Translatina Immigrant Mental Health Wellness: Suggestive Intervention Strategies the City of San Francisco Should Consider Adopting

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Translatina Immigrant Mental Health Wellness: Suggestive Intervention Strategies the City of San Francisco Should Consider Adopting

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The abuses that trans immigrant women suffer at the hands of government agents and authorities in this country continue, just as past decades have documented. Trans immigrant women also remain deeply marginalized and in need of mental health services to achieve wellness. In 2012, I began researching the intersections of immigration, crimmigration, and gender, during and after participating in a seminar taught by the brilliant Annick T.R. Wibben. I thank her for being my friend and mentor; inspiring me; believing in me; challenging me to critically question my own socialized notions of gender, race, security, war, violence, and feminism; and helping me turn on my “feminist blinkers” and fight for gender equity, truth, and justice.

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ABSTRACT

Translatina immigrants in the United States often suffer from intersectional traumas due to their race, gender, sexual orientation, religion, and immigration status — putting them in a vulnerable position socially, psychologically, economically, and medically. Due to their positionality in the intersections of migration, criminalization, cissexism, and mental health, they are often more marginalized and have greater needs than communities with privileged sociocultural identities. As a particularly vulnerable group, they need guaranteed access to gender-affirming healthcare that is inclusive of mental health services. Despite Translatinas’ need for mental health services, there exist many barriers making services inaccessible and insufficient in San Francisco, particularly limitations of low budgets, a shortage of culturally responsive practitioners, and limited affirming justice-based policies.

Through a semi-structured interview process and utilizing a thematic analysis as a qualitative research approach, I interviewed three transgender-identified individuals, I analyzed Translatina wellness, liminal legality, and limited access to culturally responsive practitioners, and the barriers Translatinatas face in obtaining necessary mental healthcare. This thesis explores navigating San Francisco as a Translatina immigrant - shared realities, collective experiences and needs, desire to obtain mental health services, and suggestions for accessibility for services to help them rebuild their lives and obtain ultimate wellness. I transcribed their interviews and analyzed their interview responses using open coding and thematic analysis methods. By exchanging critical reflections and dialogue between government and non-government actors, all transgender, this thesis acts as an intervention, culminating with suggestive strategies the City of San Francisco should consider adopting to respond to the barriers Translatinatas face in accessing mental healthcare. This thesis seeks to enrich policy by advocating for San Francisco to fund the local non-profit organization El/La Para Translatinatas to provide in-house culturally responsive psychological services for Translatinatas that are free, gender-affirming, accessible to the participant’s preferred language, and forge a safe space.

Aspirations for such city-funded services are inspired by work led by the organization Schwulenberatung Berlin, in Berlin, Germany. Its LGBT Refugee Center offers psychosocial services, legal aid, a safe space, housing, and other resources to LGBT refugees. All these services are partly funded by the German government.

In a period of time when demands for the city to divest funds from heavily-funded programs such as the police and reinvest into community programs, this thesis is written in a tone of urgent advocacy on behalf of Translatinatas. The psychological services advocated herein will create a platform for Translatina immigrants to rebuild their lives in a new country, obtain legal status, overcome extreme emotional and psychological hardship, and develop themselves into agents over their own lives, having access to such services that establish wellness may best equip them for success. More importantly, it can be a stepping-stone for other transgender women, and it will be a stepping-stone for the rights of the transgender community worldwide.

KEY WORDS: TRANSWOMEN; TRANSGENDER; TRANSLATINAS; MENTAL HEALTH; MENTAL HEALTH SERVICES; IMMIGRATION; IMMIGRANTS; ASYLUM-SEEKERS; ASYLEES; SAN FRANCISCO; LGBT; LATINX; MINORITY HEALTH; TGNC
PREFACE

In the Spring of 2013, I participated in a seminar focused on women, violence, and war. My paper for the course researched human rights abuses by Border Patrol and other government agents committed with impunity against migrant women along the U.S.-Mexico border. The abuses extended to women, including trans women, inside immigration detention. In my research, I encountered stories and videos of the horrific violence that transgender immigrant women experience inside detention – from medical and psychological neglect to sexual violence. One of these videos spotlighted a detained trans woman who was held in a detention center for “men” and had been in isolation for an extended period. U.S. Immigration and Customs Enforcement (ICE) officers alleged that isolation was for her own “safety and protection,” as she was “vulnerable” to the other detainees. The woman disclosed that she was not safe nor protected in isolation and that those she was harmed by were the detention center guards. They had violated her.

I remember feeling outrage and shock while I watched the woman’s interview, realizing the sheer cruelty and inhumanity that prison guards and the immigration apparatus inflict on all migrants but especially on trans people – individuals who flee their home countries and arrive at the United States seeking protection. Pursuant to international treaties, all people who fear for their lives have every right to seek asylum and be processed with dignity and protected. Not only is violence against migrants and detainees in direct violation of international human rights laws, such

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1 In this thesis, the terms transgender woman/women, trans woman/women, and woman/women are used interchangeably. The terms trans and transgender are also used interchangeably, with trans being a shortened version of transgender. Transgender is an umbrella term that refers to people whose gender identity or expression differs from the binary sex (“female” or “male”) assigned at birth. Some activists and academic also use the term trans* with the asterisk at the end to include individuals who do not conform to a single gender or gender expression. For visibility purposes, this thesis does not use the term trans* and instead refers to individuals who do not conform to a single gender or gender expression as Non-binary (NB) or as Gender Non-Conforming (GNC); see terminology section (UC Davis 2020; Martinez-San Miguel & Tobias, 2016; Grant et al., 2011; Xavier, Honnold, & Bradford, 2007; Gowin et al., 2017: 322). Gender identity refers to an individual’s deeply felt sense of identification with a particular gender, as male, female, or as something other than or in between these binaries. Gender expression refers to the external manifestation of an individual’s gendered self (e.g. through dress, mannerisms, speech patterns).
as the Universal Declaration of Human Rights and the United Nations (U.N.) Convention Against Torture (CAT), but the violence is a continuum\(^2\) of sexual, physical, medical, and psychological violence and abuse that trans immigrants are already fleeing. Even more disconcerting is that in addition to detainees experiencing sexual violence inside detention, several trans asylum seekers have died while in ICE custody because of medical neglect. Considering all these abuses, I became committed in my academics to exposing such violations, advocating for trans immigrants’ wellness, and helping represent trans women in the legal field as they seek safety and legal protection.

As the gross violations garnered media attention, ICE conducted “efforts” to provide “dignity” and “safety” to trans migrant women through establishing trans-only detention facilities in Santa Ana, California, and later one in New Mexico; both contracts were terminated during the writing of this thesis. ICE’s attempts were futile. Trans migrants continue to suffer abuse, negligence, and human rights violations at the trans-designated detention centers and at co-ed center. These abuses are supported in the literature review and in two of the interviewees’ experiences, which are discussed in limited detail in the findings section.

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\(^2\) The Oxford English Dictionary provides two meanings for “continuum,” the one used here is: ‘a continuous series of elements or events that pass into one another and cannot readily be distinguished’ (Kelly, 1987). Liz Kelly adopted the concept of ‘continuum of sexual violence’ to describe the extent and range of sexual violence in women’s lives. The meaning above enables documenting and naming the range of abuse, coercion, and force that women experience, which when discussing a continuum of violence, “shade into and out of a given category such as sexual harassment, which includes looks, gestures, and remarks, as well as acts which may be defined as assault or rape… the concept is intended to highlight the fact that sexual violence exists in most women’s lives… and should not be seen… as a linear straight line connecting the different events or experiences” (1987:48). She further argues that there are forms of sexual violence experienced by most women in their lives, which are also more likely to be experienced on multiple occasions (1987:49). Also applicable is Cynthia Cockburn’s concept of the ‘continuum of violence’ through which she offers a feminist analysis of gender as a means to observe the functioning of gender as a relation, and a relation of power, that compounds other dynamics. She argues that there is a connectedness between kinds and occasions of violence; that gender links this continuum of violence at different points on a scale, from the personal to the public and to the international, and that it runs the continuum runs through the social, economic, and political (Cockburn, 2004).
The continuum of (sexual) violence that trans migrants experience while in immigration custody often continues post-release. They may be exposed to societal and governmental cissexism and heterosexism in the forms of gatekeeping, which includes lack of access to medical and psychological assistance, physical and psychological violence, harassment, discrimination, and houselessness. Immigration authorities including immigration judges, government attorneys, and immigration officers who have jurisdiction over migrants’ cases often reinforce this violence. This continuum of (sexual) violence continues through legal codes that criminalize trans women’s sexual behavior and subject them to discrimination by police. It is also exacerbated by high rates of houselessness, domestic violence, and unemployment within the trans community, all part of the systemic violence against trans people. In this continuum and in the aggregate, the stresses and suffering trans migrants endure pose serious risks to their mental and physical health.

Mental health is an integral and essential component of a person’s health (WHO, 2018), especially for trans migrants. The World Health Organization (WHO) defines mental health as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to their community (2020). According to the WHO, “health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (italicized for emphasis, Id). The World Medical Association (WMA) considers that health is a basic need, a human right, and one of the essential drivers of economic and social development (2018). Further, that prioritizing the care of human beings is above any other consideration or interest (italicized for emphasis, Id). The importance of access to healthcare, including mental healthcare, is also discussed in various United Nations treaties and international organizations’ constitutions.
Despite international organizations and treaties advocating for the defense of human rights, dignity, and the combatting of pain, suffering, and illness of migrants and refugees, mental health remains largely inaccessible for trans migrants. In San Francisco and elsewhere in the United States, Translatinas, trans migrants, and trans people of color are disproportionately affected by their government’s limitations in granting them access to necessary care. Mental health is rather a privilege, mostly accessible to people of a certain upper socioeconomic standing and citizenship.

I first witnessed this reality in 2015 while working as a paralegal at an immigration firm in San Francisco where I assisted Translatinas seeking protection from deportation. Upon their requests, I referred them to organizations and clinics serving immigrant and LGBT+ communities with mental health services. Even with my referral, my clients were unable to find an organization that could provide culturally responsive, free, and immediate mental health services. They often expressed disappointment in their inability to find a space that provided one-on-one psychological therapy and therapy for Translatinas from Translatinas, important to them because they wanted to be serviced by people who identified with them, and because group therapy could sometimes be triggering. The spaces they did find were for the general LGB community or spaces that primarily serviced cis-gender women. My clients were unable to obtain services there because they did not feel comfortable entering spaces not specifically for trans women. In an interview,

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3 The term Translatina was originally coined by Alexandra Rodriguez De Ruiz, an activist for transgender Latina women, co-founder of El/La Para Translatinas, and former El/La Program Coordinator. In her reflections on coining the term, she recalls finding it difficult to refer to the program’s participants as “transgender” or “transwomen” or “trans girls,” and decided to call them “Translatina,” honoring that they all spoke Spanish and were immigrants from Latin America. (Rodriguez De Ruiz & Ochoa, 2016: 162). For Rodriguez De Ruiz and the program’s participants, the term Translatina became a way of empowerment and a way of including and giving visibility to a marginalized community, giving them space and respect, and recognizing them as a group of women with many challenges and walls to “tear down” (Id). Rodriguez de Ruiz, as Translatina herself, understood that the issues Translatinxs face are not just about language, culture, or documentation, but about issues within the LGB community as well (Id). Today, the term Translatina is internationally recognized.

4 An acronym for “lesbian, gay, and/or bisexual.” This thesis uses the term LGB given that trans inclusion is not ubiquitous as organizations remain largely LG or LGB (Enriquez, 2016: 147). This is a symptom of the transphobia and cissexism that remains today, even within the LGB community. Note: Trans people also have sexual orientations and may identify as heterosexual or LGB+. Sex and gender, although often confused with each other, are different.
Alexandra Rodriguez De Ruiz explains that her Translatina participants at El/La Para Translatinhas (“El/La”) her faced similar experiences and barriers when attempting to access services from organizations serving the general LGBT community: the women found that despite the organizations and groups serving the LGBT+ community generally, the staff, service providers, and the participants we primarily gay men. According to Rodriguez de Ruiz, Translatinhas did not want to be serviced alongside or by primarily gay men because they are trans women and there is no way they would go with the gay men (Rodriguez De Ruiz & Ochoa, 2016); they did not feel welcome to take up space and were afraid of being misgendered. At El/La, the women “knew [it]… as their space and it was for them. When they started coming… they saw that they were… treated with respect” and with humanity (Rodriguez De Ruiz & Ochoa, 2016: 160). More than a clinical space, El/La today exists as a place where the participants can build community and connect with other trans women on a humane level.

El/La remains the single organization working specifically with Translatinhas and led by Translatinhas in San Francisco. Due to its leadership in the community, and the trust the community has on El/La, it is the ideal organization to provide psychological services. This thesis will discuss the organization El/La Para Translatinhas as a suggestive place for intervention, its role as the sole organization providing Translatinhas with resources, and suggestions for the city to assist El/La transition from an HIV-prevention organization to address individuals holistically. Achieving psychological wellness will help Translatinhas heal, develop their own agency, thrive, cope with the normal stresses of life, work productively, contribute to their community, and rebuild their lives. Beyond merely obtaining therapy, it became clear while developing this project that there is also a need for a Translatina-only space where they can access other services in addition to therapy.
As cissexism and heterosexism continue to dominate academia, psychology, law, and social justice, this thesis situates itself as an intervention, uplifting and amplifying Translatina voices to determine their needs and provide recommendations to a city whose government it feels does not prioritize them. This researcher/advocate hopes the City and nonprofit organizations will collaborate to abolish systems of oppression that continue to abuse, criminalize, and incarcerate queer and trans communities of color. By abolishing these systems and creating affirming policies, Translatinlas will be in a better position to improve their psychological wellness.
“If you are not part of the solution, you are part of the problem.” - Eldridge Cleaver

“If you have come to help me, you are wasting your time. If you have come because your liberation is bound up with mine, then let us work together.” - Lila Watson

CHAPTER I: INTRODUCTION

For the United States, the year 2020 will be remembered as a year of reckoning with racial injustice, a year that has revealed the racial and gender discrimination that Black, Indigenous, and Persons of Color (BIPOC), especially those who identify as transgender or gender non-conforming (GNC) have faced. In 2020, nearly 400,000 people died in the United States due to COVID-19 (Stone, 2021) and reportedly, more than 350 were killed globally for their identity as trans/GNC (Wareham, 2020). For trans people and those fighting for human rights, it was the culmination of four years of a Trump Administration which was for lack of a better word, a nightmare of “epidemic of violence” (Heyward & Wood, 2020).

Besides inciting violence against trans/GNC people, former President Trump and his administration had an agenda to eliminate trans rights across healthcare, employment, and the government. His attempts included “erasing” trans people from the law by ordering the Department of Health and Human Services (DHHS) to determine sex through DNA tests (Crary and Alonso-Zaldivar, 2018), banning trans people from the military, removing non-discrimination protections for trans people in healthcare, and attempts to roll back protections for trans people in federal prisons and those in homeless shelters (Falulu, 2020).

For immigrant trans people, the U.S. government denies them rights both inside and outside of immigration custody. Although xenophobia, transphobia, and (cis)sexism within the immigration apparatus pre-dates the Trump Administration, it was exacerbated by its policies and negligence, which continue and have lasting legacies. Independently of the administration in
power, immigrants, especially trans migrant asylum seekers who flee to the United States seeking protection, are abused and threatened by violence perpetrated with impunity inside immigration detention by inmates, prison guards, and wardens (Aizura, 2016). Inside immigration detention, trans migrants are notoriously dehumanized, abused, and killed. Most trans women are detained at detention centers for men, which is dangerous and detrimental to their physical and mental health. The neglect they face while in U.S. Immigration and Customs Enforcement (ICE) custody includes denial of necessary access to hormones and medical treatment, leading to the deaths of several (reported) trans women in detention. In May 2018, a Honduran trans woman named Roxsana Hernandez became the 6th person to die in ICE custody (Cook, 2018) due to medical neglect. ICE held her in an infamous *hielera* (“ice cooler”), a torture tactic they employ, where she developed pneumonia (Chavez, 2018) and suffered from HIV-related complications (Cook, 2018).

Separately from immigration custody, trans migrants are also at risk of being denied protection due to transphobic adjudicators in the Executive Office for Immigration Review (EOIR) or U.S. Department of Homeland Security (DHS). Evidencing this reality, on November 12, 2020, a coalition of legal service providers, community members, the San Francisco Public Defender, and the National Lawyers Guild in the San Francisco Bay Area filed an EOIR complaint against San Francisco’s Immigration Judge Ford for “terrorizing the immigrant community” (NBC Bay Area, 2020) and being prejudiced against Black, Brown, and trans/GNC people. Judge Ford was appointed by U.S. Attorney General William Barr in May 2019 (*Id*). Another complaint against him alleged he used incorrect pronouns for a transgender immigrant and asked one who was testifying about being tortured by police whether “anyone ever insert(ed) anything into your ass in custody” (Kopan, 2021). Despite a new Biden Administration, Trump-era practices, policies, and appointees will continue to impact and have power over trans asylum seekers and their access to
protection. Immigration judges are appointed for life and, unless Biden reforms the system, they will remain in office (Id).

