational resources related to navigating the system. P014 stated,

> I mean just having maybe seminars when homeless people come in actually having presentations on these things, not like dry ass presentations … like somebody really puts their mind down to like, how do we get these people to sit and listen. In addition, support systems were recommended so that youth will not

feel alone if they find themselves homeless or in a compromising situation. P014 also stated,

I would say maybe a number to call; a hotline for a homeless youth, and then maybe even an extension for specifically devoted to LGBT, it doesn't have to be a number, but it could be like an overarching number, but then like an extension for the few specifically LGBT, that's what I think would be great so that people could talk to somebody. If there's a number you can call or, help I'm 19 and my parents just kicked me out. I think that would be highly helpful because so many kids have to find their way in those first months or years. It took me two years before I came to my first shelter, I was 21 and I had already been homeless two years. And that was out of fear because I heard terrible stories, that was out of pride because me in the shelter, I'll sleep on the streets.

P014 also recommended the following,

Get yourself a therapist. Even if it seems like an arbitrary thing, get yourself a therapist. Have somebody you can go to talk to. Even if you're not going home after it and it feels kind of silly, it doesn't matter…If you have Medicaid use it.

P008 added,

Homelessness is a systemic problem. It's not an individual problem and it's the problem of the community that we live in, and it can easily be solved just by paying for people's housing or just giving people housing. Like, I believe the short-term housing is good for emergencies, but a lot more can be done by just

giving people housing without having all these crazy rules on top of how they live.

P011 stated,

Give them more support, get informed, because sometimes. It's not because people who are on the street or transgender people, it's not because they don't want to seek help, it's because there's no information. A little more promotion and information. I would recommend looking for help, find information about organizations that give help, even from the community, because the community is very supported. My recommendation is to look for organizations or public aid.

P011 concluded,

Again, to look for help from organizations, doctors must be more aware of the answers or information they have about medical tests, I want them to be more mindful. If the lab results are positive or negative, they should report face-to-face because there are needs, and there are questions that you may have. More support is required on a personal level.

Summary

The data collected from participants examined the perceptions of homeless transgender youth and their lived experience in managing their risk for HIV and other sexually transmitted infections while dealing with the phenomenon of homelessness. This study provided insight into factors that influence the adherence and non-adherence of prevention methods. Transgender youth have identified decreased housing options, as

well as the lack of cultural competency in the healthcare system as contributors to their sexual risks.

The first research question explored youth perceptions of HIV risk behaviors. The themes identified were the knowledge of HIV, and perceived risk factors. All of the participants had knowledge some knowledge of HIV and identified transmission and prevention methods. The second theme was risk factors, participants detailed their experiences of vulnerability being in the streets where they were subjected to physical and sexual assaults as a major risk factor to HIV.

The second research question viewed the effects of homelessness on sexual risk behaviors. Four themes emerged from this question: experiences with homelessness, challenges, social network, and personal and cultural beliefs. The participants had varying experiences with their length of homelessness, ranging from 5 weeks to 8 years. Participants detailed financial resources as a major challenge, and a precursor to sexual risk behaviors. Participants credited their social network as a source for good and bad behavior adaptations, and while many acknowledged the need for a solid social network, they identified situational instances where they could not always follow the positive advice given. Personal and cultural beliefs also resulted in increased risk among the study participants as some expressed feeling untouchable, therefore they did not adhere to known prevention methods.

The final research question relates to services that are needed to combat HIV risk related behaviors in transgender youth. The themes that emerged were access to healthcare; participants identified the lack of cultural competency experienced in their

interactions with traditional health centers. Many of the participants mentioned that they exclusively seek care at LGBTQ health centers in the city. Lastly, the participants identified the necessary services that would be beneficial in decreasing their risk such as educational programs that provides computer skills that may lead to better employment options.

Chapter 4 provided a synopsis of the processes used to collect and analyze data gleaned from homeless transgender youth about their perceptions of HIV risk. Additionally, this chapter identified evidence of trustworthiness, interview setting, and participant demographics.

Chapter 5 offers an interpretation of the findings, the results in comparison to the prior literature, limitations of the study, recommendations for future research, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this research study was to: (a) understand the lived experience of transgender youth and (b) the influence of homelessness on behaviors associated with sexual risk and (c) identify effective prevention methods. In 2017, youth, aged 13-24, accounted for 21% of the new HIV infections reported; 79% of those infections were among those aged 20-24 (CDC, 2017a). Prior studies have recognized the need for prevention methods to decrease the risk of HIV in this underserved population. One way to reduce the risk is to provide stable housing. Understanding the perceptions that homeless transgender youth have about HIV risk is crucial in providing prevention measures for this population. In phenomenological studies, the recommended sample size to reach data saturation is three to ten participants (Creswell, 2014). In this study, the sample size required to reach saturation was ten transgender youth who were currently homeless or had a history of homelessness. All participants resided in the NYC area.

A phenomenological approach was used to capture an accurate account of the participants' lived experiences. In phenomenological research, in-depth interviews are used to give meaning to the participants' lived experiences (Starks & Trinidad, 2007). Open-ended research questions were used to allow participants the option to provide rich description of the phenomenon under study (Creswell, 2014). Interviews were audio-recorded, and NVivo 12 was used as the data analysis tool to organize, manage, and code the data. This allowed eight themes to emerge from the participants' perceptions and beliefs.

- Knowledge of HIV
- Risk factors
- Experiences with homelessness
- Challenges
- Social network
- Personal and cultural beliefs
- Access to healthcare
- Services

This chapter will provide a comparison of the themes to the previous literature identified in Chapter 2. This chapter will also include the interpretation of findings, limitations of the study, recommendations, implications for social change and future research, and a conclusion.

Interpretation of Findings

The interpretation of findings presented in this section of the qualitative phenomenological study results from an inductive description of the participants accounts of their lived experiences. The emergent themes derived from the study answered all three-research questions.

Knowledge of HIV

Based on the analysis of in-depth semi structured interviews, all of the participants had knowledge of HIV. Participants discussed modes of transmission for the disease, as well as the definition of the disease. There was an understanding of the concept of U=U, which indicates that if an individual has HIV and their viral load is

undetectable that the possibility of transmitting the virus is remarkably decreased. Several participants also were cognizant of the effects of the disease on specific targeted populations. The peer-reviewed literature posits that stigma faced by the transgender population is associated with HIV (Grant et al., 2011).

Risk Factors

Participants detailed situational vulnerability as a direct risk for HIV. The results of this study supported the research by Ferguson & Maccio (2015), that HIV infections are increased in the transgender population as the need for basic necessities supersedes the need to decrease risk or practice harm reduction. Additionally, this study supports the literature in regard to greater risk-taking during sexual engagement to include an increase in the number of partners (Wilson et al., 2009; Baral et al., 2013). The perceptions of risk in the study participants were directly tied to homelessness and the need for financial resources. Participants described the lived experiences of conducting survival sex to be able to procure a meal or even a place to sleep. Many participants discussed the vulnerability of being in the streets and being subject to sexual and other physical assaults in order to survive. This supports the findings by Tyler (2008a). Two participants specifically discussed their sexual risk by engaging in unprotected sex with partners who were known to be HIV positive, which aligns with data provided by the CDC.

