BEING TRANS-INCLUSIVE AND TRAUMA-INFORMED:
EXAMINING TRAUMA-INFORMED CARE PRACTICES FOR THE
TRANSGENDER POPULATION IN SHELTER SETTINGS

A Thesis

Presented to

The Honors Tutorial College
Ohio University

In Partial Fulfillment
of the Requirements for Graduation
from the Honors Tutorial College
with the degree of
Bachelor of Arts in Social Work

by

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April 2017
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ABSTRACT

Traumatic experiences including physical, emotional, and/or sexual abuse; assault; and/or violence are the norm for transgender individuals. These horrific but common experiences impede individuals’ ability to function independently and live self-sufficient lives. Although there are some excellent social services and public programs purposed to assist survivors of violence in recovery, accessibility to shelters is particularly lacking for non-cisgender survivors (Catherine Hodes, personal communication, October 26, 2016). Based on the limited available literature, it is reasonable to suggest that trauma-informed care (TIC) practices are a necessary tool to serve this population effectively. I conducted eight semi-structured interviews with service providers at shelter programs that serve transgender survivors of violence. My findings showed that shelters can provide services that are safe and inclusive for all survivors by basing practices on the five trauma-informed care values and using a screening tool that helps to identify callers as abusers or survivors. The implications of this study include increasing training and education among service providers to ensure effective and inclusive services reach the most vulnerable populations in need including the transgender population. Recommendations for future research are to study a larger and more diverse sample size including multiple service providers from each agency and consider the intersections of race, class, and gender in the service population.
INTRODUCTION

Homelessness, rape, abuse, violence, and discrimination are more likely to be the reality and common experience for members of the transgender\(^1\) and gender non-conforming\(^2\) community compared to their non-trans*\(^3\) counterparts (Mizock & Lewis, 2008, p. 337; Office for Victims of Crime, 2014). These traumatic\(^4\) experiences can hinder individuals’ abilities to function at their highest potential and force their lives into a constant state of crisis and survival. Research indicates that a majority of the trans* population are living with the aftermath of trauma and fear of possible repeat victimization (Office for Victims of Crime, 2014). This information suggests that a trauma-specific treatment approach is necessary to address this issue. In this study, I discuss trauma-informed care, which is an approach that is guided by the knowledge of trauma and its impact on an individual. The trauma-informed care approach recognizes that many behaviors and responses expressed by survivors directly relate to their traumatic experiences. Trauma-informed services look at all aspects of their program through a trauma lens and function in a way to avoid re-traumatizing of their clients (Ferencik & Rameriez-Hammond, 2013, p. 6; Guarino et al., 2009, p. 16). I argue for it as a useful treatment approach to serve trans* survivors.

Although many programs purport to serve survivors of violence, many of them are not accessible to non-cisgender\(^5\) survivors due to discrimination and misconceptions about the trans* community (Rooney, Durso, & Gruberg, 2016). In 2011, 19% of the documented trans* population reported experiencing homelessness at some point in their lives (Grant, Mottett, Tanis, Harrison, Herman, & Keisling, 2011, p. 4). Approximately 2% of the trans* population reported being homeless at that time, which is nearly twice
the rate (1%) of the general population (Grant et al., 2011, p. 4). Almost one-third (29%) of trans* people in a report for the National Transgender Discrimination Survey that tried to access shelter were turned away because they were trans* (Grant et al., 2011, p. 4).

The lack of accessibility to non-discriminatory and appropriate services puts trans* people in extremely dangerous environments. Grant et al. (2011) found that 25% of trans* people residing in shelter were physically assaulted and 22% were sexually assaulted by either another shelter resident or a shelter staff member (pp. 117-118). As a result, 47% of trans* people were forced to leave shelters for the streets (p. 116). The streets are another dangerous environment that poses just as much risk of trauma and holds an even longer history of being a place with abuse and violence against trans* people (Erickson-Schroth, 2014).

Traumatic experiences appear to be the norm for trans* people based on the literature (Choi, Wilson, Shelton, & Gates, 2015; Mizock & Lewis, 2008; Tobin, Freedman-Gurspan, & Mottet, 2015). With this information, it is reasonable to posit that trauma-informed care practices are a necessary tool to serve this population effectively. The purpose of this study is to investigate the rate at which trauma-informed care is used by shelter staff that serve trans* survivors as a treatment approach. This study primarily focuses on traumas of violence, abuse, and assault because these are experiences that are common for trans* people. Shelters for survivors of domestic violence and intimate partner violence are also a primary focus because these are environments that trans* people need, but that service systems exclude them from frequently. For this study, I investigate the prominence of trauma-informed care practices in shelters that serve trans* people. I argue that trans* people who are in need of, attempt to access, and who utilize
shelter services have a history of trauma experience. For this reason, I investigated the rate at which shelter staff uses trauma-informed care as part of the treatment modality.

The goal of this thesis is to answer the following research question: how prominent is trauma-informed care in shelters that serve trans* people? I approached this research question by asking the following questions in interviews: do you, as a service provider, see trauma in the trans* community that your agency serves? What is your response to your clients’ traumatic experiences? What is your understanding of trauma-informed care? Do you utilize trauma-informed care in your practice? If so, how do you utilize trauma-informed care in your practice?

The larger implications for this study are to continue to add to the limited research available about the trans* experience including specific experiences with social services and treatment modalities. Future research should be expanded to a larger and more diverse sample size that includes multiple service providers from one agency, a larger set of agencies, and the perspective of trans* clients. Additionally, the implications of this study include increasing training and education of trauma-specific treatment approaches and the trans* community with service providers.

LITERATURE REVIEW

Research on the prevalence of domestic violence and intimate partner violence in lesbian, gay, bisexual, transgender, or queer (LGBTQ) relationships is not common because typically society views this issue as affecting primarily heterosexual relationships where men abuse women (Miller, Goodman, Thomas, Peterson, Sheer, Woulfe, & Warshaw, 2016, p. 6). Because of the limited amount of research available, I draw from classic studies about the rate of violence against trans* people, including both
adults and youth for this literature review. I include studies on the rates of violence against the trans* community, which also includes information about the LGBTQ community as a whole. Understanding rates of intimate partner violence based on survivors’ gender identity is difficult because there is a dearth of research conducted with representative samples who are non-cisgender survivors (Miller et al., 2016, p. 6). Because of this gap in the literature about this specific demographic population, I have drawn from the literature that includes the entire LGBTQ community. In addition to historical literature, I have incorporated the most recent and trans*-specific research that is available. In this review, I will present literature discussing violence against trans* people, the impacts of violence, the lack of accessible services to address the impacts, and an overview of trauma-informed care.

**Violence Against the Trans* Community**

Studies on violence from 1997 to today indicate that trans* people experience some of the highest rates of violence, trauma, and abuse in the United States compared to their non-trans* counterparts. In 1997, a nation-wide study found that 47% of transgender respondents reported having experienced assault and 14% reported having experienced rape or attempted rape (p. 337). More recent research states that up to 66% of trans* people experience sexual assault and/or sexual violence at some point in their lives (Forge, 2012; Office for Victims of Crime, 2014). In 2005, a Washington DC-based study found that 43% of trans* respondents had experienced violence, which is more than twice the national rate for the general population (Mizock & Lewis, 2008, p. 337). In 2006, a Philadelphia-based study found that more than half of trans* respondents had experienced sexual assault, violence at home, and/or physical abuse (p. 337). A study
conducted in 2014 found that 90% of trans* youth experienced harassment, bullying, and/or family rejection; 75% experienced physical, emotional, or sexual abuse; 40% experienced alcohol and/or substance abuse; 25% experienced intimate partner violence; and 20% experienced sexual exploitation and/or trafficking. All of these are higher percentages than lesbian, gay, and bisexual (LGB) youth reported. This study did not report on straight youth for comparison (Choi, Wilson, Shelton, & Gates, 2015).

Frequently, there are multiple perpetrators of violence throughout a trans* individual’s life (Miller et al., 2016). For example, a trans* person may grow up with unaccepting parents that inflict emotional abuse. As an adolescent, they may enter a relationship that becomes physically and emotionally abusive. As an adult, they may experience microaggressions from a coworker or be physically or sexually assaulted by someone that they know. Based on a national report on various issues relating to the trans* community, 19% of trans* people reported experiencing violence by family members because of their gender identity (Grant et al., 2011). Compared to 20.4% of cis people, 31.1% of trans* people experience intimate partner violence (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). In 2013, a report on violence found that trans* survivors were 1.9 times more likely to face physical violence, 3.9 times more likely to face discrimination due to intimate partner violence, and 1.5 times more likely to experience intimate partner violence in public spaces. Trans*women reported more violence than their male counterparts (New York City Anti-Violence Study, 2014, p. 10). The National Coalition of Anti-Violence Programs (NCAVP) conducted a survey in 2014 and found that trans* survivors are two times more likely to face threats and/or intimidation, two times more likely to experience harassment, and four
times more likely to face police violence compared to non-trans* people (Miller et al., 2016, p. 8).

The NCAVP collected data on the rates of violence in the trans* community and other demographics from 2012 to 2013 and found that rates of violence were increasing. In 2013, 10% of violence survivors were trans*, which was a 3.6% increase from 2012 (New York City Anti-Violence Study, 2014, p. 26). In 2013, the Anti-Violence Study served 26% more LGBTQ survivors of intimate partner violence than in 2012 (p. 1). There was a 60% increase in reports by trans*-identified survivors between 2012 and 2013 (p. 3). The actual number of reports may have shown a greater increase if one of the organizations that reported in 2012 had also reported in 2013 (New York City Anti-Violence Study, 2014). The high rates of violence against the trans* community documented and the recent increase reported show that violence is a prevalent issue for the trans* community.

**Impacts of Violence**

The horrific experiences that trans* people face often affect multiple aspects of their lives in negative ways. Mental health difficulties are major concerns among LGBTQ people in general (Miller et al., 2016, p. 2). Individuals experiencing higher rates of traumatic events are at greater risk of developing symptoms of depression, anxiety, posttraumatic stress disorder (PTSD), and suicidality (p. 2). LGBTQ youth show significantly higher rates of depression and are more likely to consider and attempt suicide compared to heterosexual and cisgender youth (Ferguson & Maccio, 2015). Compared to non-LGBTQ youth, LGBTQ youth experience higher levels of depressive symptoms, anxiety, PTSD, and substance abuse disorder (Choi et al., 2015; Ferguson &
Maccio, 2015). Because a majority of LGBTQ survivors have experienced multiple forms of violence and abuse in their lives, the fears of experiencing these issues are greater. This is especially true for trans* survivors (Miller et al., 2016, p. 2, 46). As stated in the previous section, family members were the perpetrators of violence for 19% of trans* people and 31% of trans* people experienced intimate partner violence, which are higher than rates for cisgender people (Grant et al., 2011; Langenderfer-Magruder et al., 2016).

A recent Canadian study on the health and experiences of trans* youth shows further evidence of mental health issues among LGBTQ individuals. Nearly two-thirds of trans* youth reported self-harm in the past year; a similar number reported serious thoughts of suicide; and more than 1 in 3 had attempted suicide (Veale, Saewyc, Frohard-Dourlent, Dobson, Clark & the Canadian Trans Youth Health Survey Research Group, 2015). According to an American study, when coming out about their trans* or LGB identity, 48% of youth received a negative and traumatic response from their parents including rejection, verbal and psychological abuse, and/or physical abuse (Veale et al., 2015). Parents sometimes force youth out of the home, which can further lead to serious mental health issues and put youth in extreme danger on the streets (Ferguson & Maccio, 2015; Veale et al., 2015). Although poor mental health outcomes are common among all LGBTQ youth, the highest rates are found among trans* youth. Approximately 75% of trans* youth experienced mental health issues compared to 65% of LGB youth (Choi et al., 2015).

The Ali Forney Center (AFC) provides housing, shelter, and crisis intervention services to LGBTQ youth in New York City. AFC conducted a study that estimates 40%
of youth who are homeless identify as LGBTQ (True Colors Fund, 2015). The most commonly cited reasons for LGBTQ youth homelessness is being forced out of their homes due to gender identity, sexual orientation, and/or gender expression (Choi et al., 2015; Ferguson & Maccio, 2015). Approximately 84.5% of homeless trans* youth were expelled from their home due to their gender identity compared to 78.2% of homeless LGB youth (Choi et al., 2015). More than 1 in 4 Canadian trans* youth reported running away from home in the preceding year (Veale et al., 2015). In both Canada and the United States, LGBTQ youth who run away from home are more likely to have a history of physical or sexual abuse and be re-victimized by predators in the streets once they have no home (Ferguson & Maccio, 2015; Veale et al., 2015).

The various mental health issues and family conflicts that trans* people face increases their likelihood of experiencing poverty and homelessness. Grant et al. (2011) found that approximately 19% of trans* people were living in poverty whereas the national average was 15% prior to 2011 when they conducted their study. These numbers are difficult to accurately track and report due to a lack of inclusive data collection tools. In 2014, the Point in Time Count, a federally mandated count of homeless people in the United States, began including “transgender” as a response option in the gender question of the survey. The Team Leader of the Youth Outreach Program at Huckleberry House, a shelter for youth who have run away or have no home, in Columbus, Ohio discussed the count process. She explained that lacking this explicit count option in the survey for many years has posed a major barrier to accurately documenting the number of trans* people experiencing homelessness (K. Crockett, Personal Communication, 11 February 2016). Unfortunately, the data from the 2014 Point in Time Count was not available at
the time of this study. The lack of inclusive, affirming, and non-judgmental data tracking and collection tools underlies one reason that trans* homelessness is difficult to accurately assess and address.