The United States’ anti-immigrant policies and tactics place migrants at greater risk of developing medical and mental health-related concerns. Being forced to “leave their home countries... in some cases is a matter of life or death” (Tabak and Levitan, 2014, 8). LGBT asylum seekers already “have a higher incidence of sexual violence, persecution occurring during childhood, persecution by family members, and suicidal ideation” (Hopkinson et al., 2017: 1650). Instead of welcoming trans migrants with access to psychologists and resources to transition into gender-affirming lives after they have fled their homes and darkest memories of trauma (Cheney et al., 2017; Gowin et al., 2017), trans migrants often find themselves being terrorized, abused, criminalized, and persecuted while in the United States. Facing discrimination, harm, and threats from recipient societies and governments greatly damages LGBT asylum seekers’ psychological, medical, and physical wellbeing. This exacerbates the hardship these individuals already experience, placing them at greater risk of suffering depression, anxiety, Post-Traumatic Stress Disorder (PTSD)\(^5\), anger, and helplessness (Rainbow Health Ontario, 2015).

The adverse experiences trans migrants, particularly Translatin\(\)as, face cause them significant stress, distress, and harm. Despite coming to the United States to seek asylum, they face the most marginalized reality compared to cisgender\(^6\) LGB+ migrants. The issues Translatin\(\)as face are not just about issues of language, culture, or documentation, but include many of the other issues that other LGB groups experience as well (Rodriguez De Ruiz & Ochoa, 2016).

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\(^5\) According to the American Psychiatric Association’s (APA) revised Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Posttraumatic Stress Disorder (PTSD) is a trauma- and stressor-related disorder. The diagnostic criteria for PTSD included in this classification requires exposure to a traumatic or stressful event as a diagnostic criterion (U.S. Department of Veteran Affairs, 2013).

\(^6\) Describes individuals whose gender identity matches the sex they were assigned at birth.
To honor a Translatina’s experience, Alexandra Rodriguez De Ruiz, a Translatina from Mexico City who co-founded the organization El/La Para Translatinas (“El/La”), a Translatina rights organization in San Francisco, coined the term “Translatina.” Marcia Ochoa, El/La’s other co-founder, describes the term: “‘Translatina’ encompasses a journey of navigating survival in the wake of ongoing violence and exclusion inflicted upon trans [Latina] women” (Morris, 2018). The term ‘Translatina’ honors their origins from Latin America and Spanish-language and creates a sense of community for them. They reported that for Translatinxs, the term became a way of empowerment and a way of including and giving visibility to a marginalized community. The term gave Translatinxs space, respect, and recognition as a group of women with many challenges and walls to “tear down” (Rodriguez De Ruiz & Ochoa, 2016: 162). Today, due to the incredible advocacy of Translatina rights champions like Marcia Ochoa, Isa Noyola, and Alexandra Rodriguez de Ruiz, the term Translatina is internationally recognized.

Translatinxs are the LGBT and migrant community in most need, and local and federal government aid is insufficient or unavailable. Accessing mental health services is especially important for Translatinxs given their experiences navigating multiple landscapes and facing exclusion and barriers to belonging at the national and state levels (Morris, 2018), while also refusing inclusion on normalized terms (Id). Ochoa, seeing Translatinxs as vulnerable bodies, encourages people to consider what role the State has in positioning them in this vulnerability and how the state benefits from it. She asked, “Is ‘the State’ possible without the imposition of order on vulnerable bodies?” (Id). Here, this thesis calls on “the State,” in this case the City of San Francisco, to respond by taking urgent action to help Translatinxs, the city’s most vulnerable group.
This thesis focuses solely on the experiences of Translatinas and urges city leaders Mayor Breed, the Board of Supervisors, and the Director of Public Health to lead the fight for the dignity of trans migrants by allocating resources to El/La Para Translatinas to provide fully-funded mental health services to Translatinas. The City’s intervention is necessary to help Translatinas achieve a state of complete physical, mental, and social well-being. This thesis uses the term “well-being” as defined by the WHO: “a state... in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to her or his community” (2018). Mental health and well-being are more than the absence of mental disorders, they are “fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection, and restoration of mental health... [is] a vital concern of individuals, communities, and societies throughout the world” (Id). While all vulnerable people, including minorities, are particularly in need of access to treatment (WHO, 2018), migrants and refugees are arguably in greater need and thus entitled to psychological treatment under Article 23 of the Convention and Protocol Relating to the Status of Refugees (United Nations, 1951). Advocating for this, the WHO urges governments to pursue “national [and local] mental health policies [that are] concerned both with mental disorders and, with broader issues that promote mental health. Mental health promotion should be mainstreamed into governmental and non-governmental policies and programs (2018).” This thesis underscores the WHO’s and UN’s call to action to governments to promote mental health policies. In San Francisco and elsewhere in the United States, cities have yet to incorporate mental health promoting policies for their migrant communities.

To advocate for access to mental health and mental wellness for Translatinas, this thesis set out to understand the barriers that exist in San Francisco preventing Translatinas from accessing
mental health services. Through the narratives and experiences of three individuals who are members of the trans immigrant and activist communities in San Francisco, the barriers to Translatinás’ accessing mental health care in San Francisco were identified as: 1) inexistence of organizations that provide mental health services solely to Translatinás; 2) Translatinás’s liminal legality and organizations/agencies requiring “legal” documentation to enroll participants; 3) insufficient resources that lead to saturated services; 4) cultural competency and responsiveness regarding trans issues and trans healthcare; 5) accessibility to Spanish language practitioners; 6) limited data on the demographic and population of trans people and trans migrants; 7) limited gender-affirming care; and 8) stigma of mental health services as a requirement for obtaining gender-affirmation surgery.

From the recommendations of the three participants, this thesis suggests intervention strategies and revised policies that the city should adopt to strengthen and promote mental health for Translatinás. The services would help Translatinás facing issues such as psychological and financial hardship, liminal legality and homelessness, and other marginalization due to their gender and racial identity as trans people of color. The services should be provided by an organization solely dedicated to Translatinás and led by them, and the practitioners must be culturally responsive and fully Spanish speaking (and/or Portuguese, or Mam, or provide access to interpreters at no cost to the participants). A final but related recommendation is that the City should revise its requirements for processing an SF City ID card and San Francisco health insurance. Instead of requiring that an applicant present an original unexpired ID card to obtain health services and an ID Card, which is the current policy, the city should waive this requirement for trans migrants who so often do not have in their possession an original valid ID card. In a
separate vein, the city should also revise and loosen its requirements for accessing gender-affirmation surgery.

The findings are also influenced by global efforts existing in Sweden to provide refugees mental health services and in Germany to aid LGBT+ refugees. In Germany, the organization Schwulenberatung Berlin, a non-profit organization, created the first-ever LGBT Refugee Center and shelter. The center is funded by the State of Germany and the Berlin Senate. Their center’s model and services are significant because of their success offering quality and free therapy, legal aid, shelter, and other necessary services for LGBT refugees. Schwulenberatung Berlin’s center has also inspired other organizations to open similar centers in Germany, expanding access to the over one million asylum seekers in Germany since 2015 (Keita & Dempster, 2020).

Furthermore, this project is supported and informed by Liberation Psychology, studies on the mental health of transgender and gender non-conforming people, wellness, trans-feminism, and feminist and gender studies.

This thesis also offers a critique of the City of San Francisco’s government. The City has failed to (a) provide action and leadership to the trans migrant community, (b) provide trans immigrants with sufficient relief, assistance, and redress; (c) promote trans immigrant’s rights; and (d) secure mental health care and treatment for trans migrants. Although San Francisco prides itself on being one of the most progressive and liberal cities in the United States, the city’s inability to dignify trans immigrants may be a clear contradiction of that proud title. The education, labor, justice, transport, environment, housing, and welfare sectors must also be involved in these efforts (WHO, 2018).

Of nonprofit organizations and LGBT+ advocates, this thesis asks that they build bridges amongst each other and support the city in accomplishing the above suggestions. In the words of
Aria Sa’Id, founder and executive director of Compton’s Transgender Cultural District in San Francisco’s Tenderloin District, “the only thing we can do is continue to hold accountability and continue to demand that [politicians] expand their promise and framework of what LGBT equality looks like, and specifically for transgender people” (Mosley & Hagan, 2020). The only way we can truly begin to achieve trans equity and equality is by grounding in the knowledge and leadership of trans BIPOC, those most affected by anti-trans violence and marginalization.

The significance of this thesis is that: (a) it aids in our understanding of Translatinás’ post-migration relocation experience, (b) details the barriers they face in San Francisco to access resources, (c) and offers significant recommendations for intervention strategies and public health policies that the City should adopt for the sake of Translatinás’ and the city’s development. Both the City and the trans community stand to benefit from Translatinás’ accessing mental health services to obtain mental health wellness. In achieving wellness, Translatinás may work productively, contribute to their community, thrive as personal and public citizens, and contribute to the economy. By ensuring wellness, the City will aid in the prevention and eradication of humanitarian and public health crises in the trans/LGBT BIPOC communities, including: houselessness, suicide, substance abuse, HIV/AIDS, and other diseases that systematically impact BIPOC at disproportionate levels in comparison to non-BIPOC people. Additionally, to reduce the mortality, morbidity, and disability for persons with mental disorders (WHO, 2018). Further, through establishing pro-trans immigrant policies in San Francisco, the City will engage in protecting and promoting human rights, strengthening and empowering civil society, and creating a stepping-stone for trans and gender non-conforming immigrants’ rights.
Terminology

BIPOC – An acronym for “Black, Indigenous, and People of Color.”

Cisgender – Describes individuals whose gender identity matches the sex they were assigned at birth

Cissexism – An ideological system that privileges cissexual people.

Cultural competency – A clinician or therapist’s ability to provide services to clients that take into consideration the client’s cultural beliefs, cultural worldviews, and behaviors. The culturally competent counselor values diversity, has undergone cultural self-assessment, and knows how to adapt clinical services to reflect an understanding and appreciation of a client’s culture (Jones-Smith, 2019).

Culturally-responsive therapy – Elsie Jones-Smith (2019) describes this as, “A counseling relationship in which a client and a therapist are of different ethnicities, cultures, races, and backgrounds and the therapist (1) evidences awareness of the significance of both his and the client’s cultural stories, 2) has specific knowledge of the client’s culture, and 3) uses culturally appropriate clinical skills in working with the client”

Gender expression – refers to the external manifestation of an individual’s gendered self (e.g. through dress, mannerisms, speech patterns).

Gender identity – refers to an individual’s deeply felt sense of identification with a particular gender, as male, female, or as something other than or in between these binaries.

Gender Non-Conforming (GNC) – individuals who do not conform to societal expectations of gender expressions or roles; more commonly used to refer to gender expression.

Gender Variant – Different than trans or GNC identified person. Often-times used by parents or behavioral scientists to describe a child or adolescent (especially under the age of 16 or 18 years) whose gender identity is not definitive (Raj, 2008).

Heterosexism – An ideological system that privileges heterosexuality and serves to subordinate, stigmatize, and discriminate against non-heterosexual people and communities (Herek, 1995; Niesen, 1990, in Harper, Jamil, and Wilson, 2007: 102).

LGB – An acronym for “lesbian, gay, and/or bisexual.” This thesis uses the term LGB given that trans inclusion is not ubiquitous as organizations remain largely LG or LGB (Enriquez, 2016: 147). This is a symptom of the transphobia and cissexism that remains today, even within the LGB community. Note: Trans people also have sexual orientations and may identify as heterosexual or LGB+. Sex and gender, although often confused with each other, are different.

LGBT, LGBTI, LGBTQ, LGBTQA, LGBTSTGNC, LGBT+ – Often used interchangeably, an acronym for “lesbian, gay, bisexual, transgender,” the “i” stands for “intersex,” the “q” for
“queer,” the “TS” for “two-spirit,” and the “a” for “asexual.” This thesis uses the acronym “LGBT+” with the + as an acknowledgement that there are non-cisgender and non-heterosexual identities which are not included in the acronym. This is a shorthand or umbrella term for all people who have non-normative gender identity or sexual orientation.

**Liminal status** – The condition of transitioning one’s social and political position to another. In the immigration discourse, it is refer as being “stuck” in the transitional period without being able to move one’s status to another.

**Liminal legality** – How uncertain legality affects/shapes people’s ability to live in the United States. Although undocumented immigrants can be assimilated, their legal status prevents them from being incorporated into society economically, civically, culturally, and legally. Often, people call it being stuck in a “legal limbo.” (Menjivar, 2006).

**Non-binary (NB)** – Individuals who do not identify with the gender binary of male/female, and who embrace expressions and ways of being that are expansive beyond this binary.

**Transgender** – Describes individuals whose gender identity does not match the sex they were assigned at birth; an umbrella term that refers to people whose gender identity or expression differs from the sex (female or male) assigned at birth (UC Davis 2020; Martinez-San Miguel & Tobias, 2016; Grant et al., 2011; Xavier, Honnold, & Bradford, 2007; Gowin et al., 2017: 322).
CHAPTER II: REVIEW OF THE LITERATURE

To develop the suggestive interventions proposed herein and understand a Translatina immigrant’s need for free culturally-responsive, language-accessible, and gender-affirming mental health services, this thesis begins by reviewing the literature related to the positionality of Translatinases within Trans Studies, Feminist Studies, and Gender Studies. These fields help analyze and respond to the intersections of cissexism and gender-based violence that contribute to trans women’s vulnerability to mental and physical health issues, including depression, anxiety, suicide, and the harm, violence, and/or lack of protection they experience in their home countries. These three fields are critical in challenging the systematic oppression Translatinases face and help us develop methods grounded in producing equity and liberation, and to combat the discrimination, oppression, and injustices trans women face daily.

As the literature demonstrates and as has been widely reported, Translatinases are exposed to high levels of violence and insecurity, creating a common push factor and forcing Translatinases to migrate to the United States to seek asylum in protections of their lives. While the asylum process is bound by international and human rights and treaties to protect its applicants, the (negative) reception and mistreatment immigrants in the United States receive has been widely documented. Here, the specific harm that the U.S. asylum/immigration process creates for Translatinases and their mental health is discussed and critiqued. Of particular concern is how the immigration apparatus re-traumatizes and pathologizes Translatinases, demanding them to disclose their most painful memories and exposing them to re-traumatization without adequate support. Considering Translatinases’ pre-migration psychological vulnerability and the potential that obtaining psychological services could create for them, the literature culminates in a review of psychological interventions whose theoretical frameworks are applied.
The psychological frameworks include mental wellness and liberatory psychology, which can arguably best help Translatinás and the practitioners working with them to navigate social inequalities and work towards their gender liberation. It should be noted that this thesis does not aim to victimize Translatinás. Their suffering and pain discussed herein is with the aim of positioning the oppression Translatinás experience and demand change for them. This thesis asserts that despite their vulnerable status, Translatinás are courageous and resilient individuals who need free, easily-accessible, dignified, and humanized healing to ensure their wellness.

Trans Studies and Translatinás

The term Translatina brings together the prefix *trans-* and the noun *Latina*. It is employed as a gender-inflected synonym for Latin American or as an ethnic or racial marker for a person of Latin American descent who lives elsewhere, for example in Australia, Canada, Europe, or the United States. Given that the prefix *trans-* is used to indicate individuals who might have migrated (or whose family histories might include migration) and who might have transnational connections, it acquires a double valence, referring to geography and physical displacement as much as to gender identity and expression (La Fountain-Stokes, 2014: 237-8). Translatinás may use the following terms to identify themselves: “woman,” “trans,” “transgender woman,” or “trans woman” (Padron & Salcedo, 2013: 8). This thesis uses these terms interchangeably.

*Transgender* is a term used to describe individuals whose gender identity does not match the sex they were assigned at birth (Grant et al., 2011; Xavier, Honnold, & Bradford, 2007; Gowin et al., 2017: 322). Sex and gender are often confused with each other; sex refers to the binary categories of “male” and “female” and the traits associated with being “man” and “woman,” assuming that desires and practices are because of an assigned biological sex (Taylor, Daniel, and Haider-Markel, 2018: 13). Gender on the other hand, is expressed as an outward manifestation of
femininity, masculinity, or both, with the normalized expectation that people will express gender based on their assigned sex at birth (Id).

When people identify with a different gender and express their gender differently than that associated with the sex assigned at birth, people are seen as “gender variant” because they break the cultural rules associated with gender (Id). A person whose gender identity is not congruent with the other markers of one’s assigned sex might be described or identify as transgender. Incongruence with gender identity can also result in people identifying as gender non-conforming (GNC), non-binary (NB), gender-queer, and two-spirit, all of which are expressed differently by each individual. It is important to highlight that gender identity can be fluid and on a continuum.