The participants were aware of their HIV risks and identified strategies that they used to decrease their risk of the disease. Risk perceptions included the use of condoms; medication therapy; awareness of surroundings; discernment of situations that could increase risk; and abstinence from illegal drugs.

Experiences with Homelessness

The inclusion criteria for participation in this study was the following: (a) identify as transgender; (b) be currently homeless or have a history of homelessness in the past three years; (c) be between 18-24 years of age. The participants in this study all met the criteria. Four participants acknowledged less than a one-year history of homelessness, while the others ranged from a 2 to 8-year history of homelessness. The participants' accounts of their experiences with homelessness supported literature that identified many pathways leading to homelessness (Spicer et al., 2010; Ferguson & Maccio, 2015). The participants of this study identified being kicked out, family conflicts, and leaving due to the need for freedom of identity as some of their pathways to becoming homeless. The literature speaks to a concept called "hidden homelessness" this concept applied to most of the participants, as they did not have their own apartments but were sharing with others and did not have a lease in their name (Canadian Observatory on Homelessness, 2012). This concept is otherwise referred to as doubling up.

Challenges

There are multiple challenges associated with homelessness, and for youth experiencing this phenomenon a resilience is built because they have to be fluid to adapt to their current situations in order to survive (McKenzie-Mohr et al., 2012). Begun and Kattari (2016), defined the challenges associated with homelessness to include physical and sexual assaults for individuals on the street. The participants of this study supported this body of literature as they referenced victimization while on the streets, detailing physical and sexual assaults.

The perceptions of the need for financial resources resonated with all the participants in the study, and for many influenced their actions which ultimately increased their risk. The need for financial resources was the main challenge identified. Participants identified that a lack of education supports their challenge associated with obtaining a decent wage to account for the cost of living in NYC. Others mentioned discrimination while seeking employment, which affects their financial situation. Prior studies show that identifying as transgender results in employment discrimination, physically demanding positions, and minimum wage positions that make it difficult to rise out of their current situations (Ehrenreich, 2014; Keuroghlian, Ard & Makadon, 2017). These factors all have a tremendous impact on finances as evidenced by the participants in this study.

Substance use is another challenge faced by homeless transgender youth. Participants of this study detailed their challenges with substance use, which reportedly included alcohol and other illicit substances such as marijuana, cocaine, methamphetamines, and opioids. Substances have been linked to increased sexual risk behaviors (CDC, 2018). Six study participants articulated a history or current use of substances.

The perception of some of the participants' pertaining to shelter led them to remain on the streets for an extended period. Many referenced secondhand experiences from others related to discrimination and physical assault. However, there were participants in this study that experienced stigma and discrimination firsthand, including legal action being taken against them while at a shelter. A previous study was conducted

which referenced the lack of safety and justice in shelters, as perpetrators are often not punished for their actions; leaving victims to seek safety on the streets (Keuroghlian et al., 2014). The participants' perceptions of fear regarding shelters was evident in sharing their lived experiences.

Social Network

The feedback from the participants regarding social networks and the need for support was tremendous. Seven of the ten participants agreed that friends were an important part of their social network. Most of the participants had positive accounts related to their social networks, and even the participants who did not identify having a strong support network, agreed that it is important to have support. Participants in this study also perceived professionals such as physicians, lawyers, and mental health professionals as part of their social network. Participants credited their social network as a source for good and bad behavior adaptations. Tyler and Melander (2012) suggested that the network of individuals that transgender youths allow in their inner circle are likely to influence their behaviors. Participants in this study also noted that while their own social network may provide appropriate behavioral models; they did not always follow the advice, or the example based on 1) situation and 2) perceived need at the time.

Personal and Cultural Beliefs

The lived experiences of the participants led to perceptions and beliefs regarding their risk for acquiring HIV or other sexually transmitted diseases. Participants described the notion that being a "top" which is slang for the individual who penetrates their partner during anal intercourse was somehow protective during intercourse. In the same breath,

participants articulated that this was absurd to think that they are not at risk because of this; however, it was their stated belief. Others mentioned the use of illicit substances and expressed feeling “indomitable” which means that while using substances this participant felt untouchable; and eluded to the fact that this was a concept that definitely allowed for risk behaviors, especially since hepatitis C was contracted by this individual. This aligns with the study conducted indicating that substances have been associated with adverse consequences (Bowers et al., 2011).

Access to Healthcare

There are multiple studies written that express the barriers related to accessing healthcare. Discrimination, cost, and insurance coverage are a few of the barriers identified (Gattis, 2013; Spicer et al., 2010). Participants in this study noted an overall positive experience accessing primary healthcare, including HIV testing and prevention strategies. However, there were experiences related to gender discrimination that participants discussed; this was related to gender pronouns. Participants also noted the lack of health insurance coverage that fostered a new respect for healthcare access once coverage was obtained (Conron et al., 2012). Participants also expressed the need for healthcare that was inclusive of physical and mental health. Multiple participants stated that healthcare was received at LGBTQ health centers where they received gender-affirming care.

Services

The participants of this study identified services that they deemed necessary to prevent the risk of HIV among the homeless transgender youth. The importance of

education was identified as a tool for providing knowledge related to housing options, and HIV risk. Education, such as training opportunities were vital to providing participants with a means of becoming self-sufficient, such as learning computer skills which can be transitioned into income. Another recommendation that was identified was social support; participants felt that having a solid support system was important to risk reduction. The final service that was specific to decreasing HIV risk was the need for safe shelter and housing options among the transgender youth that participated in this study.

Applying the Theoretical Framework to the Results

The SCT provided the theoretical framework that guided this study. Findings from this study indicated that constructs related to HIV risk are influenced by personal and environmental factors that influence behaviors.

For transgender youth, the relationships fostered with their social networks had an influence on their decisions related to HIV risk. The need for transgender youth to acquire basic necessities such as food and housing was the driving force in their risk-taking decisions.

Personal Factors

The participants in the study identified their rationale for participation in risk behaviors related to HIV. All the participants provided insight on how their personal behaviors influenced their actions, which ultimately affected their risks. The participants discussed their lived experiences, and choices that they are faced with in relation to the participation of risk reducing behaviors. Safe sex practices were mentioned as a risk

reducing behavior, and while all the participants' seemed to be educated on the prevention methods they did not always adhere to the methods discussed.

Behaviors

Study participants reported the significance of having a positive social network; and ultimately detailed that this positively influenced their risk behaviors. Bandura (2004) posits that the continuation of behaviors is impacted by positive or negative reinforcements. The findings from this study align with Alanko and Lund (2019), who noted that positive relationships promote well-being among transgender youth.

Environment

Most of the participants viewed their environment as a precursor to increased risks. The participants detailed the influence of individuals in their social network on their risk-taking behaviors. Bandura (1999) posits that the way individuals respond to their environment directly correlates with the stress experienced when placed in compromising situations.