**Access to Services**

In 2013 President Obama signed the reauthorization of the Violence Against Women Act (VAWA). This reauthorization was the first federal law that explicitly protected the LGBTQ community (New York City Anti-Violence Study, 2014, p. 6). VAWA-funded programs became prohibited from discriminating against LGBTQ survivors under the reauthorization (p. 6). Although this act was a monumental support for LGBTQ survivors of intimate partner violence, there is still a significant gap between the policy and its implementation and practice because not all services receive VAWA funding and are not required to adhere to this rule. Additionally, not all shelters provider services to trans* survivors (p. 6).

Upon leaving home or abusive situations to seek refuge, trans* people often find similar discrimination, harassment, and trauma in public programs and services. According to one study, approximately 19% of trans* individuals were refused a home or apartment and 11% were evicted because of their gender identity (Tobin, Freedman-Gurspan, & Mottet, 2015). The National Center for Transgender Equality found that 32% of trans* people experienced harassment, discrimination, or violence when attempting to access government services or programs (Tobin et al., 2015). Only one in five LGBTQ victims of intimate partner violence or sexual assault receives help from service providers (Office for Victims of Crime, 2014).
LGBTQ survivors will often avoid seeking services at a shelter or reporting their abuse to the police because LGBTQ people have historically experienced discrimination in these service systems, which are intended to help them (Miller et al., 2016, p. 2, 47). When trans* survivors seek services, there is a significant lack of accessible, effective, supportive services for this population. Of the survivors surveyed in a 2013 study, 5.8% sought access to domestic violence shelters, which was a 3.7% increase from 2012. From this 5.8% of reported survivors, 20.3% were turned away from domestic violence shelters, 14.3% were denied shelter, and overall there was an increase in the number of survivors that were refused services from the previous year (New York City Anti-Violence Study, 2014, p. 12). Only 30% of women’s shelters were willing to house trans*women with ciswomen and 70% of shelters were unreachable, unsure, or unclear about housing trans*women with ciswomen; isolated or housed trans*women with cismen; or refused shelter to trans*women (Rooney, Durso, & Gruberg, 2016). These multiple studies show that shelter services are failing to serve a population experiencing significant amounts of trauma, discrimination, and service needs.

Many trans* youth have been refused services due to their gender identity (Erickson-Schroth, 2014). Over the past five years, the numbers of trans* youth being served at youth shelters has increased by 5% and the age at which youth are being served has been progressively getting younger (Choi et al., 2015). Generally, most shelters that serve runaway and homeless youth (RHY) do not have the staff, policies, or procedures to meet the documented needs of trans* youth, much less provide for this growing and emerging need (Erickson-Schroth, 2014; Choi et al., 2015). The rising numbers indicate a
need for more research, examination, identification, and implementation of the best practices to serve trans* people experiencing trauma or crisis.

Although often facing different barriers, sometimes both adult and youth trans* people have similar discrimination experiences that hinder their ability to access services. For example, residential facilities, including shelters and detention centers document inappropriately and inaccurately labeling adult and youth trans* people as “sexual predators” (Marksamer, Spade, & Arkles, 2011). Group care facilities such as the child welfare system or juvenile detention centers often label youth as “sexual predators” due to their gender identity and/or expression (Marksamer et al., 2011). As a result, trans* individuals may be mistreated by staff, more severely punished by staff, abused by other residents or staff, or placed in isolation as punishment for identity or “protection” from abusers, which is abuse in itself (Marksamer, Spade, & Arkles, 2011). Adult trans*women who attempt to access shelters are often told that if they had not had surgery, they would be housed on the men’s floor as precaution against the trans*woman raping cisgender women, they would make other residents uncomfortable to share facilities with a “man” and would be placed based on genitalia, or they could not stay at all because their body parts would make other residents uncomfortable (Rooney et al., 2016).

**Trauma-Informed Care: A Brief History**

Mental health and addiction treatment programs first conceptualized the idea of trauma-informed care (Miller et al., 2016, p. 19). In 1994, the Substance Abuse and Mental Health Services Administration (SAMHSA) held a forum for survivors to discuss their trauma histories and its impact on their physical and mental health (Wilson, et al.,
2013). This forum highlighted re-traumatization as a common experience for survivors in residential or inpatient settings (Miller et al., 2016, p. 19).

In 1998, SAMHSA sponsored the Women, Co-occurring Disorders, and Violence Study, which integrated service system strategies with mental health disorders, substance abuse issues, and trauma histories (Wilson, et al., 2013). This study allowed practitioners to identify practices and procedures in the service system that could harm individuals physically or psychologically, cause a new trauma, or re-traumatize through unnecessarily and harmfully triggering memories (Wilson, et al., 2013). This study highlights the high rate of trauma in individuals seeking services and lack of trauma knowledge in service providers which creates a high risk for re-traumatization in service settings intended to help them (Miller et al., 2016, p. 19). The results of this study display a need for trauma-informed care in the adult services systems (p. 19). By the early 2000s, social service systems were using trauma-informed care with traumatized children (Wilson, et al., 2013). Since then, the human services world has increasingly placed focus and importance on using trauma-informed care practices with all trauma survivors and specific vulnerable populations (Miller et al., 2016).

**Trauma-Informed Care: A Practice Approach**

The five core values that trauma-informed care is based on include: (1) safety, (2) trustworthiness and transparency, (3) collaboration and mutuality, (4) empowerment, voice, choice, and (5) cultural, historical and gender issues (SAMHSA, 2014; Wilson, Pence & Conradi, 2013). These guiding principles help individual workers and entire programs to understand the impacts of trauma and the paths to recovery; to recognize the signs and symptoms of trauma; to respond with policies, procedures, and practices that
integrate with knowledge about trauma; and to actively resist re-traumatization (SAMHSA, 2014). The practices based in the guiding principles and understanding of trauma allows workers to provide services that are more supportive and less re-traumatizing compared to services that lack an understanding of trauma and its impacts. This is an important finding because the lack of knowledge about trauma and its impact were issue areas that individuals with trauma histories identified as problematic in the service systems (Wilson, et al., 2013; Miller et al., 2016, p. 19).

The Trauma-Informed Organizational Toolkit and Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs are guides to utilizing trauma-informed care (Ferencik & Rameriez-Hammond, 2013, p. 6; Guarino et al., 2009, p. 2). These documents provide a further explanation of the five core values listed above and their implementation into practice. Service providers can use these documents to assess an organization’s level of trauma-informed care practices (Ferencik & Rameriez-Hammond, 2013 p. 6; Guarino et al., 2009, p. 2). All shelter residents have experienced a trauma or crisis that has either directly or indirectly led them to seek shelter services. Traumatic experiences are characterized by feelings of intense fear, helplessness, loss of control, and/or a threat of annihilation that can overwhelm individuals mentally, emotionally, and physically (Ferencik & Rameriez-Hammond, 2013, p. 3). Trauma has a significant impact on how people feel, think, behave, and relate to others and can impede on an individual’s level of resiliency (Guarino et al., 2009). The multiple areas of impact in an individual’s life indicate the importance of shelter service providers being knowledgeable and well-versed in providing trauma-informed care.
In a trauma-informed care agency, every part of the organization should aim to be trauma-informed, from the front desk workers to the clinicians and direct service workers to the administrators and board members (Wilson et al., 2013). Research shows that trauma-informed care approaches are beneficial for the participant, staff, and agency as a whole, which is the reason that every level of the agency should engage in trauma-informed practices (Miller et al., 2016, p. 19). Becoming trauma-informed begins with understanding how trauma impacts individuals’ lives and assessing all policies and procedures of the agency with that framework (Guarino et al., 2009, p. 17; Wilson et al., 2013). “Trauma-informed care recognizes that a majority of people seeking services have experienced trauma and that trauma impacts many domains of life” (Miller et al., 2016, p. 19). When evaluating and adapting its practices, an agency should use a “trauma-informed lens,” which will question the necessity, purpose, and rationale of a proposed policy or practice while keeping in mind how it may harm or help a client based on their trauma history (Guarino et al., 2009, p. 17). Each area of the agency including the organization’s structure, service delivery, and management style should be frequently assessed, reviewed, and potentially revised in order to include an understanding of how trauma impacts a client’s life and the services that the client receives (Wilson et al., 2013). Trauma-informed protocols should be implemented in the procedures for hotline calls, intake processes, support group facilitation, exit interviews, physical and emotional safety planning, self-care, and support and education for staff (Ferencik & Rameriez-Hammond, 2013, p. 76-106; Guarino et al., 2009, p. 17).

In addition to these approaches, agencies should engage in practices that directly align with the trauma-informed care values. For example, based in the collaboration and
the empowerment values, agencies should collaborate with their clients by obtaining feedback. Each service provider should serve as an equal working collaboratively with the client to reach the client’s goals (Ferencik & Rameriez-Hammond, 2013, p. 7; Guarino et al., 2009, p. 17-18). This allows the client to have a voice by giving feedback to providers, feel empowered by making decisions, and gain independence by sharing their perspective, which builds a sustainable foundation for living a self-sufficient life. Agencies should also actively engage in creating physical and emotional safety plans, a crisis prevention plan, and a self-care plan with clients, which aligns with safety values (Ferencik & Rameriez-Hammond, 2013, p. 7; Guarino et al., 2009, p. 17-18).

Although services should always be client-centered, the agency should not ignore the service workers. Organizations should have an understanding of how secondary traumatic stress can impact workers, provide formal ways to support staff, and promote self-care practices in order to prevent burn out and loss of qualified workers (Ferencik & Rameriez-Hammond, 2013, p. 7; Guarino et al., 2009, pp. 17-18). Agencies should provide trauma training for all staff and provide continuing education specifically focused on secondary trauma and self-care practices (p. 7; pp. 17-18).

The number of trans* people attempting to access and receive services is rising, but that does not mean that trans* people are now being treated fairly and appropriately, without discrimination or abuse, or by service providers that are competent to work with trans* people. As this number rises, the lack of cultural competency regarding the trans* community in service provision becomes evident. Cultural competency is a key component in trauma-informed care (Ferencik & Rameriez-Hammond, 2013, p. 7; Guarino e-t al., 2009, p. 17-18). Service providers recognize this issue as a major barrier.
Approximately 26%-37% of service providers cited a lack of training to address LGBTQ needs as a barrier to effectively serve the LGBTQ homeless population (Choi et al., 2015). Adequate training programs and curricula are in short supply because there are very little data about service providers, their experiences and perspectives of LGBT needs, and the experience of LGBTQ populations receiving services (Choi et al., 2015). Without this input from service providers and the clients themselves, determining the most needed training for service providers is difficult. To address this issue, I gathered input through interviews with service providers. In my thesis, I posit because trans* people experience extensive trauma, they are in need of, attempt to access, and utilize shelter services. Plus, I examine the rate at which service providers use trauma-informed care in response to client trauma.

METHODS

Participants and Recruitment

For this study, I conducted eight semi-structured interviews to identify patterns of trauma rates in trans* clients, implementation strategies for gender inclusive practices, challenges faced when trying to implement gender inclusive practices, guidance for organizations attempting to make changes for gender-inclusive and trauma-informed care, and incorporation of the five trauma-informed care values: safety; trustworthiness and transparency; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. Some agencies focused on certain topics more than others based on their program’s practice. I intentionally chose a semi-structured interview approach to allow for conversations to flow and be flexible while still having a focus on the topics that I identified and on which the service providers chose to elaborate. I
received approval from the Institutional Review Board at Ohio University to complete qualitative interview data collection for this study.

I identified participating agencies through online searches and snowball sampling. I selected potential participants based on their services, target population, and willingness and availability to complete a phone or in-person interview. I completed internet searches and a literature review of organizations that provide shelter services to individuals who are transgender or gender non-conforming and experienced domestic violence, abuse, and/or sexual assault. I looked for explicit markers indicating that the organization served trans* individuals. Websites, flyers, or informational material that stated that they “provide services to survivors regardless of gender identity…(etc.)” or that they were “LGBTQ trained” were initial indications of inclusivity. For example, the My Sister’s Place brochure states that services are open to “all survivors including LGBTQ individuals” and the Dove Inc. website includes a tab for the agency’s LGBTQ services.

For this study, I sought shelter services that focus intentionally on gender-inclusivity and that value and prioritize inclusivity within the agency’s work because valuing and prioritizing inclusivity often leads to sustaining inclusive practices. It was difficult sometimes to accurately identify agencies based on their website or another agency’s referral. Although a website can explain that the agency does not discriminate, has a policy supporting non-discrimination, or is identified as inclusive by another agency that does not always mean that the agency practices inclusivity and non-discrimination. For example, the Anti-Violence Study in Illinois referred a shelter as LGBTQ-friendly. The staff member that I interviewed, Advocate B explained that the
shelter has housed one individual that identifies as genderqueer, but the shelter does not have any policies or practices in place to house trans* survivors.