The term “gender dysphoria” is assigned to people who, according to the American Psychiatric Association’s *Diagnostic and Statistical of Mental Disorders* (DSM-5), have “a marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration” (Taylor, Daniel, and Haider-Markel, 2018: 14). Gender dysphoria causes a person discomfort or distress, and treatment is available to assist people with such distress. Treatment may involve exploring their gender identity and gender roles (or a combination of roles) that is most comfortable for them (Bockting & Goldberg, 2006, in World Professional Association for Transgender Care, 2012). The medical treatment options for gender dysphoria can include hormone therapy and/or surgery (World Professional Association for Transgender Care, 2012:5). There are various types of procedures and surgeries that a trans person can access to alleviate the psychological discomfort and distress caused by gender dysphoria (Id). These range from non-genital, non-breast interventions, to genital and breast/chest interventions (Id).

It is believed that in the United States, most studies conducted in the country on data regarding gender dysphoria present significantly underrepresented data. An explanation for this
could be the methodology for data collection: data is primarily obtained through self-reporting, and the data-collecting organizations utilize limited provider data and have little access to the already-limited government-collected data (World Professional Association for Transgender Care, 2012:5). In parallel to the rest of the country, data on the trans community in San Francisco is also limited. Two of this thesis’ participants share how, in their experiences, the limited data prevents the City’s development and accessibility of resources for the trans/Translatina communities.

Understanding that there is limited and underrepresented data helps us understand the reality that in comparison to the LGB movement and organizations, the transgender movement, trans activism, trans rights, and trans organizations are often under-resourced and marginalized. It is true that in the last decades, pro-trans policies and protections have significantly increased and improved, partly because other transgender movements became increasingly intertwined with the far larger gay and lesbian movement (Taylor, Daniel, and Haider-Markel, 2018: 12). This is significant because before 1990, there were few protections for transgender people in the United States (Taylor, Daniel, and Haider-Markel, 2018: 329). Now, in some states, trans people can legally affirm their name and gender identity and obtain identification documents to match their gender identity, access gender-affirming treatment, and are legally protected from discrimination in the workplace (Human Rights Campaign, 2021).

Despite the advancements, trans people still face severe discrimination, stigma, systemic inequality, and limited protections. For instance, there is still no comprehensive federal non-discrimination law that includes gender identity and there exists legislation specifically designed to prohibit trans people from accessing public bathrooms that correspond with their gender identity or to exempt discrimination based on religious beliefs (Human Rights Campaign, 2021).
Additionally, only 30% of women’s shelters are willing to house trans women, 27% of trans people have been fired due to their trans identity, and a greater percentage are not insured (Id).

There is also an alarming underrepresentation of trans leadership and underfunding of trans organizations. A 2013 report prepared and conducted by Eisfeld, Gunther, and Shlasko examining 340 trans and intersex groups throughout the world revealed that while the number of activist organizations dedicated to trans and intersex issues grew rapidly between 2010-2013, these groups are still largely led by non-trans or non-intersex people. In addition to the issue of representation, these organizations and groups often struggle to survive financially. “The majority” of the organizations led by non-trans and non-intersex people have an annual budget of under $10,000, and 95% have annual budgets under $250,000 (Martinez-San Miguel & Tobias, 2016: 8). In contrast, the organizations with leaders who identify as trans and intersex have even more limited annual budgets. The median budget is between $5,000 and 10,000 (Martinez-San Miguel & Tobias, 2016: 9). The report further demonstrates the large gaps in funding available to “LGBTI” organizations and that of general human rights organizations. For example, in 2010, only 6% of all funding of human rights work, about $72.6 million, went to promote “LGBTI” rights globally. Of that sum, only $1.6 million (or .16% percent) was invested in addressing trans issues. On the other hand, organizations working on non-LGBT+ human rights issues operated with a budget of $1.12 billion – or 15.4 times greater (Id).

In San Francisco, El/La Para Translatin as is the only organization led by Translatin as serving Translatin as. As of the writing of this thesis, their annual budget is not publicly available on their website or their fiscal sponsor’s, Community Initiatives, or on GuideStar. The only accessible data was a fundraising email in 2021 in which El/La reported to have distributed upwards of $100,000 in direct COVID-19 relief to participants, including gift cards, hygiene kits,

Mickael Enriquez’s study in Quebec, Canada, demonstrates the marginalized realities trans activists and organizations experience within the LGB+ movement and offers suggestions for improvement that can be adopted universally (2016). All of Enriquez’s participants, individuals who identify as trans militants and activists, highlight the cissexism they experience daily and how cissexism infringes on their movement, issues, visibility, and access to funding and rights. One of Enriquez’s participants shared that while LGB allies are trans people’s best allies, there is often no exchange of power, and trans people are not given the space for their issues or visibility, “Many groups marginalize and exclude trans people, mostly in an unconscious way. It manifests itself through the way that trans issues are ignored or put on the back burner. When the T is added, the group still just deals with sexuality issues, but the T is not given space or power” (Id). Another participant explained that a major issue is the power struggles and allyship from the “LGBTQ” organizations and consequences of excluding trans issues from the organizations. According to this activist, the “[LGBTQ organizations] do actions for gays and lesbians, but not for trans people. If there’s something for trans people, they rarely have the time to take care of it… they don’t know the cases well enough or because they don’t have much experience with them, well when they do take care of it, they do it all wrong!” (2016: 149).

7 These donations were cross-referenced. In 2018, according to their Form 990, Horizons Foundation issued El/La a cash grant of $13,000. In 2016, according to their Form 990, the Astraea Lesbian Foundation for Justice issued El/La a cash grant of $15,000. For detailed reports, see: https://s3.amazonaws.com/astrea.production/app/asset/uploads/2018/04/990-for-FY17-Public-Inspection-Copy.pdf and https://www.horizonsfoundation.org/wp-content/uploads/2019/11/Horizons-Foundation-2018-Form-990-Open-to-Public-Inspection.pdf
Based on Enriquez’s activist-participants suggestions, experiences, and needs, Enriquez proposes the following strategies to improve the inclusion of trans people and advance their rights:

1) Organizations (and governments) need to give equity in leadership to trans people,

2) Organizations (and governments) should open up to the sexual orientation of their members, and LGB organizations need to open up to gender identity issues,

3) Raise consciousness on trans issues and facilitate dialogue and implement the feedback being given by the trans individuals directly impacted, and

4) Ensure that trans organizations gain a leadership role in the LGBT+ movement (2016: 151).

Parallel to the suggestions above, each of this thesis’ participants self-advocated for Enriquez’s participants strategies 1, 3, and 4, as strategies the city of San Francisco should encourage and adopt in their intervention to assist trans people and advance trans rights.

Beyond the marginalized financial, social, spacial, medical, and psychological realities that trans people experience within LGBT movements, trans women, specifically trans sex workers, face further marginalization as movements, society, and the state marginalize them. Trans women are the most heavily marginalized, surveilled, and criminalized group of trans people (Butler Burke, 2016: 116). Being situated within this marginalization, heavy surveillance, and criminalization and exclusion from citizenship, is often what forces them to resort to sex work or other unsafe and precarious working conditions for survival (Ibid). While for some women, sex work is empowering, for others, sex work is the only work they think they can do (Rodriguez de Ruiz, 2016). Even if trans women don’t engage in sex work, law enforcement officers and policies profile them as sex workers and routinely “stop, harass, and demand identification from transgender women… and regularly arrest them for low-level offenses tied to suspicions of prostitution” (Carpenter and Marshall, 2017). This phenomenon is so widespread it has been colloquially labeled as “walking while trans” (Ibid). Trans migrant women of color in particular are
heavily surveilled and profiled by the police and the state for their trans and migrant identities (Aizura, 2016). The violent practice of protecting citizenship also leads to a deep divide within the dominant trans and queer political priorities as trans sex workers are often heavily marginalized within the trans community in the community’s effort to advance their priorities (Butler Burke, 2016).

With each recent administration’s attempts to manage migration through crime and deport “criminals,” the large majority of arrests that result in immigration detention happen through police profiling and brutality (Aizura, 2016). Trans migrants in particular are divided between “innocent” and “criminal,” “deserving” and “non-deserving,” rendering them “doubly punished” and exposing them to the risks of immigration detention and deportation. They may also have to register as “sex offenders” (Aizura, 2016: 128), jeopardizing their future employment opportunities and forcing them into more liminal work. This conviction will also render a trans migrant inadmissible for adjustment of status or asylum. Under the Immigration and Nationality Act, any “alien” who “has engaged in prostitution within 10 years of the date of application for a visa, admission, or adjustment of status” (See INA § 212(a)(2)(D)(ii)) is inadmissible. Trans migrants are thereby displaced and unjustly targeted in the rise in racial profiling, state surveillance, “War on Terror,” and the criminalization of migration, and their safety and protection jeopardized, as they are now vulnerable to police violence, incarceration, removal proceedings, and deportation (Butler Burke, 2016: 118).

Transfeminism

Given the control and abuse of trans women’s bodies, trans-feminist theories help us challenge such oppression by arriving at new methods of combatting discrimination, oppression, and injustices, for the equity and liberation of all women. Trans-feminism/feminist theories are
adapted from trans and feminist theories, which challenge oppressive assumptions associated with
gender, sexuality, and bodies (Martinez-San Miguel and Tobias, 2016). Still, their methods don’t
always overlap.

In fact, the field of Trans Studies emerged in the late 1970s as a response to hostility from
(primarily) white, cisgender-identified feminists (Martinez-San Miguel and Tobias, 2016), and
even hostility from gay and lesbian people (Enriquez, 2016). This has often been the case because
trans women are (wrongly) “deemed false women” (Enriquez, 2016: 150). Lesbians have also
paradoxically feared losing space and visibility to trans people (Id). Trans feminist activists were
also originally excluded from the academy due to its hierarchical structures of knowledge, and
therefore theorize outside of the academy (Martinez-San Miguel & Tobias, 2016). They practice
feminism and theorize from the borderlands of academia and in the grassroots and larger world of
activism. Whilst challenging the unifying potential of the category ‘woman’ and aiming to build
solidarity with and improve the lives of all women and oppressed groups, “Transgender
phenomena… [also] call for new analyses, new strategies and practices for combatting
discrimination and injustice based on gender inequality” (Stryker, 2006, as quoted in Martinez-
San Miguel & Tobias, 2016: 3). Emi Koyama writes that transfeminism is, “primarily a movement
by and for trans women who view their liberation to be intrinsically linked to the liberation of all
women and beyond… transfeminism embodies coalition politics” (2001, as quoted in Martinez-
San Miguel & Tobias, 2016: 10). Today, Trans Studies continues to criticize those feminists and
feminist movements that view feminism as only for white, straight/heterosexual, cisgender,
middle-class, or “developed nations” women.

Trans liberation is linked to and even helps further and expand feminist liberation because
the patriarchal structures of power that oppress women cannot be effectively dismantled without
incorporating gender liberation. The patriarchy utilizes hegemonic masculinity to guarantee (or is taken to guarantee) the dominant position of men and subordination of women (Connell, 1995: 77). Trans people, even if “passable,” are still trans, and trans migrants are further marginalized for their intersections as immigrants and people of color. Considering trans migrants’ intersections (and hierarchies) of oppression and following Connell’s analysis that masculine men are at the very top of the power hierarchy while women are at the bottom, trans women are arguably at the lowest tier of this hierarchy (1995). Such positionality places trans women at extreme vulnerability for abuse, coercion, and control.

To respond to trans women’s circumstances, we must consider the structural power imbalances and toxicity reinforced by masculinity that systematically oppresses and marginalizes them. Liz Kelly established the ‘continuum of sexual violence’ to describe the how violence against women is not linear but rather a connection of different events or experiences (1987). In her research, she analyzes the extent and range of sexual violence in women’s lives, documenting and naming the range of abuse, coercion, and force that women experience that include, “looks, gestures, and remarks, as well as acts which may be defined as assault or rape” (Id). The concept is intended to highlight the fact that sexual violence exists in most women’s lives and that there are forms of sexual violence experienced by most women in their lives, which are also more likely to be re-experienced on multiple occasions (Id). Cockburn argues that gender and the continuum of violence are interconnected by the power imbalances of gender relations in most (if not all) societies (2004). These power imbalances, she explains, generate cultures of masculinity prone to violence, which utilize any inequality to legitimize violence towards people considered by these cultures of masculinity as “worthless” (2004: 44). Here specifically, it has been established that toxic masculinity legitimizes violence against trans people. Cockburn argues that it is because
gender links the continuum of violence at different points on a scale, from the personal to the public and to the international, and it runs the continuum runs through the social, economic, and political (Ibid). Cockburn believes that since violence is a continuum, our movements have to respond in a continuum of its own – to be alliances capable of acting in many places, at many levels, and on many problems simultaneously (Ibid).

A proponent and advocate for widespread community alliances was Leslie Feinberg, a self-identified “trans, butch lesbian, and cross-dresser” activist, who used the pronouns “zie” (Feinberg, 1998). Feinberg, knowing the strengths and struggles of the various community zie worked with, spent zie’s life advocating for alliances between trans, GNC, LGB, and women’s liberation groups:

We could gain strength by working together, along with our allies, to fight for sex and gender freedom. That means the rights of people to define their sex, control their own body, and develop their gender expression free from violence, economic barriers, or discrimination - in employment, housing, health care, or any other sector of society. None of “us” can be free while the others are still in chains. That’s the truth underlying the need for solidarity. Trans liberation is inextricably linked to other movements for equality and justice (Ibid).

For the reasons that transfeminism is inclusive, diverse, radical, and an important aspect of contemporary trans activism, this thesis utilizes a transfeminist theoretical approach to inform, guide itself, approach its participants and findings, and advocate for Translatin as from a place of privilege in the academy. This thesis embodies the definition Susan Stryker (2006, in Martinez-San Miguel & Tobias, 2016: 3) gives to transgender phenomena by acting as an intervention that seeks to enrich conversations and policy. Building upon the new strategies, analyses, and practices Stryker calls for (Ibid), this thesis seeks to advance trans rights and equity in San Francisco through the exchange of critical reflections and dialogue between governmental and non-governmental trans actors, migrants, and activists.
Fleeing for their lives

The persecution and abuses Translatinazas experience in their home countries have been widely documented and are the primary reason they flee to the United States (Cheney et al., 2017). Persecution often takes place because of an individual’s perceived femininity or sexual identity, and the culture of masculinity. The continuum of sexual violence of “machismo” — male chauvinism — within the communities trans migrants come from and flee perpetuate and normalize the violence. “Machismo” is a group of attitudes of male dominance and superiority, legitimized by the patriarchy and enforced through cultural values and norms (Bilmes, 1992, and Mayo & Resnick, 1996, in Segrest, Romero, & Domke-Damonte, 2003). The abusers, in an “effort” to make Translatinazas “men,” justify the abuse fueled by their notions of social, religious, and cultural notions of gender. Often, the violence takes the form of intrafamilial sexual assault or domestic violence.

The abuses include but are not limited to sexual, physical, emotional, and psychological violence. The push factors that encourage LGBT individuals to leave their home countries “are substantial. Indeed, in some cases, the decision to leave is a matter of life or death” (Tabak and Levitan, 2014, p. 8). The abusers include community members, classmates, parents, relatives, and the police (Cheney et al., 2017) who harass, attack, and persecute Translatinazas since childhood. Gaby Morales Arellano is a Mexican trans woman whose family and society abused her for her gender identity. Her parents forced her to leave the family’s home in Mexico shortly after she began her transition to live as a woman (Transgender Law Center and Cornell University, 2016). According to Morales Arellano, “There is a lot of discrimination when you come out of the closet and you face all of these critics, first your family and your neighbors who say, ‘Why is he like that? He should be normal.’ My family thought they could beat me and correct me” (Id).
As Translatinxs grow older and more vulnerable and marginalized by society and their families, the corrupt and machista authorities in their communities become more commonly the abusers, rather than their protectors. Such was the experience of Edin Avendano-Hernandez, a Translatina from Mexico. Avendano-Hernandez fled to the U.S. after allegedly suffering repeated instances of rape in Mexico, including sexual assault at the hands of police and military members (Bekiempis, 2015). Victor Clark, a professor at San Diego State University and the Director of the Binational Center for Human Rights in Tijuana, Mexico, states that the police and military apparatuses are the “primary predators” that target Translatinxs (Transgender Law Center and Cornell, 2016, p. 18). “Mexican police target transgender women and arbitrarily arrest them for pretextual reasons such as ‘disturbing the peace’ because they were wearing female clothing; for being perceived to be sex workers even if they were not; for failing to carry a valid health card; for allegedly carrying drugs; or for being said to be gay,” Clark stated (Transgender Law Center and Cornell, 2016, p. 18).