Limitations of the Study

There were several limitations to this study. The first limitation included the "double minority" population. One of the concerns of conducting this study was the possibility of not reaching data saturation. Transgender homeless youth are an extremely difficult population to engage if trusting relationships are not previously developed. The second limitation was related to sample size and location; the geographic location of the study was NYC and there were 10 participants engaged in the study. This small sample

and concentrated location make it difficult to generalize the findings to a larger population of transgender youth. Another limitation of this study is that the participants self-reported data in response to the open-ended research questions that were asked. This created a platform for recall bias, along with the assumption that truthful details were provided during the interview process.

Recommendations

The findings from this phenomenological study contributes to the current body of literature on homeless transgender youth, their perceptions of HIV risk and the situations that influence their decision-making processes. To engage transgender youth, the first recommendation is to collaborate with agencies that provide a positive experience for the population. Collaboration is crucial to inform transgender youth of the awareness of prevention methods for both HIV risk and homelessness.

Transgender youth often described negative perceptions of shelters. This was often based on the discrimination of peers, mistrust of the system and fear. The recommendation is for stronger advocacy efforts to support inclusion of all individuals that require safe housing. Social determinants of health directly affect risk in this population. It is imperative for healthcare providers to become proficient in identifying individuals impacted by social determinants. There are screening tools such as Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), that can be used by medical, behavioral, and social service professionals to ensure that youth are identified and engaged in services in a timely manner.

Implications

Implications for Social Change

The study was conducted to gain an understanding of the lived experiences of HIV risk among homeless transgender youth. It was my intention that this study would be used to provide a voice for the community, by contributing to the current body of literature that outlines the effects of social determinants on members of the transgender community. Collaboration, education, and advocacy are three main implications that resulted from this study.

One implication for social change may involve the collaboration of stakeholders such as housing representatives, public health advisors, medical and mental health providers, to offer programs that reach the community. This will further the development of programs to provide education and support to homeless transgender youth who are at risk for contracting HIV or other sexually transmitted infections.

Another social change implication is advocacy. Policy makers can use results from this study to support laws on a city, state, or federal level that lead to safe housing options for at-risk transgender youth. Advocacy is another resource that is vital to the transgender youth population. One study participant mentioned conducting advocacy relating to the passing of the Gender Expression Non-Discrimination Act (GENDA); an anti-discrimination law and working with organizations that offer housing subsidies which potentially has the ability to decrease risk.

Education is important for social change; the participants detailed the need for accurate information regarding safe sex practices among the transgender population.

Expanded availability of educational materials is crucial to decrease the risk of infection. There is a need for enhanced education related to cultural and personal beliefs, as participants felt that they were untouchable. It is of utmost importance that health care providers are sensitive to the population, and provide appropriate information related to sexual health practices, as well as providing proper education related to disease, diagnosis, and health outcomes.

Implications for Future Studies

Housing options and support services often diminish for transgender youth after the age of 25 years of age. A qualitative research study should be conducted to identify community services. Peer support should be included in research related to population specific prevention methods. Additionally, studies are needed in this population to focus on social support as a positive influence of sexual risk behaviors and prevention practices in the transgender youth population. An additional study would include a look at race, age, and education in relation to the trajectory of presumed risk factors in the United States.

Implications for Practice

The findings of this phenomenological study support the inclusion of education to transgender youth on what constitutes risks, as well as health behaviors that are needed for disease prevention. For instance, provision of information on how to obtain shelter and housing options, should be included at gender affirming organizations throughout the city. Information regarding shelter and housing options should also be available in health care settings, in order to address social determinants of health that impact prevention of

HIV and other sexually transmitted diseases. In addition, community organizations can integrate safe sex practices such as condom distribution in barbershops or beauty salons.

Conclusion

Despite the education surrounding HIV and risks of disease transmission, transgender youth remain at risk. This study has demonstrated the importance of safe housing on the impact of HIV risk in the transgender population. In this qualitative study, I used a phenomenological design to explore transgender youths lived experiences with homelessness and HIV risks. A purposive sample of ten homeless transgender youth were recruited via flyers and word of mouth.

Findings of this study indicated that the study participants perceived basic knowledge of HIV. The participants expressed that while they had knowledge of the disease, challenges related to homelessness increased their risk behaviors. It is imperative to improve disease awareness in our communities, but to also educate and inform transgender youth on the consequences of choices made from what is considered a life or death situation. This study focused on an underserved population to decipher the lived experiences that contribute to risk behaviors and filled the gap in the literature by providing assessment of HIV risk through the lens of transgender youth in NYC.

References

Abramovich, A. (2013). No fixed address: Young, queer, and restless. In. S. Gaetz, B. O'Grady, K. Buccieri, J. Karabanow, & A. Marsolais (Eds.), Youth homelessness in Canada: Implications for policy and practice. Toronto: Canadian Homelessness Research Network Press. Retrieved from http://www.homelesshub.ca/resource/23-no-fixed-address-young-queer-and-restless

Abramovich, A. (2016). Preventing, reducing, and ending LGBTQ2S youth homelessness: The need for targeted strategies. *Social Inclusion*, *4*(4), 86-96.

Ahmed, O., & Jindasurat, C., (2014). *Lesbian, gay, bisexual, transgender, queer and HIV-affected hate violence in 2013.* Retrieved from http://www.avp.org/storage/documents/2013_ncavp_hvreport_final.pdf

Alanko, K., & Lund, H.S. (2019). Transgender youth and social support: A survey study on the effects of good relationships on well-being and mental health. *YOUNG 28*(2), 199-216. doi:10.1177/11038819850039

Algeria, C.A. (2011). Transgender identity and health care: Implications for psychosocial and physical evaluation. *Journal of the American Academy of Nurse Practice, 23*(4), 175-182.

Ali Forney Center. (2018). *LGBTQ youth crisis*. Retrieved from https://aliforneycenter.org/_aliforney/assets/File/Youth%20Crisis%20Stats.pdf

Amnesty International. (2005). *Stonewalled: Police abuse and misconduct against lesbian, gay, bisexual, and transgender people in the U.S*. Retrieved from http://www.amnestyusa.org/outfront/stonewalled/report.pdf

Anderson-Minshall, D. (2012). Homeless LGBT youth lose $7 million in NYC. *The Advocate.* Retrieved from http://www.advocate.com/society/youth/2012/05/04/homeless-lgbt-youth-lose-7-million-nyc

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Bandura, A. (1999). Social cognitive theory: An agentic perspective. *Asian Journal of Social Psychology, 2*, 21-41.

Bandura, A. (2004). Health Promotion by Social Cognitive Means. *Health Education and Behavior, 31*(2), 143-164. doi:10.1177/1090198104263660

Baral, S.D., Poteat, T., Stromdahl, S., Wirtz, A.L., Guadamuz, T.E., & Beyrer, C. (2013). Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infectious Disease, 13*, 214-222.