Additionally, I called the National Domestic Violence Hotline and asked for referrals to domestic violence shelters that serve trans* individuals. From this list, I called shelter agencies and asked them if they would participate in the study. I utilized snowball sampling by asking participants for referrals to shelters that provide similar services anywhere in the United States. As a social work student and social service worker, I have working relationships with many professionals in shelter services. I invited these individuals to participate as well as to recommend other potential participants.

Out of the 29 agencies that I contacted, I received 11 responses stating their willingness to participate. One agency discontinued contact and two agencies were unable to complete the interview over the phone or in-person and offered to answer the questions via email. IRB approved the study to complete phone or in-person interviews only and not sending answers via email because it is not a secure, confidential way to share information. For this reason, these two agencies did not participate in the study. I completed eight interviews with eight agencies from the following locations: two in Colorado, one in Illinois, two in Ohio, two in Massachusetts, and one in New York. I interviewed one staff member from each shelter agency.

**Interviews**

I primarily interviewed staff members that held a position in which they supervised or directed the shelter program and the direct service staff because they had knowledge of the program’s policies, procedures, and day-to-day operations. I chose the participants based on their availability and willingness to complete the interview. Some
of the interviewees opted to remain anonymous in the write-up of this study, while others allowed me to use their name. The interviews lasted anywhere from 30 to 60 minutes and were voice recorded then transcribed for a line-by-line analysis. The interviews were semi-structured based on a list of questions I compiled to understand the individual participant’s professional experience and background, the agency and its services, the clients that they serve, the intake process, and the policies in place (See Appendix A).

The interviews were not done with individuals who currently or previously received services from these agencies, because it could disrupt their treatment process or harm the individuals who were working through significant issues and trauma by adding stress, pressure, or re-traumatization. This practice aligns with the goal of trauma-informed care, which is to not re-traumatize clients (Ferencik & Ramirez-Hammond, 2013, p. 6; Guarino et al., 2009, p. 17). There is also a power imbalance in the relationship between a client and service provider that could create a social desirability bias in responses. Clients may feel that if they participate, it will better their relationship with the agency or please the staff, which may influence their answers in the interview. Past and current clients are also considered a vulnerable population, so the IRB could have rejected the study. Additionally, attempting to track down past clients who would be willing to participate may be difficult to achieve in the time allotted to complete this study. This approach is an idea that I would explore for future, higher-level research.

**Measures**

The measures are based on the five guiding values of trauma-informed care that SAMHSA defines and the recommendations for best practices in *Trauma-Informed Care: Best Practices and Protocols for Ohio’s Domestic Violence Programs* that support these
definitions (Ferencik & Rameriez-Hammond, 2013; SAMHSA, 2014). I used these definitions, principles, and practices as the foundation to identify patterns of knowledge base, definition, and use of trauma-informed care in the content data analysis.

Safety – Staff and clients should feel a sense of both physical and psychological safety (SAMHSA, 2014). The agency should provide safe, physical spaces both children and adults (Ferencik & Rameriez-Hammond, 2013, p. 60; Guarino et al., 2009, p. 19). This may include providing single use bathrooms with locks on the door, bedrooms with a lock and key held by the client, or a 24-hour alarm system (Ferencik & Rameriez-Hammond, 2013, p. 132; Mottet & Ohle, 2003). Staff should have a commitment to non-violence and recognize the inherent power imbalance in the relationship between a client and staff. For this reason, staff members should never use punitive or coercive interventions because this emphasizes the power imbalance in the advocate-survivor relationship and can risk the survivor feeling psychologically unsafe (Ferencik & Rameriez-Hammond, 2013, p. 56). Emotional safety is imperative for clients to feel secure and comfortable (Ferencik & Rameriez-Hammond, 2013, p. 60).

Trustworthiness and transparency – Staff should act transparently with clients and prioritize building trust and rapport with them (SAMHSA, 2014). Familiarizing clients with trauma-informed services and being open and transparent about the processes, procedures, and their rationales is important (Guarino et al., 2009, p. 25). As stated in the section on safety, advocates should not use punitive interventions that emphasize a power-imbalance. Avoiding this behavior can not only promote safety, but can also build trust between the survivor and the advocate and show that the advocate is on their side (Ferencik & Rameriez-Hammond, 2013, p. 56).
Collaboration and mutuality – Sharing the decision-making power in a meaningful and intentional way can create a partnership between a client and staff, which can level the power differences and allow healing to occur (SAMHSA, 2014). Collaboration between clients and staff relates to the values that promote choice, trustworthiness, and safety by the staff listening to and including the client’s voice in decisions which builds trust in their relationship and often leads to feelings of emotional safety for the client (Ferencik & Rameriez-Hammond, 2013, p. 56, 68). Practicing collaboration should go beyond the survivor-advocate relationship and should be a practice in the relationships that clients have with other service providers and in personal relationships (Guarino et al., 2009, p. 23-24). Mutual respect and a focus on the client’s individual strengths should be the basis of the survivor-advocate relationship (Ferencik & Rameriez-Hammond, 2013, p. 59).

Empowerment, voice, and choice – Staff should recognize, build on, and validate the client’s individual strengths as well as assist the client in developing new strengths as necessary. A belief in resilience and in the individual’s ability to recover is vital to empowering individuals. This value encourages a practice that focuses on the strengths and abilities that the client has and that can aid them in achieving their goals as opposed to the strengths and abilities that they lack and may pose a challenge to them reaching their goals (SAMHSA, 2014). Service approaches should aim to recognize that each individual has their own unique experience. Each survivor may experience and react to a trauma differently, which is why each individual requires an individual service plan that is structured around their strengths (SAMHSA, 2014; Ferencik & Rameriez-Hammond, 2013, p. 57-59).
Cultural, historical, and gender issues – Service providers should use an approach that moves away from cultural stereotypes, recognizes inherent biases, and makes a conscious effort to avoid biases from impacting the services that they provide. Programs should offer services that recognize historical trauma, and address trauma impacts, and utilize the value of cultural connections in the healing process (SAMHSA, 2014). As identified in the empowerment measure, each survivor has their own unique story and experience of trauma. Each survivor’s cultural, historical, and gendered background impacts their trauma experience and response (Ferencik & Rameriez-Hammond, 2013, p. 65). Staff should treat each survivor as an individual, while also recognizing and utilizing the strengths of their cultural, historical, and gender background (Ferencik & Rameriez-Hammond, 2013, p. 57-58).

Data Analysis

For my research and analysis, I used pure naturalistic-qualitative strategy and an applied research design. Pure naturalistic qualitative strategy involves collecting qualitative data and performing content analysis (Patton, 2002, p. 252). I collected qualitative data through interviews and performed content analysis through identifying patterns of knowledge base, definition, and use of trauma-informed care throughout the interviews. Additionally, I looked for patterns of trauma rates seen in trans* clients based on service provider perception. I identified patterns by highlighting “mentions” of trauma rates in trans* clients, implementation strategies for gender-inclusive practices, challenges faced when trying to implement gender-inclusive practices, guidance to organizations attempting to make changes to gender-inclusive and trauma-informed care, and the five trauma-informed care values: safety; trustworthiness and transparency;
collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. The purpose of this process was to highlight the problem of trauma experiences among trans* people and the actions taken to address this issue by the individuals and organizations doing the work first-hand. I then organized the transcription analysis by identifiable patterns of the topics listed above.

An applied research design aims to highlight and understand the nature and root of a societal or human issue (Patton, 2002, p. 224). The purpose of my research is to highlight the issue of accessibility to shelter services for trans* and share the effective approaches to creating gender-inclusive and trauma-informed services for trans* survivors. Applied research assumes that we can understand and solve societal and human problems with knowledge (Patton, 2002, p. 224). My research discusses service providers’ knowledge of clients’ trauma experience and experience with trauma-specific treatment approaches. This discussion is aimed to understand the issue of accessibility to shelter services for trans* survivors in the hopes of improving it. Applied research develops questions based on the problems that people experience and the concerns that society identifies as important (Patton, 2002, p. 224). The issues facing trans* people are emerging and becoming the forefront of social concerns. The recent reauthorization of VAWA, ruling by HUD, and publication by American Psychological Association reflects the emerging issues facing trans* people (American Psychological Association, 2015, p. 833; “U.S. Department of Housing,” 2016; National Network to End, 2013). A long-term goal is to take these findings and educate service providers in shelters aiming to serve the trans* community who have experienced trauma and are receiving services in a shelter setting.
RESULTS

For this study, I interviewed staff members from eight agencies that provide shelter and support services to survivors of domestic violence, intimate partner violence, or relationship abuse including transgender or gender non-conforming individuals. In addition to emergency shelter services, all of these agencies have further support programs such as outreach, prevention, education, legal advocacy, individual counseling, support groups, medical advocacy and support, abuser intervention, transitional housing, and 24-hour crisis hotline services that were often noted as gender inclusive and that have served all genders. For this study, I only focused on the shelter program because that is where lack of accessibility to services for non-cisgender individuals experiencing domestic violence and abuse is most prevalent (Mottet & Ohle, 2003; Ferguson & Maccio, 2015).

Seven out of the eight agencies are standard shelter programs which mean that the shelters simultaneously house multiple individuals or families in one stationary space. Each individual or resident family may have their own bedroom or they might have to share a room with another individual or family. A majority (62.5%) of the shelters that participated in this study explicitly stated that they attempt to place families in their own rooms for privacy and space. The remaining three (37.5%) did not mention this aspect of shelter care or do not have the facility layout and space to do so.

Five out of the eight shelters (62.5%) identified as a congregate care setting, which means many of the spaces outside of bedrooms are communal. Common spaces may include kitchen, dining room, living room, group work space, and children’s playroom. One agency, the Delores Project (12.5%), said that they only provides bed
space in two large, shared rooms with up to 16 beds per room and one large dorm-style bathroom with multiple toilets and shower stalls. One single stall toilet and sink with a lock on the door and one individual shower is available for a single person’s use if they feel more comfortable in that space. One agency, The Network/La Red (12.5%), said that they identify as a safe home and function out of a rotation of different hotel rooms for one individual or one family of survivors at a time. One agency, Advocate A’s agency (12.5%), did not specifically describe the layout of the shelter, but identified as a “safe home.”

Out of the eight agencies, four agencies (50%) mentioned five out of the five values of trauma-informed care (see pages 24-26 for explanation of trauma-informed care values), three agencies (37.5%) mentioned four out of the five, and one agency (12.5%) mentioned two out of the five (See Appendix D). All eight participating agencies mentioned practices that align with the value of cultural, historical, and gender issues. This was the only value that all eight participants mentioned, which may be a result of the interview questions and their focus on practice with clients of different genders. This value encourages practices that move away from stereotypes, recognize inherent biases, acknowledge individual experience, and recognize barriers as well as strengths related to the individual’s background, culture, etc. (Ferencik & Rameriez-Hammond, 2013, p. 57-58, 65; SAMHSA, 2014).

It is important to note that although I chose these agencies for their willingness to participate and their recognition as an LGBTQ-serving agency, all of the shelters are at different levels of providing gender inclusive shelter services. Five agencies (62.5%) have served one or more trans* survivors. One agency (12.5%) has served one
genderqueer survivor. One agency (12.5%) has served one family who had a trans* child. One agency (12.5%) was not able to provide specific numbers on trans* survivors because the staff member was no longer at the agency, which is a safe home program in Colorado. This staff member, referred to as Advocate A for anonymity in this study, explained that when they left the program five years ago, the agency was moving toward gender inclusivity and had expanded their service criteria to accept survivors other than cisgender heterosexual women (See Appendix B and Appendix C).

The following sections present my findings from identifying and analyzing patterns of trauma rates in trans* clients, implementation strategies for trauma-informed care and gender inclusive practices, challenges faced when trying to implement gender inclusive practices, and the five trauma-informed care values: safety; trustworthiness and transparency; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

**Understanding Trauma**

The trauma-informed care approach begins with realizing the impacts and recognizing the symptoms of trauma (Guarino et al., 2009, p. 17; Wilson et al., 2013). Four of the eight agencies (50%) explicitly stated that trauma is prevalent among the trans* population that they serve. Two of these service providers, Kishana Smith from the Network/La Red and Laura Rossbert from the Delores Project both stated “Yes, 100% [of our clients have trauma histories.]” Catherine Hodes, the director of a community-based domestic violence program in Brooklyn, New York, explained that service providers are “working with highly traumatized folks” that come in with multiple issues around privacy, confidentiality, and safety. Kelly Cooke, the Executive Director of My Sister’s
Place, explained that it is “rarely the case that someone walks into a shelter and the only thing going on in their lives is homelessness or domestic violence,” which acknowledged that individuals are often experiencing multiple traumas simultaneously.

The four other agencies (50%) explained the common presenting issues that their clients’ experience included substance abuse, homelessness, childhood abuse, and intimate partner violence. By the definition that SAMSHA (2014) provides, these experiences are traumatic. Therefore, the service providers acknowledged the high rates of trauma in their service population without explicitly stating that trauma is prevalent in the trans* population. Coming from a gender-inclusive lens, Smith explained that abuse can happen in any type of relationship and by an individual of any gender identity. Smith explained that to be inclusive, service workers must ignore the fact that they are talking to a male or female because abuse can be present in any relationship regardless of gender or sexuality.