Police misconduct, extrajudicial killings, and torture of trans people world-wide are well documented, particularly by human rights groups such as Amnesty International and Human Rights Watch. In 2017, Cheney et al. documented the preimmigration experiences of violence in Mexican trans women applying for asylum in the United States and had fled Mexico to “escape persistent assaults and threats to their life.” While the report highlights specifically Translatinxs in Mexico, the data presented is applicable to other Latin American countries given the widespread police corruption, machismo, homophobia, transphobia, lack of impunity, and gender-based violence therein. The report, based on the interviews of 45 Mexican trans women seeking asylum in the United States, found that:

Applicants who remained in Mexico into late adolescence and adulthood reported being targeted by the police, particularly when they dressed in female clothing.
Applicants reported multiple instances of false arrest, being picked up and taken to jail and held under charges that were later dropped or without charges. During these times, men who were in the same jail cell often sexually or physically assaulted them, with no police intervention. Physical and sexual assault by the police often occurred at gunpoint. Many of the sexual assaults described were with a group of police officers and usually at night. Some officers asked for bribes to avoid sexual assault or arrest. These experiences increased their fear and distrust of authority (Cheney et al., 2017, p.1649).

Today, such violence against the LGBT community, especially against trans women, persists and has arguably increased despite the increased visibility of LGBT individuals, increase in number of rights-based organizations, and legalization of same-sex marriage. The data supports this argument, as violence against LGBT people in Mexico increases annually. In 2019, Mexico saw a 27% increase of murders of gay, lesbian, bisexual, and trans people – with 117 murders total, and more than half of them trans women – while the number of murder victims for the general population only increased by 2.5% (Lopez, 2020)\(^8\). In comparison to 2019, the number of LGBT people killed increased almost a third than what the reported murders were in 2018, and the number was the highest it had been in the 5 preceding years (Id). According to the Transgender Law Center, the number of documented murders of trans people rose to 46 in 2012 from four in 2008 (Transgender Law Center and Cornell, 2016; Woodman, 2016). In 2019, the Trans Murder Monitoring (TMM) revealed that Mexico had the second highest trans or gender-diverse murder rate in all Latin America – following Brazil’s 130 murdered for the period October 2018 to September 2019 (2020).

An explanation for the increase in violence could be increased visibility. Same-sex marriage was legalized in Mexico City in 2010 and legalization of same-sex marriage has followed in many

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\(^8\) The official numbers are likely overwhelmingly under-reported because 90% of hate crimes, particularly transphobic hate crimes, are not reported and even less so investigated (Transgender Law Center and Cornell, 2016). An explanation for the underreporting could be explained by the police violence and persecution of trans people in Mexico, as was detailed in earlier paragraphs.
other states throughout the country. Today, there is an on-going clash between feminist groups, LGBT-rights groups, and the predominantly Catholic religious society over same-sex marriage and adoption for same-sex couples. Alejandro Brito, the director of the Mexican LGBT+ advocacy group Letra S (“Letter S”) argues that the increasing visibility afforded by advances in LGBT+ issues may have contributed to the surging violence against LGBT people \((ld)\). Brito supports his argument by explaining that every year, murders become crueler, noting that victims are subject to multiple forms of violence, before or even after they were murdered \((ld)\). Gender related killings because of gender identity have also been labeled as “gender-bias crimes” and reflect controlling – or machista – behavior in which others are judged according to heterosexual (or cissexist) norms (United Nations Office on Drugs and Crime, 2019). In all, these abuses greatly affect Translatin@’s mental health and render them to second-class citizenship status in their home countries.

**Mental Health of Trans and Translatina Asylum Seekers (Including Minority Stress)**

In the last decade, in great part due to the National LGBTQ Task Force’s and National Center for Transgender Equality’s efforts regarding national census participation and the community’s visibility, the literature on LGB and trans migrant’s mental health has increased. The literature demonstrates that LGBT+ community as a whole encounter daily systematic oppressions, with a varying degree and on a continuum depending on their identity, expression, phenotype, social class, education, and ability. Specifically, Translatin@as and trans asylum seekers are particularly vulnerable to high rates of anxiety, depression, PTSD, and suicidal ideation given various marginalizing factors, including their pre- and post-migration experiences of abuse and persecution, gender dysphoria, and their sexual orientation.

Asylum seekers or migrants who identify as LGBT are even more vulnerable than non-LGBT asylum seekers or migrants, and more-so than non-migrant LGBT people. That is because
LGBT asylum seekers “have a higher incidence of sexual violence, persecution occurring during childhood, persecution by family members, and suicidal ideation” (Hopkinson et al., 2017: 1650), causing them extreme psychological hardship. A 2015 report, “Envisioning Global LGBT Human Rights: Mental Health Challenges for LGBT Asylum Seekers in Canada,” conducted by Rainbow Health Ontario in Canada demonstrates the mental health challenges specific to LGBT asylum seekers. In partnership with the Ontario Council of Agencies Serving Immigrants, the report asserts that “LGBT individuals are at a heightened risk for post-traumatic stress disorder (PTSD), major depressive disorder, panic and anxiety disorders, difficulty with trust and intimacy, dissociative disorders, anger, self-blame, guilt, and helplessness” (2015). The results also shed light on the high prevalence of anxiety, depression, suicidality, and self-medication among the general LGBT asylum seeking community.

While the LGBT+ community is diverse and “include[s] many oppressed nationalities, people with AIDS, women, youths, elders, people who are unemployed, homeless, deaf, disabled, prisoners, people dependent on welfare, SSI, Medicaid, and Medicare” (Feinberg, 1998: 104), trans people are most vulnerable. The majority of trans people are vulnerable in ways LGB people are not, or at least not to the same level. As discussed in prior sections, the issues trans people are vulnerable to, which places their already-fragile mental health at greater risk, includes “police harassment, assault, racism, sexism, high unemployment, low wages, job insecurity, homelessness, lack of healthcare, and high rents” (Feinberg, 1998: 136). Cheney et al. concluded from their interviews with 45 Mexican trans women asylum seekers that their participants’ mental health suffered greatly due to the persecution and deprivation of basic human rights and dignity they experienced in their home countries. Indeed, El/La Para Translatinás in 2017 stated that their Translatina participants often see the world as one that “fears and hates transgender people, women
and immigrants[...][it]... see[s] us as shameful, disposable or less than human” (El/La Para Translatinatas, 2017).

A groundbreaking report regarding the suicide levels of transgender and gender non-conforming people (TGNC) migrants is that of Testa et al (2017). According to Testa et al., TGNC migrants “are three to four times more likely to have a history of suicide attempt compared to [migrants] who have not had experiences of gender-related victimization and violence” (Goldblum et al., 2012; Testa et al., 2017, p.: 127). Testa’s study evaluated 816 TGNC adult individuals. Out of this sample, 45-77% reported a history of suicidal ideation, with 28-52% percent reporting one or more suicide attempts in their life. In contrast, the suicidal ideation rates in a non-TGNC adult population were reportedly 13.5%, and 4.6% reported a history of one or more suicide attempt (Testa et al., 2017, p.125).

Gender minority stress theory (Testa et al., 2017; Singh, 2016) helps us understand why Translatinatas suffer high levels of psychological and emotional hardship, and offers insight into possible responses to move forward with. According to gender minority stress theory, “different external and internal stressors related to one’s gender minority status, as well as minority resilience factors, impact mental health in TGNC people” (Testa et al., 2017: 126). Further, that minorities suffer similar symptoms due to the similar stressors they experience, which are a result of their minority status. Studies show that many stigmatized minority individuals experience limited cultural and social inclusion opportunities throughout childhood and adulthood in comparison to non-minority individuals of the same age. Inclusion opportunities range from recognition (acknowledgment), validation (sharing views & values), legitimacy (feeling you belong), satisfaction (rewarded for what you do), respect (treated by others as someone of value and worth),
dignity (self-perception as having value and worth), and identity (sense of self, pride, self-satisfaction) (Franklin, 2004).

As a minority group struggling with social and cultural inclusion, trans people are also often targeted by societal transphobia (Gapka and Raj, 2003: 12-13 in Raj, 2016: 83). Societal transphobia can take the form of verbal, psychological, physical, or even sexual violence. Such discrimination, which can include and/or rise to the level of harassment or violence directed against trans, gender-queer, and “gender variant” individuals, is a common occurrence irrespective of artificial land boundaries. Societal transphobia or cissexism is also prevalent not just in communities where trans migrants live pre-migration, but also in the recipient communities post-migration where trans migrants settle. Immigration detention is also notorious for reinforcing notions of societal transphobia. The participants in this thesis shared their experiences with societal transphobia and its impact on their mental, emotional, and physical health. These are discussed in detail in the findings section of this thesis.

Some members of the trans community might also experience internalized transphobia (Raj, 2002a, in Raj, 2016), which Raj describes as:

an intrapsychic dynamic which commonly manifests itself as self-hatred or impoverished self-esteem, guilt, shame or embarrassment. It can take the form of parasuicidal or self-harm behaviors (e.g., cutting, head-banging, wall-punching, substance use, pounding of the breasts or genital mutilation, etc.) or self-sabotaging acting-out behaviors (e.g., getting “high” on club drugs, unsafe sex practices, bad monetary investments, obsessive-compulsive gambling, spending or sexual activity, etc.)

The effects of mental and emotional violence on a Translatina’s psychological health are serious and exacerbated further by the mental and emotional violence they will likely experience in the process of regulating their status in the United States. The transphobia they experience in
immigration detention and the immigration apparatus is described in the next section. Thus, minority stress theory is a helpful guide to understand and respond to Translatinas’ mental health.

**Liberation Psychology**

In a feminist approach to gender liberation, consciousness-raising has been used since the 1960s as an instrument to validate client experiences of the world regarding gender and culture (Singh, 2016). Consciousness-raising, or conscientization, was first proposed by Paulo Freire in 1970 as a collective process conceivable as a liberatory practice (Id). In 1994, conscientization was proposed by Ignacio Martín-Baró, a Spanish psychologist and Jesuit priest, as the process of an individual’s becoming aware of the inextricable connection between the personal and the political, allowing the individual to transform through changing his or her perception of their reality and the source of their oppression (Martín-Baró, 1994, in Russell & Bohan, 2007).

Liberation Psychology was founded in the 1970s by Martín-Baró in response to the need for psychology that addressed the oppressions and oppressive regimes in Latin America (Russell & Bohan, 2007). As a Jesuit priest working in El Salvador as a community psychologist and priest, Martín-Baró witnessed political persecution and repression, turmoil, and the harsh realities of civil war in El Salvador. Liberation Psychology, for Martín-Baró, helped empower the opposed through various strategies. Comas Diaz explained:

> Psychology of liberation attempts to work with people in context through strategies that enhance awareness of oppression and of the ideologies and structural inequality that has kept them subjugated and oppressed, thereby collaborating with them in developing critical analyses and engaging in a transforming praxis (p. 778) (1998, in Glassgold, 2007: 45).

For Glassgold, liberation psychology is a process of action-reflection (2007). It is an individual’s achievement of undoing internalized oppression and the individual’s capacity to engage in collective action to change society (Id). The action-reflection process is a means for interrupting
the cycle of oppression and submission through undoing the internalized oppressive ideology (Martín-Baró, 1994, p. 42, in Glassgold, 2016). The opportunity to name the world as oppressive is radically life-changing for a marginalized person (Freire, 1970, in Glassgold, 2016).

The path towards liberation through Liberation Psychology is critical for Translatininas in three important ways. First, the liberatory approach helps the oppressed group generate potential problems and solutions to the existing problems of injustice (Singh, 2016), equipping them with the tools they need to navigate oppression and enhance their resilience. Secondly, it has the potential to deideologize TGNC psychology to not only track the pathologization and oppression of TGNC people related to diagnosis, but also generate new ideas and theories in their place (Singh, 2016). Liberation psychology thereby can liberate TGNC people from seeing their diagnoses or issues as individual failings or deficits, which is harmful to a TGNC person’s mental health (Serano, 2006, Spade, 2008, Winters, 2013, in Singh, 2016). Finally, the liberatory approach can reduce the hierarchical power structures embedded within the therapeutic relationship and invites practitioners to increase their TGNC client’s participation in their own healing (Id). Feminists and gender scholars have long criticized the hierarchical relationship between practitioner-client and stressed the need for psychologists to develop TGNC competency (Id).

A liberatory psychology approach may be befitting in its analysis of gender and wellness for a Translatininas’ liberation, and as an instrument to offer Translatininas in their path to wellness. Translatininas navigate a world in which their extensive societal inequalities result in significant minority stress. Liberation psychology will help enhance their awareness and ability to identify and address which larger systems of oppression influence them and their diagnoses, and how. Doing so will help them identify ways of acting towards their liberation (Martín-Baró, 1994, in Singh, 2016) and ultimately achieve personal and social change. Further, engaging with a
A liberatory practitioner who is working towards their own gender liberation will help Translatinas achieve the same (Singh, 2016), increasing their ability to achieve wellbeing.

**Practice of Detention and Asylum Applications**

Anyone who successfully enters the United States, whether without inspection or by surrendering themselves to immigration officials at the border by requesting asylum, is placed into immigration custody. To understand the practice of detention and why it has skyrocketed in recent years, particularly since September 11, 2001, it is necessary to understand the history of the border and events that have led to the efforts to “manage migration through crime” (Chacon, 2009). While the U.S.-Mexico border has become increasingly militarized for the last several decades, it became a low-intensity “war-zone” (Dunn, 1996) during the 1990s, and then this “war-zone” worsened with the beginning of the “War on Terror.” U.S Customs and Border Protection, the largest component under the jurisdiction of the U.S. Department of Homeland Security (DHS), is the parent entity of Border Patrol, whose mission is to “keep terrorists… out of the U.S. [and to secure] the border and [facilitate] lawful international trade and travel…” (CBP, n.d., in Vera, 2013).

Historically, Border Patrol was created by the Immigration Act of 1924, a law setting restrictive quotas for Asian and European immigrants (Dunn, 1996, in Vera, 2013). This marked the beginning of the “regular use of a federal police force to enforce legal residence criteria... and thus better controlling... and [regulating] the flow of Mexican undocumented immigrants into the country” (Dunn, 1996: 12, in Vera, 2013). As the decades have passed, the border has become increasingly militarized, and Border Patrol increasingly powerful: the number of agents increased over 100% between 2004-2011, various operations aimed at limiting and regulating immigration continue to be created and enforced, national guards have been deployed to border states, former military officers have been hired as agents, and impunity remains rampant (Vera, 2013). Today,
Border Patrol agents strategize, are equipped, and train like military (*Id*). They respond to threats (e.g. immigrants entering without inspection) with violence and force, disregarding human and civil rights (*Id*).

Inside detention, the criminalization of migrants continues. In Michel Foucault’s work *Discipline and Punish*, he describes the extent to which the carceral system aims to control, subordinate, and reinforce a system of power over the “others” (1975: 271); in this case, undocumented immigrants and Translatin@. However, beyond control, detention is also primarily a mighty business. Annually, over $5 billion taxpayer dollars are used to pay for immigration detention (CIVIC, n.d.). On any given day, the United States is mandated to detain 34,000⁹ individuals (Endisolation.org, 2014) in a combination of public and private prisons. Sixty percent are owned by privatized corrections and detention facilities contract companies such as the GEO Group and the former-Corrections Corporation of America (CCA) (ICE, 2014), which was rebranded to “CoreCivic” in 2016.

In 2020, amid the COVID-19 pandemic, ICE approximated that out of its over 30,000 detained migrants nationwide, 31 self-identified as trans (Fernández, 2020). The data provided by ICE is difficult to confirm when the agency’s standards for identifying trans individuals are not disclosed to the public. For example, does the agency identify a migrant as a trans woman based on her own proclaimed self-identity? Or does the agency only consider trans women as those undergoing a non-clandestine hormone treatment? Or must the individual have undergone some level of sex affirming surgery?

Each day, nearly 300 migrants in ICE custody are placed in solitary confinement, many whom can be assumed to identify as LGBT given that ICE confines LGBT people into solitary as

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⁹ Despite this number, ICE often overcrows facilities. In 2018, there were 44,435 individuals in custody. At the end of FY 2015, ICE held 39,082 people in custody (TRAC, 2018).
“protective custody” given that they are “15 times more likely to be sexually assaulted than their heterosexual, non-transgender counterparts” (United We Dream, 2017). Solitary not only physically endangers an inmate, placing them at risk from abuse from guards, but it can also cause irreversible psychological damage. Yet, these tactics that LGBT individuals face in detention facilities is a recurring problem (Id). The below excerpt is one trans woman’s reflection on her psychological hardship and the state of her mental health while confined and because of U.S. immigration custody:

Do you see how much I’m suffering here? Do you think anyone deserves to be punished like this? … Sometimes I get anxious. … I thought about killing myself once, but then I regretted it and told myself I wasn’t going to do it. I said, ‘Lord, you gave me my life, why am I going to take it away?’ It’s not His fault they have me suffering here like this (Human Rights Watch, 2016, p.1).