Beemyn, G., & Rankin, S. (2011). *The lives of transgender people*. New York, NY: Columbia University Press.

Begun, S., & Kattari, S.K. (2016). Conforming for survival: Associations between transgender visual conformity/passing and homeless experiences. *Journal of Gay & Lesbian Social Services, 28*(1), 54-66.

Bender, K.A., Ferguson, K., Thompson, S., Komlo, C., & Pollio, D. (2010). Factors

associated with trauma and posttraumatic stress disorder among homeless youth in three US cities: The importance of transience. *Journal of Traumatic Stress, 23*(1), 161-168.

Benotsch, E.G., Zimmerman, R., Cathers, L., McNulty, S., Pierce, J., Heck, T., …& Snipes (2013). Non-medical use of prescription drugs, polysubstance use, and mental health in transgender adults. *Drug and Alcohol Dependence, 132*(1-2), 391-394.

Bockting, W.O, Robinson, B.E., Forberg, J., & Scheltema, K. (2005). Evaluation of a sexual health approach to reducing HIV/STD risk in the transgender community. *AIDS Care, 17*(3), 289-303.

Bockting, W.O., Miner, M.H., Romine, R.E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*(5), 943-951.

Booth, B.M., Curran, G., Han, X., Wright, P., Frith, S., Leukefeld, C.,… & Carlson, R.G. (2010). Longitudinal relationship between psychological distress and multiple substance use: Results from a three-year multisite natural-history study of rural stimulant users. *Journal of Studies on Alcohol and Drugs, 71*(2), 258-267.

Bowers, J.R., Branson, C.M., Fletcher, J., & Reback, C.J. (2011). Differences in substance use and sexual partnering between men who have sex with men, men who have sex with men and women and transgender women. *Cultural Health Sex, 13*, 629-642.

Bradford, J., Reisner, S.L., Honnold, J.A., & Xavier, J. (2013). Experiences of

transgender-related discrimination and implications for health: Results from the Virginia transgender health initiative study. *American Journal of Public Health, 103*(10), 1820-1829.

Brennan, J., Kuhns, L. M., Johnson, A. K., Belzer, M., Wilson, E. C., & Garofalo, R. (2012). Syndemic theory and HIV-related risk among young transgender women: The role of multiple, co-occurring health problems and social marginalization. *American Journal of Public Health, 102*(9), 1751-1757. doi:10.2105/AJPH.2011.300433

Burkholder, G.J., Cox, K.A., & Crawford, L.M. (Eds.). (2016). *The scholar-practitioner's guide to research design.* Baltimore, MD: Laureate Publishing.

Canadian Observatory on Homelessness. (2012). *Canadian definition of homelessness. Toronto: Homeless hub.* Retrieved from http://www.homelesshub.ca/homelessdefinition

Castellanos, H.D. (2016). The role of institutional placement, family conflict, and homosexuality in homeless pathways among Latino LGBT youth in New York City. *Journal of Homosexuality, 63*(5), 601-632.

Centers for Disease Control and Prevention. (2016). *HIV risk among persons who exchange sex for money or nonmonetary items.* Retrieved from https://www.cdc.gov/hiv/pdf/group/cdc-hiv-sex-workers.pdf

Centers for Disease Control and Prevention. (2016a). *HIV and transgender communities. CDC issue brief.* Retrieved from https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf

Centers for Disease Control and Prevention. (2017). *HIV surveillance report: Diagnosis of HIV infection in the United States and dependent areas* (Vol 29). Retrieved from https://www.cdc.gov/hiv/statistics/overview/index.html

Centers for Disease Control and Prevention. (2017a). *HIV and youth*. Retrieved from https://www.cdc.gov/group/age/youth/index.html

Centers for Disease Control and Prevention. (2018). *HIV among transgender people*. Retrieved from https://www.cdc.gov/hiv/group/gender/transgender/index.html

Centers for Disease Control and Prevention. (2018a). HIV/AIDS: About HIV/AIDS. Retrieved from https://www.cdc.gov/hiv/basics/whatishiv.html

Center for Innovation through Data Intelligence. (2015). *2015 NYC youth count report.* Retrieved from http://www.nyc.gov/html/cidi/downloads/pdf/youth-count-report-2015.pdf

Christopoulos, K. A., Das, M., & Colfax, G. N. (2011). Linkage and retention in HIV care among men who have sex with men in the United States. *Clinical Infectious Diseases: An official Publication of the Infectious Diseases Society of America*, *52*(Suppl 2), S214–S222. https://doi.org/10.1093/cid/ciq045

Clark, T.T. (2014). Perceived discrimination, depressive symptoms, and substance use in young adulthood. *Journal of Addiction Behavior*, *39*(6), 1021-1025.

Coalition for the Homeless. (2018). Ending homelessness. Retrieved from https://www.coalitionforthehomeless.org/

Coates, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: Trauma in

the lives of homeless youth prior to and during homelessness. *Journal of Sociology and Social Welfare, 37*(4), 65-96.

Cochran, B., Stewart, A., Ginzler, J., & Cauce, A. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health, 92*(5), 773-777.

Cohan, D., Lutnick, A., Davidson, P., Cloniger, C., Herlyn, A., Breyer, J., … Klausner, J. (2006). Sex worker health: San Francisco style. *Sexually Transmitted Infections, 82*(5), 418–422. doi:10.1136/sti2006.020628

Conron, K.J., Scott, G., Stowell, G.S., & Landers, S.J. (2012). Transgender health in Massachusetts: Results from a household probability sample of adults. *American Journal of Public Health, 102*(1), 118-122.

Creswell, J.W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

Creswell, J.W., & Poth, C.N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA: Sage.

Crosby, R.A., & Pitts, N.L. (2007). Caught between different worlds: How transgendered women may be “forced” into risky sex. *Journal of Sex Research, 44*(1), 43-48.

Cypress, B. (2017). Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualization, and recommendations. *Dimensions of Critical Care Nursing, 36*(4), 253-263.

Dadasovich, R., Auerswald, C., Minnis, A. M., Raymond, H. F., McFarland, W., &

Wilson, E. C. (2017). Testosterone and sexual risk among transmen: a mixed methods exploratory study. *Culture, Health & Sexuality, 19*(2), 256–266. doi:10:1080/13691058.2016.1216605

Day, J.K., Fish, J.N., Perez-Brumer, A., Hatzenbuehler, M.L., & Russell, T. (2017). Transgender youth substance use disparities: Results from a population-based sample. *Journal of Adolescent Health, 61*(2017), 729-735.

Denzin, N. K. & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research* (4th ed.). Thousand Oaks, CA: Sage Publications, Inc.

Dickert, N., Emanuel, E., & Grady, C. (2002). Paying research subjects: An analysis of current policies. *Annals of Internal Medicine,136*(5), 368–373.

Dietert, M., & Dentice, D. (2013). Growing up trans: Socialization and the gender binary. *Journal of GLBT Family Studies, 9*, 24-42.