A host of trauma histories comes with a host of coping skills to deal with this trauma. Some may be healthy, but many others may be unhealthy coping skills, according to Jessica Cohen, the Senior Manager of Residential Services at Dove, Inc. Maladaptive coping skills can contribute to a survivor’s multitude of issues, Cooke explained. Cohen and Cooke cited substance abuse as an example of a maladaptive coping skill. Cooke further explained that she views these maladaptive coping strategies as part of the trauma and abuse her clients have experienced and need to be addressed on their healing and recovery journey. Cohen discussed the factors in her client’s life that have led them to use these behaviors, which are often connected to past trauma. For example, a client that experienced chronic childhood abuse may use substances as an adolescent to cope. As an
adult, this client may continue to struggle with abusing substances due to their childhood trauma. Virginia Beckham, the Executive Director of Genesis House, also acknowledged that trauma can impact people’s behaviors and viewpoints. For example, according to Cohen, a client is not disrespectful, rude, or crazy, instead they have put tools in place to protect themselves from abuse, violence, and other traumas that cause them to react this way and shape their behavior. Cohen and Beckham utilized the trauma-informed care approach by recognizing these impacts of trauma.

Another example of understanding the impacts of trauma comes from Cooke, in a situation where a client at the shelter asked for more clothes and hygiene products than they actually needed. The client asked different staff members on various shifts for different items. A staff member could interpret this client’s behavior as being manipulative and greedy. Rather, this client was putting the tools in place in order to protect their child and themselves. By recognizing the impacts of trauma, Cooke understood that this was a survival skill for the client. They were stocking up on items that they did need and knew they could receive because they had experienced an immense amount of uncertainty in their life. They wanted to ensure that they could provide for them and their child, and this strategy was the only immediate route to do so.

Cooke, Cohen, and Rossbert highlighted a common mantra used to sum up trauma-informed care practices: Instead of saying “what’s wrong with you?” ask “what has happened to you?” This phrase comes from Ferencik & Remeriez-Hammond’s (2013) guide on trauma-informed practices and protocols for domestic violence programs. Cooke explained her summary of trauma-informed care further by stating that the goal is to “offer services that do not re-traumatize people.” Understanding the various
experiences of past trauma and the impacts it has on individuals’ behaviors can enable service providers to recognize trauma reactions and avoid re-traumatizing clients.

**A Different Approach: Trauma-Influenced**

One agency, the Network/La Red, explained that they specifically choose to not use the trauma-informed care approach and differ from the traditional shelter program type. Instead, Smith explained that they use a trauma-influenced approach and provide a safe home. Smith, the Safe homes Coordinator at the Network/La Red, explained that a safe home holds different values than traditional shelters. Smith stated that a safe home highly values confidentiality to keep the survivor currently being served, the program as a whole, and other survivors that come after them, safe. For the Network/La Red, the safe home can serve one person at a time and they use a hotel location that rotates after each client that is served.

Smith stated that at the Network/La Red they are “not psychologists” and they “try to stay away from clinical work” because it is not their area of expertise. Although they are not clinicians, the Network’s staff is supervised by a licensed psychologist. Smith recognized the trauma-informed care approach as a sort of “buzz word” in the clinical and social service world. Smith explained that many of the staff and volunteers at the Network/La Red identify as survivors and that they use those experiences to serve other survivors to the best of their abilities, which explains the idea of a “trauma-influenced” approach. According to Smith, trauma-influenced means to “recognize what [survivors have] experienced, figure out what the needs are based on what they identify their needs are and goals are” and to “meet them there” (Kishana Smith, personal communication, October 31, 2016). Although the Network/La Red does not use the
trauma-informed care approach, I coded and analyzed the parallels I found between their trauma-influenced approach and the measures of the trauma-informed care approach. The main difference between the two, according to Smith, is that trauma-informed care focuses on the clinical aspect of domestic violence work. These approaches share many similarities as well, including a survivor-led framework.

**Implementation Strategies for Trauma-Informed Care**

Cohen and Cooke explained that when implementing new approaches, sometimes you just need to try it and see what happens. Cohen continued to explain that an agency will handle whatever issues come up as they would handle any new challenge that arises in this line of work. Beckham explained that each new concept is about becoming more comfortable with the concept of change.

For trauma-informed care, Cooke discussed that it is important to consistently re-evaluate the rules and approaches in place. Flexibility in practice is imperative to healing and recovery (Ferencik & Ramirez-Hmmond, 2013, p. 58). Wilson et al. (2013) explains that every aspect of the agency, including policies, should frequently be reviewed and revised as needed to include an understanding of how trauma impacts their clients’ lives. Cooke explained that rules should not be established as a result of one incident or to punish people for someone else’s misdeed. This directly aligns with the trauma-informed care value of trustworthiness and transparency, which encourages a practice that does not punish the client (Ferencik & Ramirez-Hmmond, 2013, p. 132).

In the Delores Project’s transition toward more trauma-informed care practices, Rossbert implemented a trauma-informed care conversation in the dialogue among the leadership team and throughout the staff of the organization. Rossbert explained that it is
important to build together as a team in order to have conversations where people disagree, but listen to each other. Rossbert acknowledged that moving toward these practices often brings up a fear that trauma-informed care means there are no rules. This idea comes from the notion that anything could be re-traumatizing to a client so there cannot be any rules. This is simply not true, Rossbert explained. “It is impossible to not have rules,” Rossbert stated. When it comes to rules, trauma-informed care means really looking at which rules are necessary and which rules are not necessary. Guarino et al. (2009) supports this point by explaining that an agency should wear a “trauma-informed lens” when evaluating and adapting practices. This lens will question the necessity, purpose, and rationale of the policies and practices suggested while considering the harm or help it may provide the client based on their past trauma (Guarino et al., 2009). Similar to Cooke, Rossbert explained that a rule should never be created just for the sake of having a rule or because of one individual or incident. Additionally, Rossbert stated that any rules that counter helping staff and guests reach their goals should be eliminated.

**Implementation Strategies for Gender Inclusivity**

Gender inclusivity is an important component in trauma-informed care practices which agencies that claim to use trauma-informed care often lack. Specifically, gender inclusivity relates to both physical and psychological safety. By providing an inclusive space, clients are able to feel psychologically safe and welcome. Additionally, by promoting inclusivity to others clients and practicing no tolerance for discrimination or transphobia, the agency decreases the chance of physical harm against a trans* client. Gender inclusively evidently relates to cultural, historical, and gender issues as well. In order to avoid re-traumatizing clients, agencies must practice considering the potential
trauma that their clients may experience while not assuming that they have experienced, will think, or will behave a particular way based on a stereotype or their identity.

Hodes explained, “in order to be inclusive in a world that isn’t fully inclusive, you end up having to specialize.” People often ask about shelter because it is shelters that have really lacked accessibility for all genders, Hodes stated. Smith acknowledged that abuse happens across all identities and men inflicting abuse on women in heterosexual relationships is not the only situation. Cohen explained that, for this reason, her staff does not ask for gender when a survivor calls seeking shelter. “It’s irrelevant,” Cohen explained. Cohen recognized that it is crucial to have staff diversity and have representation of the population being served so that all survivors have someone with whom to identify. Advocate A proposed questions to assess the level of inclusivity: Could a transman be here? Could a gay man be here? The interpretation of many shelter policies is that they serve cisgender women, Advocate A explained. Sometimes shelters open that policy to survivors who “identify as a woman,” but Advocate A explained the ideal policy would be an all-gender access policy.

Implementing gender-inclusive policies begins with a staff self-assessment to self-reflect on their biases, according to Advocate A and Cohen. Advocate A supported this strategy by acknowledging that the words can be written down, but the policy is not going to work unless the staff truly supports the policy and implements it in an intentional and meaningful way. Cohen explained that people state that they really worry about how they will respond to transphobia or homophobia in the shelter. Cohen explained that this is not an issue of worrying about knowing how to handle the situation; rather it is about feeling uncomfortable talking about these issues.
At the time of this interview, Advocate A held a trainer position in Colorado where they assist different social service programs in becoming more gender inclusive. Advocate A provided insight to how agencies implement gender inclusivity. According to Advocate A, the process starts slightly differently depending on where the program is at in identifying and understanding their values. Advocate A explained that some programs have shifted values and are ready to change because they believe it as the right thing to do, but they are not sure how to change. In that case, Advocate A is helping with logistics including language in policies, “technical assistance,” intake forms, nondiscrimination policy, physical space, etc. Advocate A explained another instance that programs often hold which is, “oh my goodness. We heard through the rumor mill that our funding could be in jeopardy if we don’t serve all genders so what do we do?” Concern about maintaining funding is a very different motive than achieving justice and equality. It is important to understand how to initiate the implementation of gender inclusivity with agencies at a variety of starting points, which is why Advocate A’s insight is relevant. Advocate A explained that no matter what level an agency is at, it requires a values assessment and buy-in support throughout the organization to initiate the process and to have real potential to succeed. Without support for gender inclusivity from staff, Advocate A explained, there could still be a team that does not believe in these practices and therefore they are not going to “hold the line every day in shelter and support trans* survivors” regardless of written policy.

Rossbert referenced a specific situation where gender inclusive protocols became extremely important. Rossbert explained that The Delores Project has housed clients who have noted that for religious reasons that they do not approve of people who identify as
transgender. Staff responded by explaining their policy, which staff presents to each client at orientation, clearly and directly. Staff explained to this client that everyone is entitled to their own opinion or belief however they cannot use that to bully other residents no matter what the reason. Rossbert explained that one caller expressed disapproval of trans* people. The staff explained to that caller that they provide an inclusive space for trans* and cisgender individuals and if this person disapproved they might not be a good fit for the program for this reason. Rossbert further explained that this response was given out of concern that this person would bully trans* residents, which did not align with the value of safety in a trauma-informed care facility. Rossbert explained that a trauma-informed care practice does not put the needs or safety of one client above the needs or safety of 59 other clients.

Smith explained that providing gender-inclusive services means understanding that trauma happens across all identities. Smith acknowledged that a gender-inclusive space also means that an abuser could potentially access the space if effective screening tools are not in place. Smith explained that when answering a crisis call, providers need to focus on the content of caller’s dialogue rather than their gender identity. Smith explained that at the Network/la Red, the staff uses a screening tool which consists of specific questions geared toward identifying the caller as an abuser or a survivor. The questions look for aspects such as, empathy, assertion of will, entitlement, and fear in the caller. For example, Smith said that although they are experiencing abuse, a survivor typically has empathy for their abuser and may justify their abuser’s abusive behavior based on something they did, whereas an abuser will not and often will blame their partner for their own abusive behaviors. Abusers typically feel entitled to have certain
responses or reactions from their partner, whereas a survivor does not typically feel entitled or deserving of anything. Most commonly, survivors are fearful of their partners, and abusers aim to instill fear in their partners.

To identify an assertion of will, staff may ask “how are decisions made in your relationship?” or “how do disagreements get resolved?” In the answers to these questions, staff looks for whether both parties feel like they can share their voice and that their feelings are validated or if one partner makes all of the decisions. In order to identify isolation, staff may ask, “Do you have contact with friends, family or other supports? How does your partner feel about that? Do either of you work or go to school?” Smith explained that staff looks for patterns and asked if these are incidents that have happened before and what was the aftermath? Smith explained that staff tries to identify whose life is getting smaller in the situation and then respond appropriately by offering a survivor services or referring an abuser elsewhere and explaining that this is not a service for them.

Advocate A explained that if agencies continue to lack development of trans*-inclusive policies, practices such as safety planning will not change and be inclusive, which typically is geared toward heterosexual, cisgender women. For example, calling 911 could be a dangerous plan for a trans* person because calling the police could turn into another violent situation for a trans* survivor. The service providers explained a variety of practices that they use to create an inclusive space. Beckham explained, for example, that Genesis House posts pride flags relating to gender and sexual identities on the bulletin boards within the shelter and provides various pieces of literature that contain images of many different kinds of people of different religious, ethnic, cultural, gender,
and sexual backgrounds. Beckham explained that the agency is conscious of including multicultural representations in a variety of aspects in the space.

Hodes explained that the agency has a zero tolerance policy for homophobia, transphobia, and racism from both staff and residents. Hodes explained that this information is provided at orientation. Disrespectful, discriminatory, and phobic comments made in support groups, social settings, or elsewhere in the shelter are not tolerated. Hodes explained that the agency terminates staff from their position if they engage in homophobic, transphobic, or racist actions. With residents, Hodes explained, the agency cannot just expel participants who make a homophobic, transphobic, or racist statement in groups. Instead, they use a mediation process to address discriminatory language or behavior with the client. Advocate A explained the importance of challenging teams to understand the appropriate and inappropriate uses of language and the significance of the impact on clients. She explained that in order to have an effective mediation process, the agency staff must have the understanding, knowledge, and value base that supports an inclusive space.

Rossbert explained that in her shelter, the agency understands that people may experience their first encounter with a trans* person, which is not an excuse to act in transphobic or discriminatory way. However, it is an opportunity to educate residents at the Delores Project with accurate information about the trans* community. Rossbert explained that understanding that this may be a resident’s first encounter is helpful in effectively providing education and information. Rossbert explained that staff is able to meet the resident where they are at in terms of the inaccurate information that they have
or the lack of information they hold altogether by addressing false information with accurate information.