In February 2016, ICE claimed that “it did not know how many transgender women were in immigration detention across the U.S., let alone where and under what conditions they are being held” (Human Rights Watch, 2016). In the same year, ICE estimated that 65 of those detained identified as transgender women (Id). In a supposed effort to protect trans women, also in 2016, ICE designated the Santa Ana, California, city jail as a facility to detain trans women. However, trans women continued to be detained in facilities “for men” elsewhere in the U.S. The conditions transwomen were exposed to at the public Santa Ana city jail were not an improvement from private detention centers (Replogle, 2017), and they continued to suffer abuses, neglect, and discrimination. In 2017, after Santa Ana became a sanctuary city, and after effective trans-rights advocacy, the city ended its cooperation with ICE (Replogle, 2017).

After Santa Ana shut down, Cibola County Correctional Facility became the primary detention center with a unit for transgender women (Santa Fe Dreamers Project, 2020). Cibola County Correctional Facility is a medium-level security “male” correctional center owned by
CoreCivic. In addition to detaining immigrants, Cibola County Correctional doubles as a federal prison and serves as a county jail (DeMarco, 2018; CoreCivic, 2019). In January 2020, without warning, ICE began transferring its trans detainees to Colorado and Washington facilities (Santa Fe Dreamers Project, 2020).

The violations committed inside immigration detention upon migrants can take the form of physical, medical, psychological, or sexual violence, surmounting to the trauma previously developed in their country of origin or on their journey to the United States (Vera, 2016). Research shows that in the United States, one in five transgender women are assaulted by prison staff or other inmates while in immigration custody (Tabak & Levitan, 2014: 27). In 2017, United We Dream reported that, “Most incidents of sexual assault against LGBT detainees are by fellow detainees and by guards employed by detention facilities” (2017). Other reports support the findings that sexual assault from U.S. guards and inmates against transgender and cisgender women inside detention is a common occurrence. While the United States is bound by law to protect trans migrants, and all asylum seekers, from violence and to allow them to enter the country to seek asylum, not only does it fail to do so but it also utilizes violence against them:

Many transgender women who flee sexual violence in their home countries face further abuse when seeking asylum in the United States. LGBT immigrants in immigrant detention facilities are exposed to an increased risk of mistreatment, much like LGBT inmates in prison, who studies show are 13 to 15 times more likely than other inmates to be sexually assaulted (Transgender Law Center and Cornell, 2016: 29).

It is inhumane that transgender women flee violence in their home countries only to be further abused in the United States, often by authority figures bound to protect them. These abuses violate
international law and conventions, including the Convention Against Torture (CAT)\textsuperscript{10}, which the United States ratified on October 21, 1994 (United Nations, n.d.).

In addition to the physical and sexual abuse trans migrants are subjected to in detention centers, they also suffer medical violence and neglect, often held for months and denied medical treatment during that time (Love, 2018). United We Dream reported in 2017 that, “On multiple occasions, the denial of hormone treatment for transgender individuals has been documented as well as [denial of] care for HIV positive individuals [which] has caused deaths in detention centers.” One of the most public and horrific consequences of ICE’s denial of treatment for trans women was Roxsana Hernandez’s death in May of 2018. She was HIV positive and died while in ICE custody at Cibola from complications of pneumonia (Santa Fe Dreamers Project, 2019). In July 2018, months after her death, about 80 women were still being held at Cibola in the same abusive conditions that led to Roxsana’s death (Chavez, 2018). Medical neglect, lack of mental health services, poor conditions of detention, and abuse of solitary confinement were declared rampant at Cibola, and a reason for its shutting down (Santa Fe Dreamers Project, 2020).

\textit{The Asylum Application Process}

Applying for asylum is commonly a daunting, retraumatizing, and immensely difficult experience for any immigrant. Applicants are required to speak about their darkest and deepest memories of trauma and abuse, and fears of future persecution in their home countries. An applicant must provide evidence, including clear and consistent testimony, that there is a 10% \textit{Part 1 Article 1: … the term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from [them] or a third person information or a confession, punishing him for an act [they] or a third person has committed or is suspected of having committed, or intimidating… or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions,” - Convention Against Torture, Adopted and opened for signature and ratification on December 10, 1984.}
chance they will suffer persecution if returned to their home country: “Asylum [or Withholding of removal are] granted if it can be proved that an applicant has been, or has a reasonable fear of being, persecuted by the applicant’s home government or by those whom the government has been unwilling or unable to control” (Thaler, Bermudez, and Sommer, 2009: 159). In cases where the applicant has survived state-sponsored violence, whether from the police, military, or other government agents, discussing violence experienced at the hands of government agents to other government agents can be terrifying. Not only are the adjudicators authority figures, but the applicant may find it difficult to trust all authorities, including those in the United States, if the applicant was in immigration custody or suffered abuse by Border Patrol, CBP, or detention center guards. If a detained individual is denied release from immigration custody, they must fight their deportation proceedings from inside immigration detention.

Two additional complexities to applying for asylum is that the applicant faces deportation if asylum is not granted (Thaler, Bermudez, and Sommer, 2009) and that an asylum application must be filed within one year of a migrant’s arrival to the United States. For many applicants, the fear of being denied and deported can prevent them from applying for asylum within the first year of their arrival, barring the applicant from asylum. The decision to waive the one-year bar is up to the discretion of the Executive Office for Immigration Review (EOIR) and the Department of Homeland Security, who must assess whether there is sufficient evidence to overcome the one-year bar. This could be extreme circumstances that prevented an applicant from applying, changed circumstances, or ineffective assistance from prior counsel. An applicant’s mental health status can suffice as an extreme circumstance that prevented them from applying within their first year of arrival to the U.S. To evidence this, a mental health professional can prepare an expert mental health report regarding the applicant’s mental health and how it prevented them from applying for
asylum within one-year of their arrival. If required, the expert may also testify in court. By presenting their symptoms, diagnoses, and trauma the violence and persecution they suffered caused them, applicants must pathologize themselves.

An additional burden to TransLatinas applying for asylum is that they must demonstrate they are ‘credbly’ identifiable as transgender to a finder of fact, and that the persecution is because of their gender identity. This may be difficult for TransLatinas for several reasons, including that some trans migrants have not “come out” and the first people they come out to are those representing them or those they are testifying in front of. One of the aspects of body dysphoria is that people who suffer dysphoria may feel shame about their identity, may not be comfortable with their identities or perceived flaws, and therefore are unable to “come out” (Shultz, 2015: 95). Additionally, trans applicants must have “concrete evidence of [their] identity,” meaning their physical transitioning, including “evidence of hormonal therapy or attempts to receive such therapy for the purpose of transitioning between genders” (Tabak and Levitan, 2014: 21). In practice, the documentation can include hormonal prescriptions or a medical letter from a doctor overseeing gender affirmation procedure.

**Mental Health Wellness**

Mental health is an integral and essential component of health (WHO, 2018). It is more than just the absence of mental disorders or disabilities – it is a state of well-being in which “an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (*Id*). Poor mental health has been linked to stressful work conditions, gender discrimination, physical ill-health, and human rights violations (*Id*). As such, mental health is fundamental to our collective well-being, to a person’s ability to enjoy life, earn a living, and interact with their community.
The United States is the only industrialized country in the world where a universal healthcare system does not exist, only health insurance (Gerisch, 2018). Every other industrialized country, as well as non-industrialized ones, ensure their citizens have access to healthcare as a human right (Id). The right to healthcare has been internationally recognized since 1946, when the World Health Organization (WHO) constitution was adopted and signed by representatives of 61 member states (World Health Organization, 2020). The constitution states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (Kaufman, 2018). The WHO urges governments to develop mental health policies that are mainstreamed into governmental and non-governmental policies and programs, including developing programs targeted at vulnerable people, including minorities and migrants (2018). The United States became a party to the WHO’s constitution on June 21, 1948 (World Health Organization, 2020). Also in 1948, the United Nations codified human rights and, “including, at Article 25, the essential right to health. The United States, together with all other nations of the UN, adopted these international standards” (Gerisch, 2018; United Nations, 1948). Despite these two critical standards of healthcare, the United States remained without universal healthcare.

In 1966, years after passage of the UDHR, another UN treaty was proposed that included health care rights: the Covenant on Economic, Social and Cultural and Rights (CESCR) (Gerisch, 2018). Article 12 of the CESCR further clarified that everyone has, “the right… to the enjoyment of the highest attainable standard of physical and mental health…” and that it is states who must be the ones to “protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health… through a comprehensive system of health care, which is available to everyone without discrimination, and economically accessible to all” (Id). The CESCR
was signed by all UN countries and ratified by all of them except Palau, Comoros, and the United States.

Within the United States, universal healthcare, including mental healthcare, was first raised by former President Franklin D. Roosevelt, who listed healthcare in his draft of the Second Bill of Rights (Gerisch, 2018). As a result of his death, the Second Bill of Rights was never implemented (Id). In 1963, President John F. Kennedy’s proposed to Congress a $31.3 million dollar program to provide healthcare to the American people (Korr, 2020). The project was to be finances by federal and state or local governments with three objectives: 1) Determine the causes of mental illness and finding effective treatments for them, 2) Research and train personnel to develop the necessary skills to be advocates and practitioners, and 3) Strengthen and improve programs and facilities for treating those with mental health issues and developmental disabilities (Id). In addition, the Kennedy Administration budget for fiscal year 1964, “call[ed] for increases for all activities of the National Institutes of Health with a boost of nearly 50 percent, to $166 million, for mental health work” (Id). On October 31, 1963, President Kennedy signed the legislation known as the Community Mental Health Centers Act (Id).

Unfortunately, on November 22, 1963, President Kennedy was assassinated in Dallas, Texas (Id). His vision to enact a mental health plan that would emphasize prevention, treatment, and rehabilitation, and that would open comprehensive community centers funded by the federal government with 45 to 75 percent of costs, were unable to manifest due to his untimely death (Id). President Lyndon B Johnson’s administration only built half of the proposed centers and never fully funded them, shifting the costs to states (Smith, 2013). Then, in 1965, Medicaid was adopted, accelerating deinstitutionalization because it gave states “an incentive to move patients out of state hospitals, where they shouldered the entire cost of their care, and into communities where the
federal government would pick up part of the tab” (*Id*). During the Reagan Administration, the Department of Mental Hygiene endured a 10% budget cut, until he reversed the cuts and increased spending by a record $28 million (Gerisch, 2018).

In 1980, President Jimmy Carter signed the Mental Health Systems Act, an attempt at manifesting JFK’s dream (Gerisch, 2018); it passed only after deleting a section penalizing states that failed to protect the rights of patients that the Senate passed the act (Grob, 2005). President Carter’s Mental Health Systems Act “reaffirmed the priority for community mental health services, particularly for such underserved groups as individuals with chronic mental illnesses, children and youth, the elderly, ethnic and racial minorities, women, the poor, and rural residents” (*Id*). It also emphasized planning and accountability, mandating for “performance contracts” as a condition for federal funding, and created closer links between the mental health and the general health care systems (*Id*). The Act also provided grants to health centers that had not received federal funding, for centers to provide mental health services, and for the promotion of mental health, among others (*Id*). The National Institute for Mental Health was also required to create a mental health prevention unit (*Id*). Despite the Act’s achievements, critics regarded its language as weak and ambiguous, especially regarding patients’ bill of rights, advocacy programs, and vague generalizations about the kinds of services required by various marginalized groups, including children, minorities, and survivors of rape (*Id*). Grob (2005) criticizes the legislation’s provisions for reflecting ideology over empirical data, its shortcomings in understanding the pathology of mental illness, and its “faith” in human agency – that disease was “not inevitable and could be avoided by conscious and purposive actions.” Grob further poses the Act’s inability to create systematic provisions to ensure individual’s needs would be addressed by the agencies administering the various program, each of which had “different missions and concern” which did
little to overcome the “fragmentation characteristic of the mental health field” (Id). Months after the legislation was enacted, President Reagan repealed it in 1981. Federal spending on mental health continued to significantly decline, keeping individuals with mental health needs at risk and inadequately served. In 2010, the Affordable Care Act (ACA or Obamacare) required insurers to provide mental health as an essential benefit (Baumgartner, Aboulafia, and McIntosh, 2020).

In California, as the federal government continued its efforts for de-institutionalization, California responded by requiring private health plans to provide comparable benefits, deductibles, and copays for physical health and serious mental health illness (Wiener, 2019). In 2004, California voters approved a 1% tax on people whose incomes were greater than $1 million to invest into the mental health system (Id). In 2021, the tax yielded about $2.4 billion, most of which goes into existing programs (Kreidler, 2021). Despite the seemingly large funding, mental health advocates describe California’s mental health system as “struggling” and “broken,” a 2018 Kaiser Family Foundation poll established that 57% of respondents believe they are not able to get the mental health services they need, and over 30% of California prisoners receive treatment for a serious mental health disorder (Wiener, 2019). Additional data shows that in 2019, only 37 percent of Californian adults with mental illness received mental health services compared to a national average of almost 43 percent (Id). More than 30% of adults who have Medi-Cal and who were released from institutionalization wait longer than one month to be seen in outpatient services (Id).

A brief look at the United States’ and California’s history responding to mental health shows how both the federal and state governments have continuously made efforts to shift the costs of care for individuals with mental health needs. It is evident that in the United States, access to mental healthcare is one of privilege versus right. Such an approach violates the UDHR and international treaties and international organizations, including the United Nations and the World
Health Organization, establishing that governments are responsible for protecting the mental and physical well-being and rights of everyone within their jurisdiction. Instead, the United States has created a system that discriminates against minority groups and/or those in poverty. Individuals are conditioned to medical and mental healthcare access so long as they have citizenship, ability to pay, and ability to speak the English language (Gerisch, 2018). Considering the detrimental implications of poor mental health on a country’s society, economy, and government, it should be a priority for governments and societies to protect, promote, and restore the mental well-being of those within their jurisdictions. In the case of Translatinagas, their ability to obtain free government-funded mental health services will enable each Trans latina to realize her own potential, cope with the normal stresses of life, work productively and fruitfully, and be able contribute to her community (WHO, 2018).

**Policy and Welfare Opportunities for Survivors of Torture Immigrants in the USA**

Evidence shows that an immigrant who has survived torture has greater suicidal ideation and risk of PTSD than a non-immigrant. As asylum applicants and those who have obtained protection move forward and rebuild their lives, they might face obstacles due to their psychological scars, which can hamper rehabilitation and insertion into one’s community. To help with rehabilitation, the U.S. Department of Health and Human Services has a Survivors of Torture provision under the Refugee and Entrant Assistance Program. There is no demographical data regarding the survivors’ background, country of origin, whether they are asylee or refugees, or of their sexual orientation or gender identity, and therefore it is difficult to analyze the numbers

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11 U.S. law defined “torture” as an act which is intended to inflict severe physical or mental pain or suffering and committed by a person acting under the color of law upon another person who he has under his custody or physical control (18 U.S. Code §2340) (U.S. Department of Health and Human Services, Office of Refugee Resettlement, 2020).
and understand who is benefitting from services. What is known is that approximately 9,000 survivors of torture in 2016 benefited from services covered by the provision (Department of Health and Human Services, n.d.).

The number of beneficiaries is a small percentage of those granted protection. In 2019, 46,508 individuals were granted asylum (Baugh, 2019). As of 2015, research from the Center for Victims of Torture suggests that 44% of refugees, asylees, and asylum seekers living in the U.S. have experienced torture (U.S. Department of Health and Human Services, Office of Refugee Resettlement, 2020). In 2014, the courts received over 225,000 new applications and there were already about 410,000 pending cases only EOIR; in the 2017 fiscal year, that number had reached 650,000 (Executive Office for Immigration Review, & Office of Planning, Analysis, & Statistics, 2017). In Fiscal Year 2019, USCIS received 96,952 affirmative asylum applications while EOIR received 210,752 (Baugh, 2019). While EOIR completed a total of 275,000 cases in Fiscal Year 2019, the number of remaining pending cases was 987,000 (Executive Office for Immigration Review, U.S. Department of Justice, 2019) – more than double the backlog in 2014. The backlogs and high volume are a direct result of the increasing violence in other countries, especially the Central American Northern Triangle and Mexico, and in March 2020, the COVID-19 pandemic largely shut down operations. As the EOIR and the DHS become increasingly backlogged, the numbers of those “survivors of torture” are expected to continue to grow in parallel with the backlog.

An additional limitation is the provision’s budget, which one could argue is limited in scope in comparison to the number of individuals who should benefit from it. In fiscal year 2016, the

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12 Including 27,643 individuals who were granted asylum affirmatively by DHS, 6 and 18,865 individuals who were granted asylum defensively by the U.S. Department of Justice (DOJ). This figure includes derivatives granted on a principal asylum application but do not include follow-to-join asylum petitions (Baugh, 2019).
allotted budget for the Survivors of Torture provision was $10,735,000 (Department of Health and Human Services, n.d.). On February 15, 2017, H.R. 1095, a bill in the U.S. Congress, was presented to request the authorization of appropriations for domestic treatment centers for general nation-wide victims of torture increase to $25,000,000 for Fiscal Years 2018 and 2019 (Smith, 2017) – more than double its budget in 2016. On the same day, it was referred to the subcommittee on health and, as of May 1, 2021, has remained there since. The last time a bill for torture survivors’ relief was passed was on October 30, 1998 (H.R. 4309, 1998).