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior, 41*(6), 1319-1320. doi:10.1007/s10508-012-0016-6

Ehrenreich, B. (2014). It is expensive to be poor. *The Atlantic*. Retrieved from http://www.theatlantic.com/business/archive/2014/01/it-is-expensive-to-be-poor/282979/

Ferguson, K.M., & Maccio, E.M. (2015). Promising programs for lesbian, gay, bisexual, transgender, and queer/questioning runaway and homeless youth. *Journal of Social Science Research, 41*(5), 659-683.

Forge, N., & Ream, G.L. (2014). Homeless lesbian, gay, bisexual and transgender

(LGBT) youth in New York City: Insights from the field. *Child Welfare, 93*(2), 7-22.

Friedman, M.S., Marshal, M.P., Guadamuz, T.E., Wei, C., Wong, C.F.…, & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health,101*(8), 1481–94.

Friedman, M.R., Kurtz, S.P., Buttram, M.E., Wei, C., Silvestre, A.J., & Stall, R. (2014). HIV risk among substance-using men who have sex with men and women (MSMW): Findings from South Florida. *AIDS and Behavior, 18*(1), 111-119.

Fusch, P., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 29*(9), 1408-1416. Retrieved from https://nsuworks.nova.edu/tqr/vol20/iss9/3

Gangamma, R., Slesnick, N., Toviessi, P., & Serovich, J. (2008). Comparison of HIV risks among gay, lesbian, bisexual, and heterosexual homeless youth. *Journal of Youth and Adolescence, 37*, 456-464.

Garland, E.L., Pettus-Davis, C., & Howard, M.O. (2013). Self-medication among traumatized youth: Structural equation modeling of pathways between trauma history, substance misuse, and psychological distress. *Journal of Behavioral Medicine, 36*(2), 175-185.

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G.W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male to female transgender youth. *Journal of Adolescent Health, 38*(3), 230-236.

Gates, G.J. (2011). *How many people are lesbian, gay, bisexual and transgender?* Retrieved from https://www.ciis.edu/Documents/PDFs/Public Programs/Expanding the Circle/How-many-people-are-LGBT-Final.pdf

Gattis, M.N. (2013). An ecological systems comparison between homeless sexual minority youth and homeless heterosexual youth. *Journal of Social Science Research, 39,* 38-49.

Gay Men's Health Crisis. (2018). Current HIV statistics: Demographic statistics. Retrieved from http://www.gmhc.org/hiv-info/hivaids-basics/current-hiv-statistics

Gentles, S. J., Charles, C., Ploeg, J., & McKibbon, K. A. (2015). Sampling in qualitative research: Insights from an overview of the methods literature. *The Qualitative Report, 20,* 1772. Retrieved from http://nsuworks.nova.edu/tqr/vol20/iss11/5

Gibbs, G. R. (2007). *Qualitative Research kit: Analyzing qualitative data*. London, England: Sage Publications.

Glanz, K., Rimer, B.K., & Viswanath, K. (Eds.). (2015). *Health behavior: Theory, research, and practice* (5th ed.). San Francisco, CA: Jossey-Bass.

Grant, J.M., Mottet, L.A., Tanis, J., Min, D., Herman, J.L., Harrison, J., & Keisling, M. (2010). National transgender discrimination survey report on health and healthcare. *National Center for Transgender Equality and National Gay and Lesbian Task Force, Washington, DC.*

Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M. (2011).

Injustice at every turn: A report of the national transgender discrimination survey. *National Center for Transgender Equality and National Gay and Lesbian Task Force, Washington, DC.*

Green, K.E., & Feinstein, B.A. (2012). Substance use in lesbian, gay and bisexual populations: An update on empirical research and implications for treatment. *Psychology and Addiction Behavior, 26*, 265-278.

Green, M., & Piel, J. A. (2009). *Theories of human development: A comparative approach* (2nd ed.): Prentice-Hall, Inc.

Gridley, S.J., Crouch, J.M., Evans, Y., Eng, W., Antoon, E., Lyapustina, M.,..., Breland, D.J. (2016). Youth and caregiver perspectives on barriers to gender-affirming health care for transgender youth. *Journal of Adolescent Health, 59,* 254-261.

Groth S. W. (2010). Honorarium or coercion: Use of incentives for participants in clinical research. *The Journal of the New York State Nurses' Association, 41*(1), 11–22.

Halpern, S.D., Karlawish, J.H., Casarett, D., Berlin, J.A., & Asch, D.A. (2004). Empirical assessment of whether moderate payments are undue or unjust inducements for participation in clinical trials. *Archives of Internal Medicine, 164*(7), 801–803.

Healthy People 2020. (2018). *Lesbian, gay, bisexual, and transgender health.* Retrieved from https://www.healthypeople.gov/2020topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Herbst, J.H., Jacobs, E.D., Finlayson, T.J., McKleroy, V.S., Neumann, M.S., & Crepaz,

N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior, 12*(1), 1-17.

Hotton, A.L.., Garofalo, R., Kuhns, L.M., & Johnson, A.K. (2013). Substance use as a mediator of the relationship between life stress and sexual risk among young transgender women. *AIDS Education and Prevention, 25*(1), 62-71. doi:10.1521/aeap.2013.25.1.62

Hughto, J.M., Reisner, S.L., & Pachankis, J.E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine, 147*(2015), 222-231.

Hunter, E. (2008). What's good for the gays is good for the gander: Making homeless youth housing safer for lesbian, gay, bisexual, and transgender youth. *Family Court Review, 46,* 543-557.

Huschke, S., & Coetzee, J. (2019). Sex work and condom use in Soweto, South Africa: A call for community-based interventions with clients. *Journal of Culture, Health, and Sexuality.* doi:10.1080/13691058.2019.1568575

Johnson, T. P., Hughes, T.L., Cho, Y.I., Wilsnack, S.C., Aranda, F., & Szalacha, L.A. (2013). Hazardous drinking, depression, and anxiety among sexual-minority women: Self-medication or impaired functioning? *Journal of Studies on Alcohol and Drugs, 74*(4), 565-575. doi:10.15288/jsad.2013.74.565

Kattari, S.K., & Hasche, L. (2015). Differences across age groups in transgender and gender non-conforming people's experiences of health care discrimination, harassment, and victimization. *Journal of Aging and Health, 28*(2), 285-306.

Kenagy, G.P., & Hsieh, C.M. (2005). The risk less known: Female-to-male transgender persons' vulnerability to HIV infection. *AIDS Care, 17*(2), 195-207. doi:10.1080/19540120512331325680

Keuroghlian, A. S., Ard, K. L., & Makadon, H. J. (2017). Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT affirming health care environments. *Sexual Health (Online), 14*(1), 119-122. doi:10.1071/SH16145

Keuroghlian, A. S., Shtasel, D., & Bassuk, E. L. (2014). Out on the street: A public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. *The American Journal of Orthopsychiatry*, *84*(1), 66–72. doi:10.1037/h0098852

Khan, L. (2013). Transgender health at the crossroads: Legal norms, insurance markets, and the threat of healthcare reform. *Health Policy, Law and Ethics, 11*(2), 375-418.