Smith explained that no matter what their gender, how long they have known them, or whether they are an employee or a client, everyone is asked their pronouns throughout the agency. Smith explained that having gender neutral bathrooms in the agency is very important to the organization as a whole, as well. These practices respect every individual’s identity by allowing them to self-identify with every interaction, which can also prevent others from mistakenly misgendering or addressing an individual by the wrong pronoun, Smith explained. These practices are especially important for individuals who identify with a fluid gender identity and may have a different pronoun at different points of their life or depending on the day, Smith noted.

**Challenges of Implementing Gender Inclusivity**

Hodes explained that the issues and reluctance that surround sheltering trans* folks relate to the idea that including trans* people in shelters would open doors to serving cisgender straight men. According to Hodes, although it is not true that housing trans* people leads to housing cismen, service providers do not always explicitly acknowledge this underlying idea. The lack of an open discussion about the fears surrounding this idea inflates the problem as well, Hodes explained. Often misinformation about trans* people is at the root of the hesitation to or fears about housing them, Hodes explained. For example, there is a misconception that trans* women look like men and will bring a male dynamic into shelter, which leads to a false idea that men are trying to take up space. Hodes explained that from her experience of sheltering trans* women for the past 12 years, this is not the case. Hodes acknowledgeed that she is
only speaking from her own experience and said that the agency has sheltered trans* women that “run the gammet” in terms of different trans* female identities. Hodes further explained that the shelter’s trans* female clients vary in their appearance and in the ways that they prefer to approach communicating their identity to staff and fellow residents. Hodes explained that trans* women entering a shelter are not men trying to take up space or bringing in a “male dynamic,” rather they are survivors with an identity that is rarely included in the spaces that they need to be in order to survive.

Beckham built on the idea that misconceptions and lack of discussion about the fears associated with serving trans* people pose a major challenge for implementing gender inclusivity. To counter this obstacle, Beckham had a discussion with her staff to address the belief that because men “are bigger and stronger” they could pose a risk of physical harm to staff and other residents. Beckham acknowledged that if this is the reason that the agency is not housing men then they need to reflect on some of the women that they have sheltered. Beckham referenced some specific clients that were physically larger, had served prison time for physical assault, were capable of stabbing people, etc. Beckham then explained that if this is our logic then we need to screen these people out for safety reasons, rather than based on gender and its association to physical strength. If this is not the case, according to Beckham, screening for gender is discriminatory and unethical. Beckham’s example relates to the trauma-informed care values of safety and cultural, historical, and gender issues by addressing any legitimate physical safety concerns for physical assault and moving away from gender stereotypes that men pose a risk of physical harm because they are “bigger and stronger.” Beckham also utilized the trauma-informed care approach by evaluating the policy of restricting
services from male survivors for its purpose and rationale, which she identified as discriminatory, and recognizing the harmful impact of exclusion on male survivors (Guarino et al., 2009; Wilson et al., 2013).

Cohen added to the necessity for discussing fears by providing an example from her experience in creating an inclusive shelter service. Cohen explained that individuals that hold a shelter staff position state that they worry about how they will respond if they hear someone in the program making a homophobic or transphobic comment. Cohen acknowledged that this reaction is not a concern about how to respond but rather a lack of comfort in discussing the topics overall. Advocate A supported this statement by explaining that the panic that surrounds sheltering trans* people is rooted in discomfort around discussing sheltering trans* people with cisgender people. With the support of this example, Cohen explained the importance of staff discussing their fears, beliefs, and concerns in order to adopt values that support an inclusive shelter environment based in professional values and beliefs.

Hodes explained that a primary concern of the staff when beginning to shelter trans*women and gay cisgender men was for those clients specifically. Staff was concerned that because of the levels of violence and aggression that trans*women typically experience and because gay cisgender men were so visibly different, that there would be multiple incidents between residents based on lack of acceptance. Hodes explained that they had far fewer incidents than expected and the agency primarily found that other participants embrace both populations. Hodes attributed this reality partially to being a shelter setting and its message that all residents are equal as survivors of abuse.
Advocate B – the director of outreach, education, and training at a shelter program in Illinois – recognized the difficulty of effectively serving a population that is not being tracked. Advocate B explained that their agency has not been asking demographic questions about gender identity and sexual orientation. These data gaps inhibits the agency from identifying the rate at which they are denying services or ineffectively providing services to a particular population. Hodes explained that when the agency was preparing to shelter inclusively, they were most challenged by preparing for trans*men specifically. Hodes attributes this problem to a lack of exposure to the population and found that staff had the most questions about them, which is connected to the lack of data collected on the trans* population.

Advocate A was the former director of a safe home where they made significant progress and policy changes in becoming a more gender-inclusive shelter service for survivors of intimate partner violence and abuse. Advocate A explained that a flaw in their strategy was that they “pushed people really hard” toward gender-inclusivity. In reflecting on their work, Advocate A wondered if they created enough institutional buy-in or just bullied their way into shifting the policy. Advocate A acknowledged that at times they may have shamed members of the staff into admitting transphobic biases that are often held by every cisgender individual at some level. Advocate A did not suggest using a strategy that involves pressuring or shaming the organization’s staff into changing policies, values, or practice. Instead, Advocate A said that they recommend having value-based conversations, having open and honest discussions about fears, and addressing misconceptions as Hodes, Beckham, and Cohen also described.
Advocate A recognized how trauma-informed care can become an obstacle to implementing gender inclusivity and should be used cautiously. Advocate A explained that trauma-informed care can perpetuate transphobia and hold services back from being inclusive depending on the method that service providers use and discuss. From their work experience in training programs on becoming inclusive, Advocate A explained that a common fear of shelter programs is that they are unable to serve trans* folks or men because it will be “traumatizing for other survivors in a shelter.” This fear is based on the belief that a heterosexual cisgender woman who was abused by a man, for example, would be re-traumatized by sharing a space with a male survivor or a trans* female survivor that had male anatomy. Advocate A addressed this discriminatory argument by acknowledging that it is only applied to gender identity and that it feeds into transphobia. Advocate A explained that this argument is not applied to sexual identity such as, a lesbian cisgender women sheltered with other cisgender women, for example. This argument is only used for gender identity making it discriminatory against the trans* community. This argument also perpetuates transphobia by framing trans* people as harmful individuals who have the potential to re-traumatize individuals simply with their anatomy. For this reason, trauma-informed care and its goal to avoid re-traumatizing clients should be used cautiously when it comes to discussing gender identity and specifically the trans* population.

**Challenges: Fears About the Bathrooms and Bedrooms**

A common fear about housing different genders in the same space is the use of bedrooms and bathrooms. As mentioned previously, Hodes acknowledged that there is a misconception that trans*women are men trying to intrude on space meant for women.
Hodes explained that fear goes further with the belief that trans*women are “women dressed as men” and will assault a ciswoman in the bathroom. Hodes described that in her experience of supervising a gender-Inclusive shelter for the past 12 years that the agency has had “no problems with people respecting bathrooms and bedrooms.” Hodes discussed that the message that is spread throughout the shelter is that each client’s bedroom is their own space and no one is allowed to enter anyone else’s space without permission, knocking, or consent. The same idea goes for the bathrooms: the bathroom or the shower is each user’s own private space and not to be shared without consent. Hodes stated that staff explains this message to each client upon entering the shelter as a practice to ensure the respect, privacy, and safety of each client and their fellow residents. Hodes explained that each space is single use for this reason. Bedrooms are individual and have locks and keys and each toilet and shower is its own single-use stall with a lock as well. Staff can unlock from the outside only in the case of emergency, but otherwise the space is the client’s exclusively. Hodes acknowledged that the layout, physical space, and size of the shelter allow the agency to utilize these practices and that not all shelters have this ability, but they can implement the same message of respect and privacy.

Hodes further explained that when moving toward inclusivity, the agency decided to provide bathrobes for every individual. Hodes explained that wearing bathrobes encourages privacy and respect around bodies. For example, if a client needs to go to bathroom late at night or go between their bedroom and the bathroom before or after showering, the staff encourages residents to wear their robe for privacy and respect. Hodes reported that the robes are not gender specific. Rather they are neutral and equal across all identities, which also promote inclusivity and equality among residents.
The Delores Project is an example of a shelter that does not have the physical space and layout to enable the agency to provide individual bedrooms, but still serves both trans* people and ciswomen effectively. Rossbert explained that the bedrooms in the shelter are dorm-style. The shelter can sleep a total of 60 individuals each night. Two rooms hold up to 16 beds each with a mixture of twin and bunk beds. Rossbert explained that on evenings when they have an overflow of residents, which are most evenings, cots are set up in other rooms of the shelter such as the TV room or art room to accommodate as many individuals in need as possible. Rossbert acknowledged that it is not ideal to house so many people in that space. Rossbert recognized that ideally each resident should have their own bedroom and single bed and that most individuals would rather not share a bedroom with 15 other strangers or sleep above or below a stranger on a bunk bed, but they do the best with what is available.

Rossbert explained that although the set-up is not ideal, the staff works with each individual to identify and meet their needs as well as they can during their stay. Rossbert discussed the importance of recognizing and addressing the difference between discomfort and lack of safety when housing trans* people and cisgender women in dorm-style sleeping rooms. Rossbert explained that a trans* client who has had a bad experience previously in a shelter, for example, may feel safer in a sleeping room with more people around as witnesses. Or they may feel more comfortable in a smaller room with less people. Another example is an individual who lost their home in a fire may feel more comfortable in a spot of the room closer to the door. Or they may feel comfortable in a smaller room with less people to evacuate in the case of a fire.
Rossbert reported these examples as issues of safety because of a previous traumatic experience that relates to the trauma-informed care value of both physical and emotional safety. The example including the trans* individual with a bad past experience in shelters also relates to the value of cultural, historical, and gender issues. This example recognizes the historical trauma that trans* people often experience in shelters but does not assuming that they have experienced this because they are trans*. Rossbert further explained that an individual that does not want to share a bedroom or bunk bed with a trans* client because they “feel unsafe” or because they “do not agree with” their trans* identity, for example, is uncomfortable. Rossbert explained it is important to identify the difference between an issue of potential safety risk and discomfort with a new encounter to ensure that survivors have fair access to services. Regardless, the staff communicates with each client to identify their needs and accommodate them to the best of their ability.

Rossbert explained that single-stall bathrooms and showers as well as dorm-style bathrooms with multiple stalls in one room are available at the shelter. Rossbert explained that when a trans* guest comes in, staff explain that the single-stall bathrooms and showers are available for them to use and encourages clients to use whatever is most comfortable for them. This relates to the value of empowerment and choice in trauma-informed care. This is specifically communicated to trans* clients because the staff recognizes and understands the historical trauma that trans* people may have experienced surrounding the use of bathrooms, which relates to the value of cultural, historical, and gender issues.
Trauma-Informed Care Values: Safety

All of the participating agencies with the exception of one, My Sister’s Place, mentioned the value of safety. In trauma-informed care, safety is both physical and psychological. This value includes a commitment to nonviolence, which means that interactions do not include punitive or coercive interventions. Every agency that mentioned the value of safety identified a specific example in their practice where they prioritize safety and confidentiality. To promote emotional safety, Hodes explained that the workers “do not encourage [clients] to be completely vulnerable to each other right away.” For the Network/La Red’s Safe home, moving the safe house’s location after each resident’s stay heightens the chances of remaining confidential, which promotes both emotional and physical safety. As Smith and Rossbert identified earlier, 100% of their clients experience trauma prior to entering the shelter. Frequently, trust has been broken and can lead to danger for the individual. For example, if an abuser reads through a survivor’s computer history and becomes angry by what they find, the survivor may become at-risk of having the abuser to lash out at them. Another example is if an abuser convinces a survivor that the abuse they have inflicted is in the past and will never reoccur, but then the abuser assaults the survivor again. Maintaining confidentiality of the survivors’ status in the program and whereabouts is very critical to ensure they are physically safe from their abuser. Maintaining confidentiality also builds trust between the client and staff. Knowing that the staff will not share their very personal information and can ensure psychological safety for the client builds a level of comfort for them.

Practices that promote physical safety include 24-hour staffing in shelter and having a full alarm system (Ferencik & Ramierz-Hammond, 2013). For example, at most
shelters, a staff person is available at all times and all shelter windows and doors that lead outside are locked and armed with an alarm at all times. Hodes’ and Cooke’s shelters have a 24-hour staff person available and they lock all windows and doors. Cooke did not explicitly discuss measures of safety, but she did mention having a 24-hour staff person and locked windows and doors at the shelter. The remaining shelters did not explicitly mention this practice as part of their program, but they did not state that they did not use these safety practices. Residents are able to leave the shelter at any time, but no one is able to enter the shelter without preapproval. As reported earlier, physical safety includes single-stall bathrooms and showers with a lock on the door. Staff members can only unlock doors in the case of an emergency where an adult is unconscious in the bathroom or a child locks themselves in the stall. Otherwise, for each resident, when they are in the bathroom or shower, that is their personal space and should never be intruded upon. Four of the eight (50%) agencies definitively stated that they are able to provide single-stall bathroom facilities and/or bedrooms with locks and keys to residents. The remaining four agencies (50%) did not provide this information.