Considering that the vast number of individuals who have survived torture is at least 3 times those currently benefiting from the program, including those pending asylum adjudications and those who are granted asylum annually, the budget cannot be expected to support all those who meet the definition of “survivor of torture.” If the operating budget for “survivors of torture” is only enough to provide assistance for 9,000 people, how can the remaining tens of thousands of “survivors of torture” access resources to heal? Without assistance, how can they be expected to integrate and recover from their past traumas, from the torture they have endured?

Besides the Survivors of Torture provision, there is no other government-sponsored benefits for survivors of torture to assist in their rehabilitation and reinsertion into their new communities. The United States’ history of xenophobia and systemic racism is in part to be blamed for this. The 1996 “welfare legislation” or Personal Responsibility and Work Opportunity Reconciliation Act ensured that federal public assistance programs became unavailable to undocumented individuals (Johnson et al., 2015). While asylees and individuals granted withholding of removal can receive some government benefits, these are limited to “[Temporary Assistance for Needy Families], Food Stamps, Medicaid, [Social Security Income], unemployment compensation, school loans and grants, and subsidized housing” (Johnson et al., 2015: 2).
Undocumented people – including those pending an asylum application – became unable to receive any federal assistance following the 1996 act and the lasting effects of the act continue to be felt especially today, with undocumented people being one of the most marginalized communities during the COVID-19 pandemic.

Mental Health Services Currently Available in the Bay Area and San Francisco

As of the writing of this thesis, no single Translatina-led or Translatina-servicing organization provides psychological services to Translatinhas. While there exist several organizations in San Francisco providing a range of mental health services to the LGBT or migrant community, they are insufficient in addressing the needs of Translatinhas. There are two organizations of particular importance, neither of them specifically LGBT-supportive, that offer services in a model which could be adopted by El/La Para Translatinhas given their funding model. One is Legal Services for Children (“LSC”), a non-profit in San Francisco providing government-funded legal and mental health services to children, and the other is the Center for Survivors of Torture (“CST”) in San Jose, which offers various services to survivors of torture.

With limited opportunities for public assistance, it is common for undocumented people turn to non-profit organizations and mutual aid groups, some government funded. One organization bridging the need for mental health and legal aid is Legal Services for Children (“LSC”) in San Francisco. As a non-profit organization, LSC was founded with a holistic approach to representing children and youth. LSC advocates for and empowers its clients by providing them with legal and social services to ensure they achieve stability and realize their full potential (Legal Services for Children, 2017). “Without the comprehensive [mental health] services [of our social workers] the legal victories would be hollow for many of our clients who struggle a great deal to cope with their traumas and [need to] develop tools to move forward from them” (Id). LSC is able
to provide mental health services through their government grants. Of their 2017 budget, 28% came from government grants and contracts (2017: 5). In 2018, that amount had significantly increased – 44% of their budget was from government grants and contracts (Legal Services for Children, 2018: 4). In 2018, LSC reportedly conducted more than 105 onsite therapy sessions and psychosocial assessments of their clients (2018: 3).

Another organization providing rehabilitative services to survivors of torture is the Center for Survivors of Torture (CST) in Santa Clara, founded in 2000. One of its goals is “to open a door to hope and healing by providing rehabilitative services to survivors of politically motivated torture and refugees” (Center for Survivors of Torture, 2017), so that refugees and asylum seekers can become productive members of the community. The organization estimates that there are currently 1.3 million individuals in the United States who meet the definition of “survivors of torture” – individuals who subjected to politically-motivated torture (2017). They estimate that in California, “the number of torture survivors… is estimated around 500,000. However, many Californians are unaware of their presence, and are even less aware of the challenges these individuals have to endure in suffering with consequences of torture and difficulties in resettlement” (Id).

One way CST achieves its objective of helping torture survivors rehabilitate is by providing culturally responsive direct psychological, medical, and social services to survivors and their family, including forensic evaluations (Center for Survivors of Torture, 2017). Their services are free or on a sliding scale and range from casework, psychotherapy, psychiatry, medication, and neuropsychological testing. CST’s approach “empowers the client to make informed choices to address [their comprehensive] needs” (Id). The federal government fully funds CST through the Office of Refugee Resettlement under the Department of Health and Human Services, and the County of Santa Clara through its Mental Health Department (Id).
In San Francisco, there are currently many organizations and programs offering mental health services to the adult LGBT community that Translatinas can benefit from, but none are solely for Translatinas. An anti-violence organization supporting healing is Community United Against Violence (CUAV), an organization working to build the power of LGBTQ communities to transform violence and oppression through short-term counseling and support groups (CUAV, 2021). Other organizations that offer counseling are the Positive Health Program at San Francisco General Hospital for people with HIV (City and County of San Francisco, 2020), counseling services on a sliding scale at Queer LifeSpace, counseling for Latinos with HIV at Mission Neighborhood Health Center, counseling and support groups at Instituto Familiar de la Raza, counseling at the Castro Mission Health Center, counseling, therapy, and support groups for sex workers at St. James Infirmary, counseling for those living with HIV, substance abuse, and mental illness at the Alliance Health Program (AHP) (Id), psychotherapy through the UCSF Transgender Care clinic (UCSF, 2021), and mental health therapy at Lyon Martin (Lyon Martin, 2021).

Two organizations have led efforts to offer psychosocial and medical services cisgender women, the LGBT community, and sex workers in San Francisco. The organizations St. James Infirmary and the Tom Waddell Urban Health Clinic provide health and safety services in the Tenderloin. St. James Infirmary services current or former sex workers of all gender identities and sexual orientations and is run by current or former sex workers (St. James Infirmary, 2021). Tom Waddell Urban Health (TWUH) clinic is a program through the Department of Public Health (Tom Waddell, 2021) and serves adults experiencing homelessness, residents of supportive housing, and other members of San Francisco’s Tenderloin neighborhood community (San Francisco Health Network, 2021). Tom Waddell also has a transgender clinic, committed to providing quality, integrated health care “in an atmosphere of trust and respect… [to] anyone who identifies as
transgender” (Tom Waddell, 2021). They treat all medical issues (not just issues related to gender), including mental health and social services, and they work closely with community organizations (Id), though they do not service specifically Translatinas. In January 2020, St. James Infirmary opened its first transitional housing program for TGNC adults, the Bobbie Jean Baker House through Our Trans Home SF (St. James Infirmary, 2021). This housing program is the first of its kind, providing trans-specific cultural competence, an all-trans staff who are majority trans women, and majority people of color (Id). The transitional home prioritizes houseless TGNC individuals who are BIPOC, disabled, elders, HIV+, and/or current or former sex workers, helping them with rental assistance, navigating housing, and offering transitional housing and houses where up to 15 people reside together (Id). While St. James Infirmary has an activism group for Translatinas, they do not service them solely and it is offered only periodically (Id). Due to the high demand for St. James Infirmary’s free services, they “frequently keep a wait list” (Id).

Both the United States and the City of San Francisco have historically offered funding to trans-serving organizations with HIV/AIDS-prevention is because the approach to funding the trans community is from the perspective of a public health issue against HIV/AIDS rather than holistically. The U.S. first began providing funding for HIV/AIDS treatment in 1987 (Rosenberg, 2017). While the domestic and global efforts to prevent and fight HIV/AIDS has changed over time, in 2017 the budget was $32.9 billion, and it was distributed as follows: 60% of spending was allocated to care and treatment; global funding accounts for 20%; cash and housing assistance accounts for 9%; research accounts for 8%; and prevention accounts for 3% (Ochoa Camacho et al., 2011). This is problematic because when trans people are primarily associated with HIV/AIDS, or when trans organizations must have HIV/AIDS prevention projects as their central purpose to obtain funding, it becomes an issue of association with stigma and discrimination, leaving little
room for development beyond offering the trans community holistic services to treat them as human beings to develop beyond HIV/AIDS prevention.
CHAPTER III: METHODOLOGY

Methods and Approach

To best understand the barriers that exist in San Francisco limiting Translatinas’ access to mental health services and the best responsive strategies, this qualitative study utilizes a semi-structured interview approach to examine the interviews of three individuals who identify as trans and are active participants in the trans community in San Francisco. The interviews reflect a broad cross-section of transgender rights advocates and trans experiences in San Francisco.

The research received ethical clearance from the University of San Francisco Institutional Review Board (IRB# 1229) and the data collection occurred between September 2019 and November 2019. The interviews for this study were intended to explore participants’ views and experiences regarding San Francisco’s Translatina community and mental health needs, reflections of personal trans activism and advocacy, barriers the trans/Translatina communities face in accessing mental health services, and participants’ personal hopes and goals.

The narratives were collected from semi-structured in-depth interviews using a twenty-nine-question instrument (See Appendix A). Two guides were developed and used to provide structure to the interviews. The interview guides were organized by type, one for Translatina Asylum Seekers and Asylees, and another for Stakeholders and Trans Allies. Some of the interviewees fell into both categories and therefore were asked questions from both guides. Five lines of inquiry were explored: 1) Translatina Immigrant experiences in the Bay Area and the Dynamics of Life Post Migration, 2) Translatina Need/Access to Psychological Services and General Resources in San Francisco, 3) Relationship of San Francisco Organizations with Translatinias and their Role as Providers of Resources, 4) San Francisco City Hall as a Place of Action/Inaction, and 5) the State of Public Funding for the trans community.
Interview questions were both factual and interpretive in nature. To avoid unintentionally influencing participant responses, care was taken to frame questions in a broad and open-ended manner related to four themes: 1) Resources for Translatinæs in San Francisco, 2) Accessibility, 3) Healthcare as a Tool for Translatinæs to Rebuild Their Lives, and 4) Translatinæ Migrant Wellness. Broad questions were followed by probing questions intended to obtain more detailed information about the individual’s experiences, observations, and recommendations. The questioning techniques encouraged respondents to communicate their underlying attitudes, beliefs, and values that are central to this research and were successful in obtaining them.

The importance and effectiveness of semi-structured interviews in psychosocial research is widely recognized among scholars for its ability to find out participants’ perspective regarding their experiences and allows the participant the freedom to express their views, emotions, and feelings in their own terms (Fylan, 2005; Cohen & Crabtree, 2006). Proponents of semi-structured interviews point out the fact that through this method, the interviewer can talk through a topic with a participant, including answering their questions about the researcher’s purpose in investigating this line of inquiry and to stop at any point during the interview. In this way, researchers can be “much more confident” that their participants will not be worse off emotionally than they were prior to the interview (Ids). Allowing participants such freedom to express their experiences on their own terms and to ask questions is particularly helpful and appropriate when working with vulnerable populations and discussing sensitive topics (Ids). Further, semi-structured interviews are recognized for providing reliable, comparative qualitative data (Ids). Accordingly, semi-structured interviews are particularly appropriate to analyze the participants’ subjective and objective experiences. Further, the interviews helped the researcher appropriately analyze, from the point of view of Translatinæ immigrant women and trans advocates, the mental health needs of
Translatinás, barriers to their accessing mental health, and possible solutions to overcoming existing barriers.

The methods used in this research were informed by trans-feminist theory, trans-liberation theory, gender studies, trans studies, minority-stress theory, and liberation psychology. The methodology positions Translatinás as active, resilient agents. It also challenges and counters the tendency of academia, policy, the media, and criminal and immigration law to portray trans people as victims, criminals, and dangerous (Aizura, 2016).

Judgement and snowball sampling methods were used to recruit participants, selecting respondents based on the author’s volunteer experiences and participation/activism and observation of the transgender and LGBT rights movement. Over 13 invites to participate were sent out via email or text.

Participants chose the location of the interviews. Locations included the University of San Francisco, the author’s place of employment in downtown San Francisco, and a public park in San Francisco. All interviews were conducted one-on-one, in person. Oral consent was obtained from participants and interviews were recorded with their permission. Interviews were conducted in Spanish, Spanglish, and English, and were transcribed and translated by the author and by Happy Scribe, an automatic transcription software.

The data analysis followed a thematic approach and open code techniques following Saldana (2009). “Pre-coding” was conducted following Layder’s advice and Boyatzis’ techniques by “circling, highlighting, bolding, underlining, or coloring rich or significant participant quotes or passages that strike [the researcher] – those ‘codable moments’ worthy of attention” (1998, 2013). Happy Scribe is GDPR compliant, uses field-standard TLS 1.2, and provides data encryption, DDoS protection, and network level security monitoring and protection. For more, see https://www.happyscribe.com.
quoted in Saldana, 2009). In Vivo Codes were used in the analysis to generate codes, and emergent themes and categories were identified (Saldana, 2009).

In addition to the data gathered from semi-structured interviews, information was gathered from participant observation in LGBT and trans-only events in the City of San Francisco between the years 2017-2020, which include: pro-Translatina vigils/protests, solidarity events hosted by denominational groups, San Francisco Trans Marches and Pride Parades, San Francisco Trans Day of Visibility, San Francisco Transgender Day of Remembrance, Miss El/La, El/La Annual Gala, SF Transgender Film Festival, and through the author’s volunteer and immigration law work.

The juxtaposition of methods used helped the researcher understand and explain the lived experiences of activists, asylees/asylum seekers, advocates, and allies, and the barriers they face and their needs. Specifically, to understand the availability and the need for city-funded psychosocial services for the Translatina community, and the best approach for it: through programs that offer them in-house psychological services provided by existing organizations that already serve the Translatina community. This includes those that reflect Translatinias, provide them services explicitly for them, and are led and staffed by them. All participants in this study insisted on the importance of Translatinias obtaining free mental health services through organizations that represent only Translatinias, are led by Translatinias, and whose practitioners are trans and/or culturally responsive. The author is confident that the demographic sampling, though limited, closely reflects the Translatina population in San Francisco and the United States.

Finally, the author has chosen to examine the existing role of the organization El/La Para Translatinias, based in the Mission District of San Francisco, as a place of intervention and implementation of Translatina psychological services. El/La Para Translatinias is a non-profit located in San Francisco that emerged in 2006 to serve migrant trans women in the Mission
District. The organization has been around for more than 10 years and has dedicated their work to empowering trans women to find community and support amongst their peers. The decision to analyze and propose El/La for this role is due to El/La’s representation and service to the Translatina community. As of the writing of this piece, El/La is the only project/community organization in San Francisco fighting for Translatina rights, providing resources, and offering personal development in a safe space (El/La Para Translatinhas, 2020). Although attempts were made to partner with the project to interview its participants, due to both parties’ unavailability this was not possible. Nonetheless, its leadership expressed to the author their participants’ desires and need to obtain in-house psychological services.

In the end, the methods used helped the author examine and understand the collective experiences of Translatina migrants in San Francisco, the resources available to them, and the resources they need and demand. It is with confidence and with Translatinhas’ best interest that this author offers her recommendations.

**Positionality Considerations and Bias**

It is true that narratives obtained through semi-structured interviews are often criticized for not presenting objective or truthful accounts (Smith, 2000). However, there are methods to help minimize the level of bias. Additionally, the possibility of bias is preferred due to the important information and knowledge the narratives are capable of providing, as such information may not be available by other methods (Bruner, 1986; Polkinghorne, 1988; Veroff, Sutherland, Chadiha, & Ortega, 1993, in Smith, 2000). For subjects of semi-structured interviews, the process of reflecting back on events and talking about them during narrative interviews can provide meaning and perspective on their experiences, construct their knowledge (including their sense of identity
or self), and bring about emotional adjustment and healing (Bruener, 1986; Daiute, 1995; McAdams, 1993; Miller et al., 1994; Polkinghorne, 1988, in Smith, 2000).

Cornwell fund that building trust and rapport between the interviewer and the participant can help the participant provide more reliable and truthful accounts (Cornwell, 1984), and their methods were applied in this research as follows: the interviewer made attempts to develop trust and rapport by immersing herself in the community and positioning herself as an “insider” given her and the participants’ shared identity politics, linguistics, and ethnic heritage (Ganga & Scott, 2006). These include identifying as an immigrant, a trans rights activist, a member of the LGB+ community, and a Spanish speaker. Due to the shared characteristics between researcher and participant, and the researcher’s desire to engage in the interest of allyship and advocacy, trust felt easily established with all participants. The researcher acknowledges that despite her best attempts to establish shared space and trust with the participants, there are power dynamics and differences that likely impacted rapport and level of trust established. For instance, there were differences between participants and researcher in education, background, immigration status, class, and gender and sexual identity.

The researcher attempted to diminish any power dynamics by entering the interview space as a place of conversation and dialogue. She explained to each participant her goals and purpose: that she sought to understand the participants’ experiences for the purpose of advocating for the Translatina community. The researcher chose to take an ethical stand in favor of the group of Translatina immigrants being studied, and it was the researcher’s goal from the initial creation of the research question to utilize the results to advocate for social policies and ameliorate the conditions of the interviewee/participant (Fontana and Frey, 2008, in McIntosh and Morse, 2015).
Conscious efforts were made to minimize the risk of empathetic interviewing in this study to avoid retraumatizing participants or obtaining information not necessary for the purposes of this thesis.