Kim, Y. (2011). The pilot study in qualitative inquiry: Identifying issues and learning lessons for culturally competent research. *Qualitative Social Work*, *10*(2), 190 - 206. doi:10.1177/1473325010362001

Korstjens, I., & Moser, A. (2018). Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124, doi:10.1080/13814788.2017.1375092

Kosciw, J.G., Greytak, E.A., & Diaz, E.M. (2009). Who, what, where, when and why:

Demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual and transgender youth. *Journal of Youth and Adolescence, 38*(7), 976-988.

Kraft, J.M., Beeker, C., Stokes, J.P., & Peterson, J.L. (2000). Finding the "community" in community-level HIV/AIDS interventions: Formative research with young African American men who have sex with men. *Journal of Health Education and Behavior, 27*(4), 430-441.

Leedy, G., & Connolly, C. (2007). Out of the cowboy state: A look at lesbian and gay lives in Wyoming. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 19*(1), 17-34.

Leibler, J. H., Nguyen, D. D., León, C., Gaeta, J. M., & Perez, D. (2017). Personal hygiene practices among urban homeless persons in Boston, MA. *International Journal of Environmental Research and Public Health, 14*(8), 928. doi:10.3390/ijerph14080928

Livingston, N.A. (2017). Avenues for future minority stress and substance use research among sexual and gender minority populations. *Journal of LGBT Issues in Counselling, 11*(1), 52-62.

Lyons, T., Shannon, K., Pierre, L., Small, W., Krüsi, A., & Kerr, T. (2015). A qualitative study of transgender individuals' experiences in residential addiction treatment settings: Stigma and inclusivity. *Substance abuse treatment, prevention, and policy, 10:*17, 1-6. doi:10.14288/1.0223060

Maxwell, J. (2013). *Qualitative research design an interactive approach* (3rd ed.).

Thousand Oaks, CA: Sage.

McKenzie-Mohr, S., Coates, J., & McLeod, H. (2012). Responding to the needs of youth who are homeless: Calling for politicized trauma-informed intervention. *Children and Youth Services Review, 34*(1), 136-143.

Meade, C. S., Lion, R. R., Cordero, D. M., Watt, M. H., Joska, J. A., Gouse, H., & Burnhams, W. (2016). HIV risk behavior among methamphetamine users entering substance abuse treatment in cape town, South Africa. *AIDS and Behavior*, *20*(10), 2387–2397. https://doi.org/10.1007/s10461-016-1333-x

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation.* San Francisco, CA: John Wiley & Sons.

Miller, N.E., & Dollard, J. (1941). *Social learning and imitation*. New Haven: Yale University Press.

Miller, J., & Glassner, B. (2004). The "inside" and the "outside": Finding realities in interviews. In D. Silverman (Ed.), Qualitative research: Theory, method, and practice (pp. 125-139). Thousand Oaks, CA: Sage.

Miner-Romanoff, K. (2012). Interpretive and critical phenomenological crime studies: A model design. *Qualitative Report, 17*(27), 1-32.

Moran, M. (2013). New gender dysphoria criteria replace GID. *Psychiatric News*. Retrieved from http://psychnews.psychiatryonline.org

Morse, J.M. (2000). Determining sample size. *Qualitative Health Research, 10*(1), 3-5.

Moskowitz, A., Stein, J.A., & Lightfoot, M. (2012). The mediating roles of stress and

maladaptive behaviors on self-harm and suicide attempts among runaway and homeless youth. *Journal of Youth and Adolescence, 42*, 1015-1027.

Mottet, L., & Ohle, J. (2006). Transitioning our shelters: Making homeless shelters safe for transgender people. *Journal of Poverty, 10*(2), 77-101.

Moustakas, C. E. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

Mustanski, B., Andrews, R., Herrick, A., Stall, R., & Schnarrs, P. W. (2014). A syndemic of psychosocial health disparities and associations with risk for attempting suicide among young sexual minority men. *American Journal of Public Health, 104*(2), 287–294.

National Alliance to End Homelessness. (2019). Youth and young adults. Retrieved from https://endhomelessness.org/homelessness-in-america/who-experience-homelessness/youth

National Health Care for the Homeless Council. (2011). *Frequently asked questions about health care for the homeless*. Retrieved from https://www.nhchc.org/faq/official-definition-homelessness

National Health Care for the Homeless Council. (2018). *What is the official definition of homelessness?* Retrieved from https://www.nhchc.org/faq/official-definition-homelessness

NYC Association of Homeless and Street-Involved Youth Organizations. (2012). *State of the city's homeless youth report 2011*. Retrieved from http://www.empirestatecoalition.org/main/pdf/2011.nyc.homeless.youth.report

NYC Commission. (2010). All our children: Strategies to prevent homelessness, strengthen services and build support for the LGBTQ youth. Retrieved from http://www.nyc.gov/html/om/pf/2010/pr267_10_report.pdf

Obedin-Maliver, J., Goldsmith, E.S., Stewart, L. White, W., Tran, E., Brenman, S.,…Lunn, M.R. (2011). Lesbian, gay, bisexual, and transgender related content in undergraduate medical education. *Journal of American Medical Association, 306*(9), 971-977.

Pajares, F. (2002). *Overview of social cognitive theory and of self-efficacy*. Retrieved August 03, 2018 from http://www.emory.edu/EDUCATION/mfp/eff.html

Patrick, M.E., Maggs, J.L., Greene, K.M., Morgan, N.R., & Schulenberg, J.E. (2014). The link between mother and adolescent substance use: Intergenerational findings from the British cohort study. *Longitudinal and Life Course Studies, 5*(1), 56-63.

Patton, M.Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Poggenpoel, M., & Myburgh, C. (2005). Obstacles in qualitative research: Possible solutions. *Education, 126*(2), 304–311.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine, 84*, 22-29.

Poteat, T., Wirtz, A., Radix, A, Borquez, A., Silva-Santisteban, A., Deutsch, M.B., …& Operario, D. (2015). HIV risk and preventive interventions in transgender women sex workers. *The Lancet, 385*(9964), 274-286.

Quintana, N.S., Rosenthal, J., & Krehely, J. (2010). *On the streets: The federal response to gay and transgender homeless youth*. Retrieved from https://www.americanprogress.org/issues/2010/06/pdf/lgbtyouthhomelessness.pdf

Ravitch, S.M., & Carl, N.M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Thousand Oaks, CA: Sage Publications.

Reck, J. (2009). Homeless gay and transgender youth of color in San Francisco: "No one likes street kids" – even in the Castro. *Journal of LGBT Youth, 6*(2-3), 23-242.

Rickard, A., & Yancey, T. (2018). Rural/Non-Rural differences in psychosocial risk factors among sexual minorities. *Journal of Gay & Lesbian Social Services, 30*(2), 154-171.

Rowe, C., Santos, G-M., McFarland, W., & Wilson, E.C. (2015). Prevalence and correlates of substance use among trans*female youth ages 16-24 years in the San Francisco Bay area. *Journal of Drug and Alcohol Dependence, 147*(2015), 160-166.