A common fear that surfaces in the discussion of gender-inclusive spaces is the misconception of a trans* person, specifically the false image of a “man dressed like a woman,” who will attempt to invade a private bedroom or bathroom space and assault a cisgender person. For example, North Carolina attempted to discriminate against trans* people by proposing bills such as House Bill 2 that require individuals to use bathrooms and changing facilities that correspond with the sex on their birth certificate (“General Assembly,” 2016). The argument for this bill is to “protect men, women, and children” when using a public space (CNN, 2016). This argument perpetuates transphobia and
promotes an irrational fear that trans* people are predators from which non-trans* people need protection.

Many of these shelters have been sheltering survivors of all gender identities for many years and none of the shelters identified this service as being an issue. Hodes explained that in the 12 years that her agency has sheltered trans* women, “we have no problems with people respecting bathrooms and bedrooms”¹⁰ (Catherine Hodes, personal communication, October 26, 2016). The single bathroom and shower stall practice has proven to be successful because it allows all residents the ability to use a facility that meets their comfort levels. Additionally, this practice demonstrates that the fear of trans* people as predators in the bathroom is irrational because service providers did not experience any assaults while housing different genders and using single-stalled or communal facilities. Although this study has a small sample size, it is worth noting that these gender-inclusive practices are being used without issues of assault specifically in the bathrooms by trans* people.

**Trauma-Informed Care Values: Trustworthiness and Transparency**

The following service providers mentioned this value: Cohen, Cooke, Smith, Rossbert, and Advocate B. This measure consists of being clear, upfront, and honest with survivors seeking services (Ferencik & Ramierz-Hammond, 2013). Providers should prioritize building trust and rapport, familiarize clients with trauma-informed care services, and avoid punitive actions or interventions. For example, at the Network/La Red, during the initial phone intake the staff explains that there are no 24-hour staff members at the safe home. Staff is clear and direct with the information and discusses issues that may be difficult to handle without staff in the shelter such as drug use or
abuse, psychiatric issues, or suicidal ideations. At the Delores Project, staff openly
discusses that the shelter is an inclusive space during the initial phone intake. This gives a
clear, transparent message that the organization does not condone discrimination. The
staff further explains what that means. For trans* clients, staff discusses bullying and
explains that the staff is there to support them, which also builds a sense of physical and
emotional safety. For cisgender clients, staff explains that this inclusive space means that
the caller could share a space with a trans* person and they ask how the caller feels about
that. The staff further discusses bullying and pronoun use in regards to trans* residents
and a no tolerance for transphobia in the facility.

Dove, Inc. provides each family, whether one individual or multiple people, with
their own bedroom. Cohen explained that each room can hold up to a family of five, but
Dove would never turn a family away because they have more than five members. Cohen
explained that staff is very honest and upfront about the capacity and space and recalls an
example that relates to this value with a male survivor seeking shelter. The staff was
upfront with the caller and explained that the shelter is gender inclusive and happy to
serve him, but wanted to inform him that they had not had a male resident in a long time.
These practices of trustworthiness and transparency roll into the value of empowerment,
choice, and voice, which are discussed in a later section.

At My Sister’s Place, there is a belief in the harm reduction approach. This is an
important belief and asset in building rapport and trust with clients. In my analysis, this
was not counted in the safety value section. Although Cooke discussed a belief in the
harm reduction approach, she did not explicitly discuss using the approach as concrete
practices and explained that this approach is typically used when treating individuals with
substance abuse issues. For example, a harm reduction approach can be taken with a pregnant woman who smokes cigarettes. Workers should not use punitive action because it will damage the trust between the client and worker that impedes successfully work on goals together. Instead, workers should attempt to make risky habits safer for the client by offering them less harmful options. This practice aligns with the value of trust and transparency because it does not use punitive interventions. For example, a staff member can encourage and support a client that is smoking while pregnant to decrease from three packs per week to two packs per week. This strategy is not to encourage the harmful behavior, but to meet the client where they are and work with them toward healthier behaviors. This approach also builds trust and rapport with the client by communicating that staff is on their side and willing to assist and support them through their challenges.

Cooke explained: although harmful, a behavior such as smoking while pregnant is serving that person in some way. Although an unhealthy form of stress relief, smoking is relieving stress in their very chaotic and complex situation. Many people do not want to do something that is harmful to themselves or others, but sometimes the behavior has a benefit that they do not feel that they could find in other ways. Change is difficult and can happen gradually.

**Trauma-Informed Care Values: Collaboration and Mutuality**

All of the participating service providers with the exception of one, Advocate A, mentioned the value of collaboration and mutuality. To maintain the value of collaboration and mutuality in trauma-informed care, clients and service providers should share decision-making power, base their relationship on respect, and focus on the individual’s strengths (SAMSHA, 2014). Hodes provided a related example from a
situation with housing a trans*woman. Hodes stated that the staff received questions about this person from others’ clients. The staff worked with that client, asked how they wanted to deal with it, and the staff supported this person in her decision. Hodes explained that staff asked the client how she wanted to handle it and recalls that the client participated in creating an appropriate space for herself in the shelter. The client chose to address the other clients directly herself. According to Hodes, the staff supported her decision, which worked quite well.

Hodes explained that staff promotes keeping appropriate boundaries and not becoming vulnerable with new people quickly among clients. Staff does, however, encourage residents to connect with each other through programming such as support group and art therapy classes over time. This example connects to the value of safety in trauma-informed care by promoting emotional safety to clients. “We encourage people to connect through the programming we have” while “encouraging respect for boundaries,” Hodes reported. “Art therapy [is] used to connect people to each other, particularly across differences. Doing that kind of connecting, creating that connecting community, creating opportunities to sort of, um, relate to each other in ways that bring down defenses and allow for vulnerability is crucial and that we find really the art therapy works amazingly for that” (Catherine Hodes, personal communication, October 26, 2016). Hodes discussed that basing relationships on respect can translate into building healthy peer relationships and is another way to practice collaboration and mutuality.

In addition to these examples, six of the eight providers identified utilizing strengths-based approach as a foundation of care, recognizing individual experiences, and including all identities as practices that align with the collaboration and mutuality value.
Although Advocate A did not explicitly discuss using practices that align with the value of collaboration and mutuality, they defined the value as using practices with an “egalitarian perspective; not like a power relationship model.” Cohen posited that it is important to be survivor-inclusive by obtaining the input and feedback from survivors of all demographics. Cohen further discussed that staff and survivors engage in collaboration when the survivors are a part of the process and shape the program.

**Trauma-Informed Care Values: Empowerment, Voice, and Choice**

All participating service providers with the exception of one, Advocate A mentioned this value. Practicing the empowerment, voice, and choice value in trauma-informed care means to recognize individual experience, build on and validate strengths, and believe in the client’s resilience (Ferencik & Ramierz-Hammond, 2013). Rossbert and Advocate B explained that their shelters’ approach views each resident as an individual and recognizes that they each have different adaptations and responses to trauma. Advocate B reported that these various systems of behavior and their adaptations are not a dysfunction, which connects to the trauma-informed framework of, “what happened to you, not what is wrong with you?” (Ferencik & Ramierz-Hammond, 2013).

Cooke discussed the importance of caring for people in a way that acknowledges that the experience they bring into the shelter will most likely differ for everyone even if they come in with a similar background, racial identity, religion, gender identity, etc. Beckham explained that part of the shelter staff’s role is to help the client pursue whatever path they feel is right for them. This approach encourages the client to voice their own desires and needs and allows them to choose their own path. Allowing choice empowers individuals to lead more confident, independent lives. Rossbert explained that
each individual can move toward stability on their own journey. Expecting every individual to achieve a stable living environment in 90 days, as the state of Massachusetts requires, which is the home to Dove, Inc., is not realistic. Beckham noted that these approaches work in part because every person has their own unique strengths and barriers that service providers must identify and consider when developing a stability plan.

Advocate B and Smith’s organizations take a “survivor-led” approach and encourage survivors to take control. A “survivor-led” approach means that service providers encourage their clients to advocate for their wants and needs, voice their opinion, and make the ultimate decisions for their situation. The goal of this approach is to promote independence, confidence, and empowerment in clients. Rossbert reported that her agency is re-evaluating their rules to ensure that they are providing the least restrictive environment, which allows for independent decision-making and aligns with promoting empowerment. Rossbert’s staff is currently examining their curfew rules to determine whether this rule is necessary and serves a purpose that benefits or hinders the clients’ progress. This practice utilizes the trauma-informed care approach by reviewing and assessing policies with a “trauma-informed lens” (Guarino et al., 2009; Wilson et al., 2013). According to Rossbert, they are evaluating policy options and intend to maintain curfew, but in a way that allows clients more autonomy and provides the least restrictive environment. Hodes stated that her agency aims to approach every action that they take “with an eye toward healing and empowerment” for clients. Beckham explained that to help promote empowerment, choice, and voice, clients are encouraged to cook their own meals, make a grocery list that the staff uses to purchases groceries for the house, and to ask for specific cultural items that could give them more comfort during their stay.
Hodes’ example from the collaboration and mutuality section in which residents asked several questions about a trans*woman that the shelter was housing also promotes empowerment and choice. Hodes recalled that the staff asked the client how she wanted to handle the situation. When the client decided to address the other shelter residents directly, the staff honored that choice and supported her during the process. This action empowered the client to make a decision that was best for her. For others, Hodes reported, disallowing conversation of her identity at all may be best, which the staff could support and enforce to the best of their ability.

Cohen explained that cultivating a space where survivors can have conversations and address each other is an important practice for promoting empowerment. In her agency, Cohen avoids setting up situations where staff is there to rescue a situation. Similarly, Hodes recalled instances when residents would like to address pronouns with staff or with other residents. Staff is open to this request and assists residents in this process, but they do not necessarily take this action for them. Rather, they support them in addressing the issue themselves. Of course, going back to what Rossbert described as a vital practice of checking in with the client to understand their needs, staff honors a client’s choice and clients are not forced into anything. Cohen explained that her staff aims to help individuals transform their challenges into their goals. For example, it may be a challenge for an individual to address a conflict they have with another client. With the assistance and support of staff, this challenge could be a goal for the client to learn how to address issues and resolve conflicts in a healthy and effective manner.

Rossbert reported that giving clients options promotes empowerment and choice. Cohen’s example from the trustworthiness and transparency section which describes an
instance where a male survivor called seeking shelter also promotes empowerment and choice. In this situation, the staff member was transparent and honest with the caller that the shelter is gender-inclusive and that they are happy to serve him, but wanted to inform him that the shelter currently has all women residents. The staff member gave the caller options. The staff offered to not make any mention to the other residents that he would be coming and/or let him address anything directly once he arrived or to inform the other women that he would be arriving. The staff also made sure that the client understood that no matter what his choice was, the staff would be supportive and assist him with handling any situation that arose. The client preferred to have the staff inform the women that a male survivor would stay in the shelter. Another example Cohen described in the previous section is informing a family of six or more that room sizes are made to fit a family of five. The staff will explain that they can still accept them, but are up front about the accommodations so that the family can make a choice. Cohen explained that having such large families seeking shelter, but the possibility exists and their described practice is designed to promote empowerment and engage in transparency.

To affirm people’s empowerment, Cooke explained the importance of caring for people using practices that do not control people and their decision making. Rossbert asserted that taking action that limits unnecessary power struggles promotes empowerment and choice. For example, when My Sister’s Place housed their first trans*woman, Cooke recalled that the client disclosed that she was transgender during her initial request over the phone. Once admitted to the shelter, she was given the choice about disclosing her identity to shelter residents. “It was no one’s business but her own to share that with people,” Cooke explained. The client identified as a woman and did not
disclose any other information about her identity to her fellow residents. Staff knew this information in order to support her choice and ensure that her privacy was maintained.

**Trauma-Informed Care Values: Cultural, Historical, and Gender issues**

All of the participating agencies mentioned this value. Practices that align with the value of cultural, historical, and gender issues involve moving away from cultural biases and stereotypes, making conscious efforts to avoid allowing biases to influence practice, offering services that address historical trauma, recognizing cultural influences, and utilizing cultural strengths and connections. The participants in this study were all staff members at shelter programs serving individuals and families that have experienced domestic and/or intimate partner violence. For this value, a key to success begins by recognizing the trauma that survivors of intimate partner violence experience historically, as Hodes did. Hodes noted that a variety of trauma responses, including post-traumatic stress disorder are prevalent among their service population. Hodes also reported that safety issues are a consistent concern, often due to their history of abuse.

Cohen reported that historically, trans* people often experience trauma by being discriminated against, harassed by, or excluded from shelter services. Cohen explained that shelter workers are the gatekeepers to shelter services and have the ability to turn people away from services. This policy has done a major disservice to the LGBTQ population, Cohen explained. Cohen’s report of the trauma that trans* people often experience is an excellent example of an agency being knowledgeable about historical trauma.