**The Research Group and Setting**

The term and identity of “Translatinases” is explained in the introduction and terminology sections of this piece. Please refer to those sections for that definition. Nonetheless, Marcia Ochoa’s reflection of Translatinases is discussed here. As co-founder of El/La Para Translatinases, a Translatina rights organization in San Francisco, Ochoa knows “Translatina” encompasses “a journey of navigating survival in the wake of ongoing violence and exclusion inflicted upon trans women” (Morris, 2018). Ochoa encourages people to consider how trans women navigate multiple landscapes of being excluded from forms of belonging (national, state, and otherwise), while also refusing inclusion on normalized terms. As a community, they are marginalized in various ways, including due to their gender, legal status, sexual orientation, health, employment opportunities and options.

The setting – the City of San Francisco – is a progressive and liberal city in California. Since at least the Beat generation, San Francisco has been viewed as a place of liberation and refuge for LGBT people (Mosley & Hagan, 2020). On February 12, 2004, San Francisco lived up to its proud identity and became the first city in the United States to issue marriage licenses to same sex couples (Mason, 2018). Since San Francisco is regarded as a place of acceptance and liberation for the LGBT+ community, Translatina immigrants, like the ones interviewed for this research, dream of arriving in San Francisco. They believe that in San Francisco, they will be able to walk down the streets in freedom showing their greatest selves to the world and, more importantly, be uplifted and live safely and protected from the discrimination, abuse, and death they leave behind in their home countries. As a beacon for LGBT+ rights, it is only right for San
Francisco to pave the way for trans mental health by creating a mental health program, a first in its kind in the nation, that provides free mental health services for Translatina immigrants for which they are eligible throughout their lifetime. Through these efforts, the city will help trans migrants feel secure, find wellness, achieve equity, and develop themselves and their dreams. Both the City and the trans community stand to benefit from Translatinatas’ accessing mental health services to obtain mental health wellness. Translatinatas may work productively, contribute to their community, thrive as personal and public citizens, and contribute to the economy. By ensuring wellness, the City will aid in the prevention of issues that systematically impact LGBT BIPOC and BIPOC immigrants at disproportionate levels in comparison to non-BIPOC, non-LGBT, and non-immigrant individuals, including: houselessness, suicide, substance abuse, HIV/AIDS, and other diseases, and reduce their mortality, morbidity, and disability, which is common for persons with mental disorders (World Health Organization, 2018).
CHAPTER IV: FINDINGS

This chapter begins with an analysis of El/La Para Translatinias, a non-profit organization in San Francisco and the only organization in the city serving Translatinias. The role El/La plays in the community, and its potential as a place of intervention, is analyzed and discussed.

El/La Para Translatinias

The author has chosen to examine the existing role of the organization El/La Para Translatinias as a place of intervention and implementation of psychological services. The decision to analyze and propose El/La for this role is due to El/La’s representation of the Translatina community, the community it serves, and its existence as the only organization in San Francisco solely serving Translatinias. Further, it is led primarily by Translatinias.

El/La Para Translatinias is a non-profit organization in San Francisco’s Mission District serving Translatinias – one of the most vulnerable populations in San Francisco. El/La serves 300 to 325 participants a year, with a core group of about 30 participants who use their services weekly (Interview by Community Initiatives, 2019). El/La also hires Translatinias, with six of their eight staff members identifying as Translatinias and former program participants (Id).

Although El/La emerged in 2006, it began as a San Francisco program called Proyecto ContraSIDA Por Vida (PCPV, “Project Against AIDS for Life”), an HIV-prevention program founded in 1993 (Rodriguez de Ruiz and Ochoa, 2016; Martinez-San Miguel and Tobias, 2016). PCPV emerged in response to the AIDS/HIV epidemic and was the first Translatina HIV prevention program in Northern California (Interview by Community Initiatives, 2019). At the time PCPV was founded, the U.S. had provided funding for HIV/AIDS treatment for about 7 years (Rosenberg, 2017). As a non-profit HIV-prevention agency located in the Mission District of San Francisco, emerged from a variety of organizations that aimed at reducing the spread of HIV in
communities of color, and the community-based contributions PCPV provided remain important today. For one, PCPV’s organizing practices challenged existing identity-based models of community engagement (Rodriguez, 2003). Additionally, their approach to community well-being and HIV prevention stressed the impact of a “bottom-up” approach, and PCPV showed how this approach could be successful in its ability to reach and serve marginalized communities (Ochoa Camacho et al., 2011). While the domestic and global efforts to prevent and fight HIV/AIDS has changed over time, in 2017 the budget was $32.9 billion, and it was distributed as follows: 60% of spending was allocated to care and treatment; global funding accounts for 20%; cash and housing assistance accounts for 9%; research accounts for 8%; and prevention accounts for 3% (Id). In 2005, PCPV lost its funding, and El/La was founded in its place (Interview by Community Initiatives, 2019). El/La exists today as a fiscally sponsored project by Community Initiatives (Id).

In their reflections on their experiences with El/La in its initial stages of formation, Ochoa and Rodriguez de Ruiz (2016) discuss the challenges of doing community work for Translatinás and immigrants in SF, as well as the strategies they’ve developed to access the Translatina community and the financial struggles they face(d) to fund El/La. While both PCPV and El/La began with a strong focus on HIV prevention, one of the organization’s missions was to create a community to uplift Translatinás and help them access social opportunities. Ochoa recalls from her own observations and proximity to the trans women she worked with at PCPV that they were “dying, depressed, not able to be employed” (Rodriguez de Ruiz and Ochoa, 2016: 156). Ochoa envisioned El/La as an egalitarian community, “a social movement,” where Translatinás could find and build protection, love, and self-development, the building blocks to protect themselves from violence, abuse, and illness, and which allows them to fully realize their dreams (Id). Rodriguez de Ruiz recalls being “fed up” seeing, reading, and hearing about trans women being stigmatized,
victimized, dying, and murdered – both in newspapers and personally; her own friend lost her life to domestic abuse (Rodriguez de Ruiz and Ochoa, 2016: 157).

When Rodriguez de Ruiz first started working at El/La, she recalls misjudging the women by offering them what she herself thought they needed – a space according to her own terms (Rodriguez de Ruiz and Ochoa, 2016). For instance, she opened El/La’s drop-in space during the daytime and was surprised when attendance was minimal or non-existent (Id). She began listening to the Translatina community around her for their needs. The participants’ vision for El/La was a space for them to be human, to sit in community and socialize, for a safe space with dignity:

Well, we don’t go to [HIV prep orgs] because they always give us condoms, they give us a plate of food, and all they talk about is HIV prevention. We already know all that. We want something different, we want a place where we can come in the afternoons and stay there and echar cotorreo and checar our emails, or our Facebook or whatever… (2016: 159).

Rodriguez de Ruiz also recalled how the women did not feel like they could go to the “gay” spaces and take up space there (Id). There were barriers to them approaching those groups because they were for gay men, and the women did not want to be serviced by primarily gay spaces because of their identity as trans women (Id). She listened to her participants and offered them what they needed: she opened in the afternoons, served food and coffee, and created a space where the participants could talk about anything (Id). An increase in participation allowed El/La to expand to provide more than just HIV prevention; participants came to El/La to talk about other vulnerabilities, including domestic violence suffered at home, lack of legal status, need for hormone treatment, and struggles with houselessness and mental health (Id).

Reflecting on her achievements, Rodriguez De Ruiz believes that listening to her community was the key to success, and to the El/La operating today. El/La has broadened its focus to issues beyond HIV prevention and maintains a heavy focus on community building. El/La exists
as the place where Translatinatas and other LGB+ Latinxs can build community, dialogue, and feel safety, and where participants can create space for themselves on their own terms (Rodriguez de Ruiz and Ochoa, 2016). El/La advocates for their participants and helps them build resilience by offering them peer support, offering workshops, and providing experienced guidance and advice (Personal interview, 2019; Interview by Community Initiatives, 2019). El/La also connects their participants with necessary resources, services, and networks but does it with “direct, warm hand off’s” (Id). Currently, El/La has five types of programs: Community Strengthening through Safe Space, Advocacy (including on trans issues regarding immigration, violence, health, and city funding), HIV Prevention & PrEP Navigation, Violence Prevention, and Leadership Development (El/La Para Translatinatas, 2021).

Since its founding, El/La has undergone fiscal sponsorship from 3 different organizations. Their first fiscal agent was Mobilization Against AIDS International (Rodriguez de Ruiz and Ochoa, 2016). One year, the contracts that supported El/La’s HIV prevention activities through the San Francisco Department of Public Health (which, at the time, comprised most of their funding), were put through a public bidding process and their contracts were awarded to another San Francisco organization (Id). Rodriguez de Ruiz, knowing the importance of El/La’s social justice work on Translatinatas, managed to keep El/La’s operations going and were only able to make it through the year with private funding (Id).

For over 10 years, El/La has dedicated itself to empowering Translatinatas by helping them find community, providing them resources, offering them opportunities for personal development, and creating a safe space for Translatinatas to be themselves (El/La Para Translatinatas, 2020). The decision to analyze and propose El/La as the place of intervention is due to El/La’s representation of Translatinatas, their service to the Translatina community, and the potential they have in
responding to Translatina’s needs. Due to various factors, primarily budget limitations, the direct services El/La offers is also limited. One reason its budget and services are constrained is arguably due to El/La’s founding and identity as an HIV prevention organization. With an identity rooted in HIV prevention, how have funding and its mission prevented the organization from developing services and treatments for other human rights work?

Recent trends show that HIV/AIDS funding has remained relatively flat since 2010, and that when adjusted for inflation, funds have actually been on a downward trajectory since 2010 (Rosenberg, 2017). Although treatment and prevention for HIV/AIDS remain necessary, the budget has not increased. When resources for the trans community have historically been approached from an HIV/AIDS-prevention perspective, what does it mean for recipient organizations when the budget decreases? How can organizations that seek to shift away from HIV/AIDS prevention to more holistic direct services expect to be supported financially by a government that prioritizes HIV/AIDS prevention and that has decreased its funding for such programs? In not providing financial resources to expand services to include psychological and medical, the San Francisco government causes the Translatina community great harm. An organization, in this case El/La, cannot holistically advocate for Translatinhas if its finances dictate services, for instance, if its funding is too low or if certain services cannot be offered because of its identity as an HIV prevention program.

Participant Interviews

The next section discusses the narratives shared from three trans participants in their semi-structured interviews: an asylum seeker, a non-profit employee, and a City of San Francisco government employee. They all identify as trans and LGB immigrant activists. From their perspectives, we understand the need for city-funded psychosocial services for the
Translatina community and the best approach for it: through programs that offer them in-house psychological services provided by one existing organization that already serves the Translatina community. All participants in this study insisted on the importance of Translatinas obtaining free mental health services through organizations that represent only Translatinas, are led by Translatinas, and whose practitioners are trans and/or culturally responsive. The author is confident that the demographic sampling, though limited, closely reflects the Translatina population in San Francisco and the United States.

**Jesica Reyes, Honduras, Asylum Seeker**

Jesica Reyes is from Atima, a municipality in Honduras. In August 2019, she was released from ICE custody after spending three months at the Otay Mesa Detention Facility. She spent her first 11 days in custody inside a *hielera*[^14], or “ice box”. Jesica and I met in May 2019, in Tijuana, Mexico, shortly before she entered the United States. At the time, I was volunteering as a legal observer with Al Otro Lado’s Border Rights Project in Tijuana and Jesica was waiting for her quota number to be called so that she could finally, after months of living at-risk in Tijuana, be “legally” processed into the United States to seek asylum. In the days leading up to her entry, Jesica arrived at Al Otro Lado’s workshop seeking legal orientation and I helped inform her of her rights as a trans asylum seeker. Following Jesica’s release from immigration custody, she moved to the Bay Area to live with her sponsor, the person who declared herself financially responsible for Jesica and helped secure her release from immigration. Jesica’s sponsor and I are friends, and I remained in contact with Jesica through her sponsor. Shortly after her arrival to the Bay Area, I

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[^14]: In immigration detention, *hieleras* are rooms with no windows and no beds, only benches, where the air conditioner is set to the highest and coldest setting. *Hieleras* function as a torture tactic to elicit immigrants to sign voluntary deportation. This often happens because while inside the *hieleras*, immigrants may not know their rights and are denied the right to speak to family or a lawyer.
referred Jesica to legal organizations and attorneys to represent her in her immigration proceedings. To help Jesica find community, I also introduced and accompanied her to El/La one afternoon. The circumstances in which we met allowed us to build rapport overtime, which helped us feel more at ease during the interview (Fayan, 2006).

Jesica’s interview was conducted at a conference room in the University of San Francisco’s main campus for privacy and to uphold professionalism. There was no payment for participation. However, snacks were provided and Jesica was provided a ride to and from campus as public transportation would have caused an undue burden.

We began our interview discussing Jesica’s experiences in immigration detention. She spent about three months at various centers and described the conditions inside all of them as “inhumane” (Personal interview, 2019). Jesica recalled detention as a place where “you live in despair,” and are treated “like a serial killer… with your liberty restricted… a uniform and a number that is your sole identifier... it was all very detrimental to my [mental health]” (Id). Jesica believes that time does not exist in detention, that rather it felt time-less, “a place where one does not see if it is day or it is night, you do not know the time…” (Id). The impact detention and the criminalization of immigrants have on an immigrant’s mental health is supported by Aizura, who contends that the guilt and stigma of the criminalization of immigration harms trans detainees’ mental health and reinforces the belief that they are criminals (Aizura, 2016).

Jesica endured transphobia, cissexism, misogyny, and xenophobia inside detention, causing her severe re-traumatization. Rather than protecting her, the guards, officers, and staff all treated her inhumanely, reminding her of the similarly-traumatic events she had endured and fled from in Honduras and Mexico. The first incident occurred once she arrived at the Otay Mesa detention center, where she would be permanently detained at after her release from the hieleras.
The officer examining her upon arrival demanded she cut her hair short to match her birth sex. Jesica shared with me that being forced to cut her hair was devastating, as she felt like she could not express her gender the way she wanted to. She recalled that having long hair was her dream, but it wasn’t until after she left Honduras that she started growing her hair out. In Honduras, having long hair is viewed as feminine and would have put a target on her back. Jesica recalled another incident with a hostile nurse who policed Jesica’s body and gender expression. Jesica was gone to the nurse’s office for a routine exam. As she talked to the nurse, Jesica sat cross-legged. Seeing Jesica’s legs crossed, the nurse told Jesica that “men” do not cross their legs and forcibly pushed Jesica’s leg off her other leg, violently uncrossing them. When Jesica told the nurse that she identified as a trans woman and that she wanted to cross her legs to sit like a woman, the nurse told her that “‘real transgender people are only those who are operated,’ not those who are in the process of transitioning, and she had such a nasty tone about it” (Id). Jesica felt extremely vulnerable and afraid knowing that her health and safety were in the hands of such transphobic people. She realized that the U.S. government had no interest in protecting her. Further, Jesica realized that cissexism and transphobia exist even in the United States, and she began to worry that she may never feel safe in the United States.

Jesica also recalled enduring abuse from the “male” inmates in the detention center, who violently fought with each other and made threats against the trans women in the unit due to their gender identity and gender expression. The prison did not offer them protection from the men.

Jesica’s experiences during the three months she was in ICE custody caused her to feel panic, disappointment, sadness, and depression. Her negative experience inside detention re-traumatized her by reinforcing past traumas, including fear and distrust of authorities. When asked why she believed her experiences in detention would be different, or that she could expect
protection from U.S. authorities, Jesica stated the United States is known as a haven for LGBT people, where LGBT rights are upheld, cissexism does not exist, and where the government protects trans people. She believed this because she, “had read articles on the Internet [about trans rights in the United States], and in the course of my journey of immigrating to the United States, I was talking to other girls and boys about the opportunity we had to be legal in this country, and they and other friends I’ve had in my life told me about the laws that protect us here” (Id). Months after being released from detention and living in the Bay Area, she stated that she realized, “…that [in the U.S.] we have our rights, but I also realize that even in a country that is liberal and free, there is always transphobia, homophobia. And there are people who give us bad looks. So we [trans people] do not feel, like, agusto\textsuperscript{15} (“comfortable”)” (Id). The hardship from detention is one of the reasons why Jesica now seeks mental health services.