Rubin, H.J., & Rubin, I.S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Salazar, L., Crosby, R.A., & DiClemente, R.J. (2015). *Research methods in health promotion* (2nd ed.). San Francisco: Jossey-Bass.

Santos, G.M., Rapues, J., Wilson, E.C., Macia, O., Packer, T., Colfax, G., Raymond, H.F. (2014). Alcohol and substance use among transgender women in San Francisco: prevalence and association with human immunodeficiency virus infection. *Drug Alcohol Review, 33*, 287-295.

Selvey, L. A., Hallett, J., McCausland, K., Bates, J., Donovan, B., & Lobo, R. (2018). Declining condom use among sex workers in western Australia. *Frontiers in public health, 6*, 342. doi:10.3389/fpubh.2018.00342

Sevelius, J.M. (2013). Gender affirmation: A framework for conceptualizing risk behavior among transgender women of color. *Sex Roles, 68*(11-12), 675-689.

Shannon, K., Strathdee, S.A., Shoveller, J., Rusch, M., Kerr, T., & Tyndall, M.W. (2009). Structural and environmental barriers to condom use negotiation with clients among female sex workers: Implications for HIV-prevention strategies and policy. *American Journal of Public Health, 99*, 659-695.

Shelton, J. (2016). Reframing risk for transgender and gender-expansive young people experiencing homelessness. *Journal of Gay & Lesbian Social Services*, *28*(4), 277-291.

Simon, M., & Goes, J. (2012). Dissertation and scholarly research: Recipes for success. doi:10.13140/RG.2.1.5089.0960

Singh A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development, 89*(1), 20-27. doi:10.1002/j.1556-6678. 2011.tb00057.x

Smith, J., & Firth, J. (2011). Qualitative data analysis: application of the framework approach. *Nurse Researcher, 18* (2): 52-62.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research.* Thousand Oaks, CA: Sage.

Solorio, M.R., Rosenthal, D., Milburn, N.G., Weiss, R.E., Batterham, P.J., & Gandara,

M. (2008). Predictors of sexual risk behaviors among newly homeless youth: A longitudinal study. *Journal of Adolescent Health, 42*(4), 401-409.

Soriano, F.I. (2013). *Conducting needs assessment: A multidisciplinary approach* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Spicer, S.S. (2010). Conference proceedings the psychiatric needs of the transgender homeless population: Healthcare needs of the transgender homeless population. *Journal of Gay & Lesbian Mental Health, 14(4),* 320-339.

Spicer, S.S., Schwartz, A., & Barber, M.E. (2010). Special issue on homelessness and the transgender homeless population. *Journal of Gay & Lesbian Mental Health, 14*(4), 267-270. doi:10.1080/19359705.2010.509004

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17,* 1372-1380. Retrieved from http://journals.sagepub.com/home/qhr

Stevens, R., Bernadini, S., & Jemmott, J.B. (2013). Social environment and sexual risk-taking among gay and transgender African American youth. *Culture, Health & Sexuality*, *15*(10), 1148-1161.

Stieglitz, K.A. (2010). Development, risk, and resilience of transgender youth. *Journal of the Association of Nurses in AIDS Care, 21*(3), 192-206.

Stotzer, R.L. (2009). Violence against transgender people: A review of United States data. *Aggression and Violent Behavior*, *14*(3), 170-179.

Substance Abuse and Mental Health Services Administration. (2010). *Results from the*

2009 national survey on drug use and health: Volume I. Summary of national findings, Rockville, MD: Office of Applied Studies. Retrieved from http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf

Substance Abuse and Mental Health Services Administration. (2018). *Transgender health and HIV*. Retrieved from https://www.samhsa.gov

Sue, D.W. (2010). *Microaggressions, marginality, and oppression: An introduction*. Hoboken, NJ: Wiley.

Swank, E., Fahs, B., & Frost, D. (2013). Region, social identities, and disclosure practices as predictors of heterosexist discrimination against sexual minorities in the United States. *Sociological Inquiry, 83*(2), 238-258.

Tagliamento, G., & Paiva, V. (2016). Trans-specific health care: Challenges in the context of new policies for transgender people. *Journal of Homosexuality, 63*(11), 1556-1572.

Thomas, D.R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.

Toro, P.A., Dworsky, A., & Fowler, P.J. (2007). *Homeless youth in the United States: Recent research findings and intervention approaches*. U.S Department of Housing and Urban Development.

Torres, C.G., Renfrew, M., Kenst, K., Tan-McGrory, A., Betancourt, J.R., & Lopez, L. (2015). Improving transgender health by building safe clinical environments that promote existing resilience: Results from a qualitative analysis of providers. *BMC Pediatrics, 15;* 1-10.

Trans Student Educational Resources. (n.d.). LGBTQ+ definitions. Retrieved from http://www.transstudent.org/definitions

Trochim, M. W., & Donnelly, J. P. (2007). *The research methods knowledge base* (3rd ed.). Mason, OH: Thomson Custom.

Tufford, L., & Newman, P. (2012). Bracketing in Qualitative Research. *Qualitative social work, 11*(1), 80–96.

Tyler, K.A. (2008). Social network characteristics and risky sexual and drug related behaviors among homeless young adults. *Sociology Department, Faculty Publications, 47*. Retrieved from http://www.digitalcommons.unl.edu/sociologyfacpub/47

Tyler, K.A. (2008a). A comparison of risk factors for sexual victimization among gay, lesbian, bisexual, and heterosexual homeless young adults. *Violence and Victims, 23*(5), 586-602.

Tyler, K.A., & Melander, L.A. (2012). Individual and social network sexual behavior norms of homeless youth at high risk for HIV infection. *Children and Youth Services Review, 34*(12), 2481-2486.

University of Kansas (2017). *The community toolbox: Collecting and analyzing data*. Retrieved from http://ctb.ku.edu/en/table-of-contents/evaluate/evaluate-community-interventions/collect-analyze-data/main

Valentine, D., (2007). Imagining transgender: An ethnography of a category. *Duke University Press, Durham, NC.*

Valera, R.J. Sawyer, R.G., & Schiraldi, G.R. (2000). Violence and posttraumatic stress

disorder in a sample of inner city street prostitutes. *American Journal of Health Studies, 16*(3), 149-155.

Visnyei, K., Samuel, M., Heacock, L., & Cortes, J. A. (2014). Hypercalcemia in a male-to-female transgender patient after body contouring injections: A case report. *Journal of Medical Case Reports, 8(71)*. doi:10.1186/1752-1947-8-71

Walls, N., Hancock, P., & Wisneski, H. (2007). Differentiating the social service needs of homeless sexual minority youths from those of non-homeless sexual minority youths. *Journal of Children & Poverty*, *13*(2), 177-205.

Wanta, J.W., & Unga, C.A. (2017). Review of the transgender literature: Where do we go from here? *Transgender Health, 2*(1), 119-128.