Rossbert explained that providing trauma-informed care means having cultural sensitivity, being aware of identities that people name for themselves, and acknowledging
the pieces of that identity. Advocate B reported that understanding cultural differences and respecting individuals’ identities – including gender, ethnicity, sexuality, and others – is essential to practicing in a way that aligns with this value. According to Beckham, people come to shelter with a plethora of secondary and tertiary issues, which may come from their background or cultural experiences. These identities and experiences can influence how the individual engages with the world.

Because they experience power and control differently, Hodes reported, power differentials differ for men and women. Smith expanded on this concept by explaining that one size does not fit all in this work, which means policies must allow for individual differences. Service providers need to know each survivor’s needs to develop a plan for change that will work for that client. These concepts connect to the issues value because culture, history or background, and gender will impact the way the client has experienced power and control, what strengths they hold, what needs are unmet, and the best route to fulfill those needs.

Smith explained that providers need to be aware of the multiple aspects of dealing with each community including how different populations can experience abuse. For example, a trans* or gay person may be threatened by their partner with outing their identity to others (Erickson-Schroth, 2014). This threat can be a form of abuse for this population that cis or straight individuals may not experience. Rossbert also reported as an example that consistently using the wrong pronoun with an individual is considered bullying particularly for trans* people. As another example, Smith explained, the importance of understanding how individuals can practice sadomasochism\(^{13}\) (SM) consensually and or how individuals can use SM as abuse. Smith explained that people
practice SM consensually by using safe words, establishing rules, etc. Smith asserted that violating the established rules or ignoring safe words is not SM. It is abuse. For example, Smith explained that it is important to understand the practices specific communities use to accurately identify an abusive SM situation.

Rossbert recognized the importance of understanding cultural, historical, and gender issues, while not making any assumptions based on that knowledge. Advocate A explained that an identity does not equal behavior. Beckham reported that an abusive situation is not the same for everyone and based on various internal and external factors, each individual will have their own unique barriers and reactions. Rossbert explained that being aware of triggers is important, but that does not mean “you’re part of this group so stereotypically you must have this as a trigger.” For example, Rossbert reported that for many trans* individuals the public restroom is a place of trauma where either they or a friend has experienced violence. This does not mean all trans* folks have had traumatic bathroom-related experiences or that they have the same comfort level surrounding a particular bathroom space, such as an individual single stall or larger bathroom with multiple stalls. This example relates to the value of cultural, historical, and gender issues because the staff members recognize the historical trauma that the trans* population could experience, but they do not assume that they have experienced this trauma based on their identity. These examples aligned with and connected to the trauma-informed care values of issues and safety were discussed earlier in the section on implementation of gender inclusivity. Agencies are gender inclusive by utilizing practices based in the trauma-informed care value of cultural, historical, and gender issues such as recognizing the potential historical trauma that trans* people often experience.
DISCUSSION

This study originally intended to investigate the use of trauma-informed care as part of treatment modalities for trans* people in shelter programs. The study found additional implications than the original purpose that highlight the benefits of using trauma-informed care practices when serving trans* people in shelter settings. Additionally, the findings revealed the aides and challenges to implementing trauma-informed and gender inclusive practices. Because the non-cisgender community is at high risk of experiencing violence and trauma, they display a high need for support services aimed toward recovery, which includes shelter (Choi et al., 2015; Miller et al., 2016; Grant et al., 2011). The significance of these findings is to highlight the lack of access to shelters for non-cisgender survivors of violence in need of safe shelter and to discuss achievable and effective implementation strategies to improve accessibility.

Although this sample size is small, I posit that based on the unanimous answers from service providers and the literature available that trauma is consistently found in the trans* population receiving shelter services (Mizock & Lewis, 2008, p. 337; Grant et al., 2011; Miller et al., 2016, p. 1). From these findings, I argue that trauma is a recurring and prevalent issue among the service population. Therefore, a treatment modality designed specifically to address the trauma that trans* people experience is necessary to effectively serve and benefit the population. With further research, social systems can identify and utilize the most effective policies and practices to serving trans* people with trauma histories in shelter settings.

The findings showed that all of the service providers from several regions of the country had an understanding of trauma-informed care, but that did not mean that they
necessarily used the practice in a trauma-informed way. Four of the eight agencies (50%) mentioned five of the five trauma-informed care values and three agencies (37.5%) mentioned four of the five values. One agency\(^{11}\) (12.5%) mentioned two of the five values. Although this sample size is small, this finding highlights that trauma-informed care is an emerging policy and treatment approach that has the attention of service providers.

A mention of a trauma-informed care value does not establish that shelters use trauma-informed care practices. In order to highlight the actual practices that the agencies utilize, I found specific examples of trauma-informed care practices that service providers described to further support the findings established by mentions. Seven out of the eight (87.5%) service providers stated specific examples of practices that align with trauma-informed care values. One service provider (12.5%), Advocate B, mentioned all five of the values but did not provide any specific examples of use of trauma-informed care practices at that agency. I believe that based on Advocate B’s interview, the agency may hold the trauma-informed care values, but do not implement them in practice and do not fully engage in trauma-informed care. Because the sample size is small, I cannot use these findings to generalize to other shelter programs serving trans* people. These findings can acknowledge that although an agency may believe in the values of an approach, they may not use them in their practice and are not truly utilizing trauma-informed care.

Although all of the service providers that participated in this study had an understanding of trauma-informed care and most used it to respond to their clients’ trauma histories, one agency, The Network/La Red understands the practice and
specifically chooses not to utilize it. Instead, they use a trauma-influenced approach, which is less clinical compared to trauma-informed care. This approach utilizes service providers who have their own trauma history, but are in a stable, healed place.

Although these approaches are different in theory, many of their practices are similar. Both approaches value “survivor-led” or empowering practices (Ferencik & Rameriez-Hammond, 2013). These approaches also recognize the strength in peer support and collaboration (Ferencik & Rameriez-Hammond, 2013). I argue that the trauma-influenced approach draws from a peer collaboration model because the staff at this agency have their own trauma histories and/or are LBGTQ-identified. The peer collaboration aspect in the trauma-influenced approach supports the idea that treatment modalities that service providers design specifically to address the client trauma are necessary. Additionally, the discussion of the trauma-influenced approach acknowledges that trauma-informed care may not be the only beneficial approach.

**Implications for practice**

This study contributes to the evidence that trauma affects the trans* population. For the trans* population, accessing shelter services is extremely difficult and is a barrier toward their recovery. In order to address this issue and to provide effective services, shelter services must utilize methods that integrate knowledge of traumatic experience, impacts of trauma, and the specific needs of trans* individuals (New York City Anti-Violence Study, 2014; Tobin et al., 2015). Trauma-informed care is emerging as one approach to address this issue. All of the service providers in this study were aware of the trauma-influenced approach, but they did not necessarily all use it in practice. For example, Advocate B understood trauma-informed care, but did not provide specific
examples as to how the agency uses the approach in practice and therefore, I argue that this agency does not practice trauma-informed care rather they only believe in its theory.

These findings point to a lack of trauma-informed practices and suggest that service providers should increase education and training. Education and training for service providers should focus on understanding strategies to effectively implement the trauma-informed care approach as a practice and how the approach may vary for clients of intersectional identities of race, class, age and gender. From a social work lens, it is imperative to provide services in a culturally competent way. The National Association of Social Workers (NASW) requires social workers to follow its Code of Ethics which includes a responsibility of being culturally competent (National Association of Social Workers, 2017). Additionally, education about best practices for clinical services related to trauma-influenced care should increase. With an increase in education, service providers can utilize the most effective and beneficial approaches and individualize them for their clients. To implement these practice implications, more research is required.

**Implications for policy**

To effectively serve the transgender population in shelter settings, simultaneous development of gender-inclusive policies and practices must occur and align with one another prior to implementation. Advocate A explained that a policy that includes all genders in their services is the ideal, but cannot be effective without the support of the appropriate training and education in shelters around implementing gender-inclusive policies effectively. The U.S. Department of Housing and Urban Development (HUD) recently expanded their ruling for inclusive housing because the previous rule did not address accommodations for trans* people in emergency shelters. The new law is being
finalized and explains that facilities using HUD funding cannot discriminate based on gender identity or because individual does not conform to gender or sex stereotypes (U.S. Department of Housing, 2017).

In addition to this ruling, individual shelter programs should adopt a gender-inclusive policy such as the one HUD developed in order to serve all populations in need. Shelter programs should especially adopt a similar policy if they do not receive federal funding because it would otherwise not be able to be enforced on a national level. Generally, policies should adopt the trauma-informed value of cultural, historical, and gender issues and implement its practice which minimizes stereotyping and biases. In this case, the policy moves away from the misconception and irrational fear that trans* people will assault cisgender people in sleeping spaces or bathroom facilities by including trans* people with full access to sleeping spaces and bedroom facilities that align with their gender identity.

Limitations

One of the main limitations in this study, which I discussed previously, is the small sample size and limited perspectives gathered for this study. I surveyed eight agencies through one service provider per agency. The participants were supervisors or directors of their programs, which means they were knowledgeable in the policies and services provided at their agency, but they are not necessarily providing direct services. Basing data on the perception of the service providers may be problematic because it could inaccurately represent the actual rate of trauma in the trans* population. Additionally, the services that the direct service workers provide may be practiced differently than the policies intend or state. This situation provides a limited perspective
on services and practices and leads to a recommendation of gathering more service provider and client perspectives for future research.

The measures and interview questions that I use in this study provide possible limitations. The measures are the five values of the trauma-informed care approach. The definitions of the values as stated in the Substance Abuse and Mental Health Services Administration are the basis for the measures and the recommendations for best practices by *Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs* support these definitions (Ferencik & Rameriez-Hammond, 2013; SAMHSA, 2014). Applying the value definitions to the practices that the service providers describe in the interviews can be subjective by the person applying them, me. In this case, my professional experience as a domestic violence shelter service provider and student of social work aids me in accurately applying the definitions. I am trained in trauma-informed care practices and utilize these practices in my daily work. Even with my co-workers, we are trained in the same way, but still practice with some individual variation because we are each different human beings.

However, my knowledge base is still limited and I may have missed some practices that should be linked to the trauma-informed care values. For example, I may have missed additional aspects of trauma-informed care practices related to identities of race or class rather than gender, which I focused on primarily. More than one interviewer trained in trauma-informed care may be beneficial to a future study to prevent missing any trauma-informed care aspects in the identification process assuming that each interviewer is trained and a system established to ensure inter-rater reliability. The interview questions, which did not specifically ask about intersections of race, age or
class as issues to accessibility to shelters for trans* people and mainly focused on gender, may have caused this as well. A more inclusive discussion and focus on intersectional identities in relation to trauma-informed care is recommended in the following section on future research.

The sampling procedures provide another possibility for limitations. I searched for agencies that were gender-inclusive, particularly for the trans* community and I utilized snowball sampling. Snowball sampling can be problematic to obtaining a diverse and representative sample because the participants have some connection to one another. Additionally, it was difficult to accurately identify shelters that practice inclusivity. Although an agency can advertise or be referred by another agency as inclusive, that does not mean that they appropriately practice inclusivity. For example, an LGBTQ organization referred one of the participating agencies as being welcoming and friendly to the entire community. While interviewing Advocate B for this agency, they explained that they do not have policies or practices in place related to serving trans* people yet. Advocate B explained that they are working toward these actions. This suggests that this agency advertises that they are inclusive by saying that they would accept an LGBTQ survivor. However, the agency has not done the work to ensure that it is realistically a safe and welcoming space that an LGBTQ survivor would feel comfortable contacting and entering.

Advocate B explained that the agency has served one genderqueer survivor. This is not to discredit the service that they provided to this individual, but to acknowledge that the way this individual presents to others or what their documentation said for their gender is unknown. Although unknown, based on the literature discussing frequent
discrimination and harassment in shelters, there is a chance that this individual identified as genderqueer, but presented female or had that identity on their documentation (Rooney et al., 2016). Because this agency explained that they do not yet have policies or practices to effectively serve trans* survivors suggests the possibility that this could be the case with this genderqueer survivor. The outcome for a trans* woman survivor who had male as the gender on their documentation or presented as a trans* woman or with any masculine features could have resulted in the survivor being denied shelter or being harassed or assaulted in shelter, based on the previous and common experiences documented by trans* people attempting to access shelters (Rooney et al., 2016).

**Recommendations for future research**

Based on this study, recommendations for future research would be to gather a more comprehensive set of perspectives from direct service workers and past clients. A direct service worker perspective can provide insight into whether they actually practice each policy that is in place. Because each individual service worker’s practice will vary slightly, it would be best to gather multiple direct service provider perspectives. Future research should also gather quantitative research that explores what service providers know about trauma-informed care in shelters because this study only collected qualitative data. Additionally, more than one interviewer trained in trauma-informed care would benefit a future study by helping to identify patterns of trauma-informed care values and practices in interviews. An additional interviewer would help ensure that the researchers did not miss connections between the interview content and trauma-informed care values for the data analysis. Past client perspective is extremely important to include the voice of the population that services are aimed to serve. This relates to the trauma-informed care
value of empower, voice, and choice (SAMHSA, 2014). This is a delicate situation to navigate because this population has experienced high levels of trauma. My recommendation would be to gather perspectives of trans* people who have received shelter services through public narratives such as, blogs, books, documentaries, etc. or an anonymous online so as to not disrupt the treatment and recovery process for survivors to heal.

The trauma-informed care approach and rates of violence against trans* people are topics that are under-researched, but that are emerging quickly (Miller et al., 2016). Generally, much more research needs to be done about the best practices for working with and treating trans survivors, For future research, my recommendation is to complete a study with a larger sample size and to focus on researching individual sub Populations with various intersectional identities of class, race, age and gender.

**Conclusion**

This study contributes to the limited literature on the trans* community, the issues they face, and the discrepancies in our services’ response as their visibility increases. Furthermore, this study provides important findings that suggest improvements that we can feasibly make as service providers. These findings show that service providers can safely house survivors of all gender identities in one facility by basing their practices in trauma-informed care values. Highlighting the successes of their work disproves the misconception that trans* people are predators in public spaces, which some believe is a major barrier to agencies providing inclusive practices. To improve services, these findings suggest an increase in research, education, and training of trauma-informed care policies and practices among service providers to ensure appropriate care. Service
providers should develop policies and practices simultaneously to ensure that policies function as intended in practice. Service providers should develop policies and practices with the clients’ best interest in mind. Additionally an increase in data collection about the LGBTQ community, especially the trans* community, independently can aid workers in providing effective services with sustainable effects. Future research should pay specific attention to identifying effective individualized treatment plans. Researchers should place a key focus on investigating the approaches to providing trauma-informed care to marginalized groups and intersectional communities of race, class, and gender to ensure that no communities are excluded from the services that are imperative to their survival.
Appendix A

Interview Questions

1. After this interview, may I contact you in the future with follow up questions, if needed?

ABOUT YOU
2. What is your role at your agency?
   a. What is your specific title?
   b. What are your responsibilities?
   c. Please indicate the level of anonymity that you would like to have in this study (i.e. Name, Job Title, Agency, or a combination of that information). You may remain anonymous in this study by indicating that is your choice. In that case, I will use a pseudonym when referring to your organization and will state the services offered by your program and the demographic served by your program.

3. How long have you worked in this position?
4. Have you always been in that position?
   a. If no, could you please speak to your experience in that position?
   b. How long were you in that position?
   c. What were your responsibilities?

5. What is your knowledge of trauma-informed care?

ABOUT THE AGENCY
6. Is your agency a trauma-informed care agency?
   a. If so, how does the trauma-informed care approach play a role in your work?
7. What kind of training does the staff at your agency complete?
   a. Please describe the content, nature, objectives, and frequency of the trainings.
8. How would you advise shelter programs that are making the transition to serving the transgender community and/or becoming a trauma-informed care agency?
9. How many transgender clients has your agency served (based on data available, in the past year or overall)?

10. Have you always served the transgender population?
   a. When did you begin actively serving the transgender population?
   b. What changes did you need to make in your practice and policies in order to effectively serve the transgender population?
   c. What resources and supports did you utilize to make these changes?

11. How are clients referred to your agency?

POLICIES

12. Please describe the policies and procedures surrounding the following topics and its relations to transgender people
   a. Sleeping arrangements
   b. Bathrooms
   c. Showers
   d. Harassment
   e. Non-discrimination
   f. Conflicts and resolutions

13. What is your staff’s interpretation of the policies your agency employs? How are policies and procedures and changes to them communicated to staff?

14. What model or information did you use in designing these policies and practices?

15. How often are policies and procedures reviewed and revised?

INTAKES

16. Could you please describe the intake process?

17. Is there any difference in the intake process used with a transgender client and a cisgender client?

18. May I receive a copy of some of the forms used with clients including a standard intake form?

19. What does the intake form say under the “gender” section?

20. What answers are offered to answer the “gender” question on the intake form?
21. How are the questions for the intake process administered? Are they read verbally to the client or does the client fill out a form? If read verbally, how do you ask their gender? (if direct service provider)
   a. If not direct service provider, ask to speak with direct service provider or ask how this individual expects their direct service provider to ask the question in the most appropriate way.

ABOUT CLIENTS
22. Please tell me about your understanding of the experience of the transgender people that you have served as your agency, providing their gender identity, but without giving identifying information:
   a. Were there any issues that came up these clients? Please give a summary of the situation.
   b. How were the issues handled?
   c. Who was involved in the situation initially, during, and after?
   d. What did staff do?
   e. What policies and procedures did you fall back on in resolving the issue?
   f. What policies and procedures do you have to address conflict between residents and/or conflict between residents and staff?
   g. What policies and procedures do you have in addressing harassment and violence in shelter?
   h. How is working with a transgender client different than working with a cisgender client?
### Appendix B

**Participating Shelters Agencies that Serve Transgender Survivors of Violence**

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Agency Description</th>
<th>Location</th>
<th>Job Title</th>
<th>Job Description</th>
<th>Years Position Held</th>
<th>Previous Work</th>
<th>Years in Previous Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Hodes, LCSW</td>
<td>Community-based domestic violence (DV)/intimate partner violence (IPV) shelter; small congregate care; specifies services for LBGTQ survivors</td>
<td>Brooklyn, NY</td>
<td>Program Director</td>
<td>Programming, grant writing, staff supervision, ensure staff is trained, ensure services are in line with mission</td>
<td>10</td>
<td>Clinical Supervisor</td>
<td>10</td>
</tr>
<tr>
<td>Jessica Cohen Dove, Inc.</td>
<td>Emergency DV shelter; 6 bedrooms, 18 beds communal kitchen, living room, and dining room; first call of the day is first served; referred by the Network/la Red as trans-inclusive</td>
<td>Quincy, MA</td>
<td>Senior Manager of Residential Services</td>
<td>Oversee all programming, protocols, and staff of shelter</td>
<td>6</td>
<td>Bachelor’s Degree in Clinical Trauma</td>
<td>N/A</td>
</tr>
<tr>
<td>Kelly Cooke, My Sister’s Place</td>
<td>Emergency DV shelter; 4 bedroom, 10 bed facility</td>
<td>Athens, OH</td>
<td>Executive Director</td>
<td>Grant writing, fundraising, staff supervision, liaison to Ohio DV Network to ensure using best practices and up-to-date with state coalition</td>
<td>5</td>
<td>Counselor</td>
<td>N/A</td>
</tr>
<tr>
<td>Name</td>
<td>City</td>
<td>Title</td>
<td>Experience</td>
<td>Role</td>
<td></td>
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<tr>
<td>Advocate A, Safe home</td>
<td>CO</td>
<td>Former Director</td>
<td>N/A</td>
<td>Significant advocate and change agent in creating a more gender-inclusive shelter program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laura Rossbert, The Delores Project</td>
<td>Denver, CO</td>
<td>Deputy Director</td>
<td>&gt;1</td>
<td>Responsible for the internal management of organization and ensuring that program is in line with mission and values</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Kishana Smith, The Network/La Red</td>
<td>Boston, MA</td>
<td>Safe home Coordinator</td>
<td>6 months</td>
<td>Hotline coverage, initial intake process, assist with long-term housing/employment goals, advocate for survivors</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- Safe home, hotel room, location rotates to ensure confidentiality; can only serve one survivor at a time due to confidentiality and funding reasons; “as far as I know we are the only program in this state that does it this way”; explicitly states gender-inclusive services on website and named as model for gender inclusive care by other shelter services.
<table>
<thead>
<tr>
<th>Advocate B, Shelter services for survivors of DV/IPV</th>
<th>IL</th>
<th>Director of Education and Volunteer Coordination</th>
<th>Recruit, train, and supervise direct service volunteers for agency programs</th>
<th>15</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Beckham, Genesis House</td>
<td>Lorain County, OH</td>
<td>Executive Director</td>
<td>Grant writing, liaison to Board of Directors and community leaders, guide the philosophy and programmatic development of agency, ensure continuing education of professional development in staff</td>
<td>4</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Appendix C

#### Demographics of Participating Shelters’ Service Population

<table>
<thead>
<tr>
<th>Client Demographics</th>
<th># of LGBTQ survivors sheltered</th>
<th># of cisgender heterosexual male survivors sheltered</th>
<th>Rational for # served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Hodes, LCSW</td>
<td>15-20 trans<em>women 2-3 trans</em>men</td>
<td>None</td>
<td>“Probably a matter of outreach and the fact that people don’t know that the services are there”; potentially more trans*men in shelter space that are not out in interest of personal safety</td>
</tr>
<tr>
<td>Jessica Cohen, Dove, Inc.</td>
<td>2 transgender people 1 gay cisgender man</td>
<td>Unknown; received calls from hetero cisgender men, no space available when called and serve in community office</td>
<td>“Which might sound like a very small number and yes it is, but also just be mindful that people stay with us for up to a year and a half so our turnover for our population is not that high”</td>
</tr>
<tr>
<td>Kelly Cooke, My Sister’s Place</td>
<td>1 trans*woman (identified as woman)</td>
<td>None</td>
<td>Not known in the community as LGBTQ-friendly shelter; recently receiving more calls from non-cisgender heterosexual</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Name</th>
<th>Serves all LGBTQ survivors; primarily trans* people or gay male survivors</th>
<th>Unknown</th>
<th>Other shelters are more prone to accept more people from our communities rather than gay men or trans people; Ex. lesbian women can likely walk into any shelter and have higher change of getting in than trans person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kishana Smith, The Network/La Red</td>
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<tr>
<td>Laura Rossbert, The Delores Project</td>
<td>Many trans*women (did not provide exact #)</td>
<td>None</td>
<td>Explicitly states that services provided to trans*women and women</td>
</tr>
<tr>
<td>Advocate A, Safe home program for survivors of DV/IPV</td>
<td>Could not provide this information because no longer at agency; was moving toward gender inclusivity and accepting survivors outside of heterosexual cisgender women</td>
<td>None</td>
<td>In early stages of becoming gender inclusive</td>
</tr>
<tr>
<td>Advocate B, Shelter services for survivors of DV/IPV</td>
<td>Sheltered LBQ survivors, no trans* survivors 1 genderqueer survivor</td>
<td>None</td>
<td>“Hard to have clear number of the survivors we’ve served who identify as LGBTQ because we have not asked those questions”; this is an</td>
</tr>
</tbody>
</table>

female survivors and making efforts to be more inclusive
area that “we are working on now”; the goal is to provide equal access to trans*women and men

<table>
<thead>
<tr>
<th>Virginia Beckham, Genesis House</th>
<th>&gt;10 LGBTQ survivors (mostly lesbian women and gay cisgender men)</th>
<th>1 trans* youth (child of female survivor)</th>
<th>&gt;10</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>“People still don’t know that we serve all these different people no matter how many times we say it and we try to say it everywhere we go”</td>
</tr>
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</table>
Appendix D

Service Provider Use of Trauma-Informed Care Values

<table>
<thead>
<tr>
<th></th>
<th>SAFETY</th>
<th>TRUST.</th>
<th>COLLAB.</th>
<th>EMPOWER.</th>
<th>CULT./HIST./GEN ISSUES</th>
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<tbody>
<tr>
<td>DV/IPS SHELTER</td>
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<td>DOVE, INC.</td>
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<td>MY SISTER'S PLACE</td>
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<td>THE NETWORK/LA RED</td>
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<tr>
<td>THE DELORES PROJECT</td>
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<tr>
<td>ADVOCATE A</td>
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<tr>
<td>ADVOCATE B</td>
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<tr>
<td>GENESIS HOUSE</td>
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</table>
References


Endnotes

1Transgender is an umbrella term for people, whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth, including but not limited to people who are transsexual, who cross dress, who are androgynous, who are genderqueer, and who are gender non-conforming. Transgender is a broad term and is good for providers to use (Mottet & Ohle, 2003).

2Gender non-conforming is a term for individuals whose gender expression is different from the societal expectations based on their assigned sex at birth (Mottet & Ohle, 2003).

3Trans* is an abbreviated term that will be used throughout this paper to mean transgender and gender non-conforming.

4Trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014).

5Cisgender is a term for someone who exclusively identifies as their sex assigned at birth. This term is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life (LGBTQ Definitions).

6A subtle but offensive comment or action directed at a minority or other nondominant group that is often unintentional or unconsciously reinforces a stereotype; the act of discriminating against a nondominant group by means of such comments or actions (“Microaggression”).

7The Violence Against Women Act (VAWA) was reauthorized in 2013 to continue to provide and improve advocacy, services, and support for all victims of domestic violence,
sexual assault, dating violence and stalking (National Network to End Domestic Violence, 2013).

8For the purpose of this study, a “mention” is constituted as a fragment of or a full sentence discussing the value or a phrase discussing the value stated multiple times i.e. “we promote safety” or “self-determination.”

9Misgender is defined as a verb “to refer to or address (a person, especially one who is transgender) with a pronoun, noun, or adjective that inaccurately represents the person’s gender or gender identity” (“Misgender”).

10The topic of bathrooms and bedroom spaces will be further discussed on page 51.

11The interview with Advocate A mainly focused on the service provider’s past experience as a former safe home director and a change agent toward gender inclusivity. The content of this interview primarily contains information about implementation strategies toward gender inclusivity, which may have caused this agency to only mention two of the five values.

12Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use (Harm Reduction Coalition, 2017).

13Sadomasochism is “the interaction, especially sexual activity, in which one person enjoys inflicting physical or mental suffering on another person, who derives pleasure from experiencing pain” (“Sadomasochism”).