Warf, C.W., Clark, L.F., Desai, M., Rabinowitz, S.J., Agahi, G., Calvo, R., & Hoffman, J. (2013). Coming of age on the streets: Survival sex among homeless young women in Hollywood. *Journal of Adolescence, 36,* 1205-1213.

Willging, C.E., Salvador, M., & Kano, M. (2006). Pragmatic help-seeking: How sexual and gender minority groups access mental health care in a rural state. *Psychiatric Services, 57*(6), 871-874.

Wilson, E.C., Chen, Y., Arayasirikul, S., Fisher, M., Pomart, A., Le, V., …, McFarland, W. (2015). Differential HIV risk for racial/ethnic minority trans*female youths and socioeconomic disparities in housing, residential stability, and education. *American Journal of Public Health, 105*(S3), e41-e47. doi:10.2105/AJPH.2014.302443

Wilson, E.C., Garofalo, R., Harris, R.D. Herrick, A., Martinez, M., Martinez, J., &

Belzer, M. (2009). Transgender female youth and sex work: HIV risk and comparison of life factors related to engagement in sex work. *AIDS Behavior, 13*(5), 902-913.

Wurth, M. H., Schleifer, R., McLemore, M., Todrys, K. W., & Amon, J. J. (2013). Condoms as evidence of prostitution in the United States and the criminalization of sex work. *Journal of the International AIDS Society, 16*(1), 18626. https://doi.org/10.7448/IAS.16.1.18626

Xavier, J., Honnold, J.A, & Bradford, J.B. (2007). The health, health-related needs, and lifecourse experiences of transgender Virginians. *Richmond: Division of Disease Prevention through the Centers of Disease Control and Prevention, Virginia Department of Health.* Retrieved from http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf

Yüksel, P., & Yildirim, S. (2015). Theoretical frameworks, methods, and procedures for conducting phenomenological studies in educational settings. *Turkish Online Journal of Qualitative Inquiry, 6*(1), 1-20. doi:10.17569/tojqi.59813 Z

Yule, A.M., Wilens, T.E., Martelon, M.K., Simon, A., & Biederman, J. (2013). Does exposure to parental substance use disorders increase substance use disorder risk in offspring? A 5- year follow-up study. *American Journal of Addiction, 22*(5), 460-465.

Zhao, Y., Montoro, R., Igartua, K., & Thombs, B.D. (2010). Suicidal ideation and

attempt among adolescents reporting ‘unsure’ sexual identity or heterosexual identity plus same-sex attraction or behavior: Forgotten groups? *Journal of the American Academy of Child & Adolescent Psychiatry, 49*, 104-113.

Appendix A: Demographic Questionnaire

<table>
<tr><td colspan="4">PARTICIPANT INFORMATION</td></tr>
<tr><td colspan="4">The purpose of this form is to identify and confirm your ability to be invited to participate in a research study that will examine how homelessness affects sexual risk in transgender youth.</td></tr>
<tr><td colspan="3">Name:</td><td>Today’s date:</td></tr>
<tr><td>Date of Birth:</td><td colspan="2">E-Mail Address:</td><td>Phone number:</td></tr>
<tr><td>What was your Sex Assigned at Birth?

☐ Male
☐ Female
☐ Intersex</td><td>What is your Gender Identity?

☐ Man
☐ Woman
☐ Transman
☐ Transwoman
☐ Other:
_____</td><td>Do you have a lease in your name?

☐ Yes ☐ No

If “Yes” have you been homeless in the past?
☐ Yes ☐ No

If “No” select which best applies:

☐ Living on the street
☐ Homeless Shelter
☐ Transitional Housing
☐ Doubling Up (not paying rent)
☐ Other: _____</td><td>Have you had an experience that places you at risk for HIV or other sexually transmitted infections (STIs)?

☐ Yes ☐ No</td></tr>
<tr><td colspan="4">I certify that the information above is true and correct.

Printed Name: _____ Date: _____

Signature: _____</td></tr>
<tr><td colspan="4">Researcher’s Initials _____ ☐ Eligible ☐ Not Eligible</td></tr>
</table>

Appendix B: Recruitment Email

I am a graduate student in Public Health at Walden University. I am conducting interviews for a research study of homeless transgender youth. Do you fit the following criteria?

- Are you 18-24 years old?
- Do you identify as transgender?
- Are you currently homeless or have been homeless in the past?

If you answered yes to the questions listed above, I urge you to make your voice heard. Participation in the study includes sitting through a recorded interview that will last between 45 minutes to 1 hour. All information that you provide will be completely confidential. You will be compensated for your time with a gift card for $25.00. Please contact me at (xxx) xxx - xxxx for additional information or if you are interested in participating.

Sincerely,

Darcia Bryden-Currie

Appendix C: Recruitment Flyer

Homelessness & Sexual Risk In Transgender Young Adults

Seeking participants for a research study

Be the change in your community!

- Do you identify as transgender?
- Have you ever been homelessness (streets, shelter, car)?
- Are you 18-26 years old?
- Do you feel that you might be at risk for contracting HIV and/or other sexually transmitted infections (STIs)?

If you answered yes, and would like to participate in a research study you will be asked to:

- Sign an informed consent form
- Participate in a recorded interview for 1 hour
- Review interview materials for accuracy

Participants will receive a $25.00 gift card

If interested contact Darcia Bryden-Currie at:
E-mail: darcia.bryden-currie@waldenu.edu
Phone #: (xxx) xxx-xxxx

Appendix D: Interview Guide

Homelessness and HIV Risk: Experiences, Perceptions, and Beliefs of Transgender Youth (18-24)

Date:
Interviewee #:
Age:

My name is Darcia Bryden-Currie MPAS, PA-C. I am a Ph.D. student at Walden University, pursuing my doctorate in Public Health with a focus in Community Health. I am currently working on my dissertation and am conducting a research study. The title of this study is “Homelessness and HIV Risk: Experiences, Perceptions, and Beliefs of Transgender Youth (18-24)”.

The study will be conducted by audio-recorded interviews, that will be approximately 45-minutes to 1- hour. The interviews will be held at a place of mutual convenience. Compensation will be in the form of a $25.00 gift certificate for interview participation. You have an opportunity to make an impact on transgender youth issues related to homelessness and HIV risk.

Interview Questions

RQ1: What are the perceptions of HIV risk behaviors among the homeless transgender youth of New York City?

1. What do you know about HIV?
2. How does being homeless or identifying as transgender affect your risk for HIV transmission?
3. Is it difficult for you to insist on protection? If so, why?
4. How often do you engage in unprotected sex?

RQ2: How does being homeless affect sexual risk behaviors in transgender youth?

1. How long have you been homeless?
2. What does social support mean to you?
3. Who do you currently consider to be included in your social network?
4. How does your social network influence your health behaviors?

RQ3: What specific services are needed to combat risk in homeless transgender youth?

1. What do you think about the current availability of shelter/housing options?
2. How often do you seek medical care?
3. What else would you like to add that is imperative to understand your experience of homelessness and HIV risk?