Once released from custody, despite hoping to obtain freedom and access to legal and health-related resources, Jesica’s biggest issue was the liminal legality she experienced. Her liminal status prevented her from immediately registering for healthcare, obtaining a government identification card, and accessing other necessary resources. Accessing psychological services was particularly challenging because, “... we don't really have like a medical insurance... or... like an official identification to be able to access a clinic or what do I know to be able to access therapy and medical assistance” (Personal interview, 2019). Jesica explained that it is often “very difficult for [Translatinas] to obtain an ID” because ICE “keeps our legal identification documents, so we don’t have them. I think there should be laws that will be more, like, to instruct organizations that

\textsuperscript{15} A gusto is an expression that beyond meaning “comfortable,” can be contextualized as a feeling of safety. Jesica not feeling a gusto is describing her inability to feel safe and protected, because she feels discomfort knowing the rampant transphobia and homophobia that exist even in a developed and liberal country like the United States. Her inability to feel safe and comfortable are detrimental to her mental health, causing her to feel panic and depressed, rendering her unable to find wellness.
we don’t need to have a legal identification or have anything else in order to receive that benefit such as psychological therapy” (Id).

Besides her liminality, Jesica struggled to find organizations available to assist her, and she describes her experiences below and how they further harmed her mental health:

I've come across these situations that sometimes tell me the same thing… that “we don’t have the space,” or “we’re saturated,” or “if we can’t take you on/offer you our services, we’ll try to recommend you to another organization,” but they always take away one’s hope, because they tell you “[a referral] doesn’t mean they’re going to take your case.” So, one is always adrift, in crisis, going back and forth, between here and there, so no, no, we don’t have this benefit [of therapy] after we get out [of detention]. And that's the most important thing (Personal interview, 2019).

When asked to consider why organizations are “saturated” and unable to assist new arrivals, she believes the capacity limitations are a result of organizations having insufficient financial resources. Jesica told me, “…if there were resources, the [organizations] would hire more staff to help all the people who are coming, because every day new people arrive… So what is needed here are financial resources. If there were financial resources, there would be more staff, and an increase in staff would allow more of us to have access to benefits” (Id).

To the date of our interview, about one month after Jesica’s release from custody and arrival in the Bay Area, Jesica had still not found any legal or psychological aid. She shared her and her sponsor’s efforts in her first month after arrival: they called dozens of organizations and met with a few, but at the time of our interview, nobody had been able to provide Jesica legal or medical assistance, and she was still looking for independent housing to transition into from her sponsor’s home. Some of the organizations who could not assist her offered to advocate for and refer her elsewhere but she had not received any calls or emails back from those who promised to refer her or from anyone offering her services or placement. “For one to be told, ‘Right now we can’t help you, we’ll try to contact other organizations to see if they can help you,’ it is very, very
heartbreaking” (Id). Jesica noted that although she preferred to work with organizations servicing trans people specifically, the limited number of organizations – and the fact that E/La is the only organization serving Translatin@ – forced her to seek assistance from all sorts of organizations, including organizations that serve the general LGBT community, Latinx immigrants, and immigration-focused organizations. It would take many more months, many calls, and many visits to organizations, before she finally secured representation.

When I inquired about what specific resources Jesica needs, she spoke generally, sharing that, “what we really need [the] most when we arrive here in the country is what are special medical resources, what is psychological therapy, and then what has to do with the corresponding [legal] processes of each one of us, but the most important thing is that [therapy]… to be able to keep going, as they say, to be able to continue day by day then, to go adapting to the different life of this country ” (Personal interview, 2019). Despite her desperately wanting to access therapy, she explained that because of limited resources, she has not yet been able to: “Since being released in the United States, I haven’t gone to psychological therapy and I think it should be a priority that there be psychological help for Translatin@” (Id). Jesica reiterated throughout the interview that for trans migrants, “psychological help is always the most fundamental thing” because “being... locked up in detention, where you see so many things that cause you panic, and then leave there to a super different world, to a language that is not yours, then you are in panic and in shock, and so you need those therapies…” (Id). Jesica views therapy as a mechanism for a Translatina to keep going, adapt, and survive.

Having the tools to “keep going, adapt, and survive” is especially important for Translatina migrants who as a community, explains Jesica, are sensitive and vulnerable given their experiences (Personal interview, 2019). Oftentimes, they are “without the support of society and our families
and the government,” and live their lives in fear, unable to “breathe and find tranquility” (*Id*).

Jesica continued explaining why Translatina migrants have the most need in comparison to other marginalized communities, and why she believes they should have access to free therapy:

I speak for myself, [because] of everything that one experiences with our families, then on the journey [here], then in the iceboxes, and then living in detention; Our life happens in ways nobody could have imagined... We, as trans people, are aggravated and traumatized by the conditions we face while awaiting our asylum process. While we wait, we (1) do not have a job, and (2) we do not have a legal identification. To have to think about all that, in addition to worrying about what the outcome of our case will be, living in a different environment, being locked up, living in enclosed spaces, wanting to speak English, everything builds up and creates a psychological trauma for us (*Id*).

Jesica further explains that Translatinats will likely encounter discrimination and negative behavior from others throughout their lives – from a judge, to co-workers, classmates, any agent of society – and therefore Translatinats should always have access to free therapy should they need and want it. In this way, they may be able to have ongoing and constant tools to process, react, act, and overcome when they experience hardship and threats.

In Jesica’s views, a Translatina’s immediate needs upon release from custody are the following: medical healthcare, mental healthcare, legal aid/representation, and housing. Jesica offered suggestions for the government of San Francisco, informing me the city should 1) provide free mental health services to Translatinats, 2) adopt laws that are less restrictive about the documents needed to access such services, 3) provide identification documents to Trans immigrants without requiring another original valid document, and 4) provide resources to Translatinats from one single location. Her recommendations are described in detail below.

Jesica proposes that a solution for the shortage of therapy for Translatinats is to have a specific Translatina-mental health policy allocating mental health resources for Translatinatas. She stated that in the Bay Area, “we [Translatinatas] have so much need... [and] [the government]
know[s] that when a person is transgender, or gay or whatever [their identity/orientation are], that person needs help” (Id). In addition to the struggles imposed by her trans identity, Jesica reflected on society’s further marginalization of trans and LGB immigrants and “would like it if the government focused more on this issue” of LGBT immigrants being seen differently and discriminated against. She feels that if the government prioritized trans migrants instead of “put[ting trans and non-trans] immigrants to the side, and it really shouldn’t be like that,” then society would also view and treat trans migrants differently (Id).

Jesica explained that although she has never received therapy from a practitioner who identifies as trans, she knows she would prefer working with a trans woman. This is because she seeks understanding, empathy, and guidance from her therapist, and a trans practitioner would understand and provide her trusted guidance. Only a trans woman could help her navigate the world based on the practitioner’s own experiences navigating spaces as a trans woman:

I think that it is preferable for us as trans women that there be a psychologist who is a trans woman… because she will understand our pain, she will understand our suffering, she will understand each of the obstacles and problems that we have experienced because she has already been through them. So then she would best... know how to help calm us down. Between two trans women, we would best understand the pain each of us suffers (Personal interview, 2019).

When asked to reflect on how she would feel with a non-trans therapist, she responded that she would feel “a little uncomfortable because it would be like talking to a person whom I feel can’t understand me or cannot comprehend me” (Id).

Jesica’s vision for a single organization that offers various services to Translatinhas was born from her participation at El/La Para Translatinhas and wishing they had more services to offer, but all in one roof. She sought legal and medical assistance from El/La and because they don’t offer either of these services in-house, El/La helped connect her to other organizations for her needs. At El/La, “they have a good heart and want to help all of us, but they also can’t because
they only have a specific amount of money from the government… and… I imagine… donations from other people or through support from other LGBTI organizations” (Personal interview, 2019). Although she lamented that El/La does not have the resources to give her direct services on-site and that they had to refer her elsewhere, she explained that for those reasons, the government should provide El/La with the necessary resources to be the one organization that serves Translatina immigrants. “We are human beings, and we really need psychological and medical assistance… an expansion [of services and resources] is needed because more help is needed, more opportunities for Translatinás are needed” (Id). Jesica hopes to be served by a Translatina-led organizations and that services are provided by trans doctors and practitioners. Ideally, she would access all services from one single location:

In addition to what is psychological therapy or hormone treatment, or [gender affirmation] surgeries, we also need like the dental treatment, medical assistance for some other disease or infection that we can acquire. So then I believe that it would be good to have all these services in one single building. That way, the providers have one file for each woman they see and they evaluate what she requires or what she does not. Otherwise, we are forced to go to various places, which is hard because they give us examinations, various appointments... but if it were all in one building, where we could get it all, all that we need would be in one place (Personal interview, 2019).

My last question to Jesica was to envision what policy she would prioritize if she were mayor or if she could speak to the mayor. She responded that she would urge her government leaders to prioritize Translatina mental healthcare access in policy and to increase the resources they provide Translatinás and the general LGB immigrant community to ensure they receive timely, efficient, and free services.

Victoria Castro, El Salvador, Former Participant & Counselor at El/La Para Translatinás

Victoria Castro is a Testing and HIV Counseling & PrEP Navigator at El/La Para Translatinás (“El/La”). She is also an LGBT immigrant activist and advocate from El Salvador.
Victoria has been a human rights activist since she was 14 years old and studied human rights in college (Women’s Funding Network, 2019). She was targeted and attacked due to her work running workshops on trans health and safety, particularly with trans sex workers (Alvarenga, 2018). In 2017, while in her late twenties, she fled El Salvador to save her life. When Victoria first surrendered herself to immigration authorities at the U.S.-Mexico border, ICE held her at the infamous hieleras (“iceboxes”) and transferred to six detention centers “for men” before finally placed in a center for trans women (Feliciano and Green, 2019). She has lived in the Bay Area for the last several years. Before arriving in the Bay Area, Victoria was forced to live in a shelter in Los Angeles for nine months. There were delays in her immigration case, delaying the adjudication of her employment authorization, and in turn delaying her ability to find employment and independent housing.

I met Victoria while attending one of El/La’s events in 2018. I requested an opportunity to interview her while meeting in person at El/La and then followed up via email to explain the purpose of my research and coordinate a meeting. Prior to selecting her as a possible participant, I learned about and researched her work, activism, and published interviews. Victoria’s wealth of knowledge as both a Translatina immigrant and a former participant at El/La, and now as a local activist, advocate, trans rights champion, and service provider at El/La are supremely valuable to understand the barriers Translatina immigrants in San Francisco face and to develop solutions.

My interview with Victoria was conducted in November 2019 at a private conference room in my work office. No payment was provided for participation. I began by explaining the purpose of my research and my background working with Translatinias as an immigration paralegal. To establish trust, I also positioned myself as an LGBT immigrant, activist, and pro-immigration paralegal. I also conveyed my support of and interest in working with El/La. Our common goals,
interests, and experiences allowed for us to build rapport before starting the interview so that both sides could feel more at ease (Fayan, 2006). Victoria and I quickly and easily immersed ourselves in conversation.

Given Victoria’s experience working with and advocating for Translatinatas, she was candid about the issues Translatinatas face daily in San Francisco, explaining that trans people:

... Are getting murdered... being discriminated against in their employment... don’t have access to healthcare; [their] mental health is deteriorating each day... are falling into drugs, into alcoholism... are sleeping in the streets... are lining [the city’s] streets with tents because [the city is] not providing them with a place to live. I ask the city: then, what are you going to do for these people who are being discriminated against, who don’t understand the language, who have so many traumas, who are possibly facing immigration proceedings? So then, what solution will you give them? (Personal interview, 2019)

In Victoria’s experience, given San Francisco’s vast wealth, it is disappointing that the city does not offer greater resources for trans women and Translatinatas for housing, medical and psychological care, and other necessary resources.

For Victoria, the Transatica community is the community in San Francisco with greatest need. She believes that access to free, safe, efficient, and culturally competent mental healthcare for Translatinatas is a fundamental right that will help Translatinatas rebuild their lives, take control of their lives, find dignity, and become active participants in society:

If we are healthy, if we are well, we can find many ways to be able to excel, to have a more dignified life, to be able to find those things. But if we come here and all the burden of all our problems, all those needs – housing, money, work – everything starts to fall, then our health deteriorates. And more so if we don’t have a therapist who can help us manage those situations, all those problems, [our mental health] declines. Therefore, I believe [mental health services] are a primordial service necessary for people, for trans people (Personal interview, 2019).

Victoria and I discussed the barriers Translatinatas face when accessing services in San Francisco. We realized our experiences were similar when referring Transatica immigrants to services locally, especially when it came to obtaining mental health services, housing, and medical
healthcare. For Victoria’s participants, access to safe and stable housing is their number one priority, and their second priority is access to mental and medical health services, but there are great barriers to accessing both. She shared that, “the city doesn’t have… a single [housing] space [solely] for trans women,” and that in most cases, unhoused trans women/Latinas who stay in non-trans shelters suffer transphobia, abuse, and discrimination (Personal interview, 2019). Furthermore, that the language barrier poses a significant obstacle as it prevents a Translatina from advocating for her needs and communicating the abuse she may be experiencing (Id). Regarding mental health, I explained that my clients often told me that the organizations I referred them to were not taking new cases, or they had long waiting periods, while others had requirements the clients could not meet, and most were costly. Victoria agreed that her participants and her team at El/La face the same frustrations about not finding sufficient resources, inaccessibility, and the negative repercussions on participants’ mental health. She shared that:

[The team at El/La] always works hand-in-hand to find [participants] a place to live… we, as a team, actively work on helping [participants] with other things that they need, including… helping them apply for their Medical or their [San Francisco] Healthy… registering them for a medical service so they can get a check-up, have access to hormones, and have everything they need in terms of their physical health… an attorney… [But] the organizations are limited; sometimes, we try but are unable to find them representation in the legal system because places tell us, “We are at capacity. Our attorneys are at capacity and cannot take your case.” So then the girls have to go to their courts, ask for a continuance, and that in itself causes so many delays because if you don’t submit your asylum application, you can’t apply for employment authorization. So everything becomes a cycle. If one piece falls… then another one falls, then another one. So then [the girls] start having more problems and their mental health goes totally south. Sometimes, they arrive at the organization [El/La] very frustrated, they cry and request to us, and many times, I want to be able to tell them, “I have the solution,” but I don’t have it, we cannot find it because the city does not provide us services, and the few [resources] it brings us are already saturated, already full, there is an enormous wait list, it’s very difficult (Id).

Victoria shared that one of the barriers El/La faces in obtaining funding to increase their services is due to the city’s limited data on demographics of trans women, Translatinahs, and trans
homeless individuals. She lamented, “... We don’t know how many trans people there are in a city, [therefore] we cannot know the number of resources that are needed” (Personal interview, 2019). She acknowledged that the only way the city will have accurate data is through government mobilization, initiative, and taking trans individuals and especially Translatinlas into account (Id). When asked if El/La has the capacity to determine the number of Translatinlas in the city, Victoria shared that they do not for various reasons. For one, the organization has a drop-in model, meaning outreach is limited and participants arrive to El/La by word of mouth of by referral from outside organizations. Although they wish to access as many Translatinlas as possible, they are unable to. As of November 2019, El/La had registered 320 girls as participants. But this was by no means an accurate number. When asked if the census had the possibility of providing the necessary data, she shared that the census cannot accurately or truthfully reflect the general trans or Translina population for the following critical reasons:

1. Trans immigrants/Translatinlas fear of ICE: Despite increase in outreach efforts, many of the homeless people in the streets are LGBT immigrants, and they are afraid of filling out documents out of fear that immigration authorities will obtain this information and detain them. This is especially true for Translatinlas who have had prior ICE contact or who have criminal histories;

2. Self-identity: Many Translatinlas, particularly those who are homeless, have not undergone a legal gender or name change, and therefore, they do not identify as “transgender” in any legal documentation; and

3. Skepticism: Trans people often do not want to get involved because they are skeptical about the outcome of the census. They believe their participation will not make a difference to improve their situation. They are accustomed to the city marginalizing them and believe the city does not intend to help them or have their best interests at heart.

Victoria acknowledged that Translina’s limited participation extended beyond the census. Most recently, she recalled that during one of the 2019 Our Trans Home SF\(^{16}\) campaign

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\(^{16}\) Our Trans Home SF is a coalition working to address homelessness and housing instability impacting “Transgender, Gender Variant, and Intersex (TGI) people” in the San Francisco Bay Area (Our Trans Home SF,
advocacy meetings at City Hall, only five trans Latinx individuals attended. “When we went to City Hall, there were only about 5 [trans] Latinx people, even though the invitation [to participate] was open to everyone, but many times [the lack of participation] is because we have lost the ability to believe that a place will give us a service, and this is because we’ve been asking and asking and they [the City Government] has not taken initiative,” she shared, acknowledging the history of broken promises from the city to the trans community (Personal interview, 2019). Victoria stated that the city and its leaders have failed to provide substantive change and resources to the trans community even though the serious need is widely and publicly acknowledged by the city. She does acknowledge that Mayor Breed has shown her commitment to the trans community through various initiatives, including launching a campaign in 2018 that provides housing and jobs for Transitional Age Youth, about half of whom are homeless and identify as LGBT; established the LGBTQ Immigrant Fellowship; is a regular attendee at events such as the trans march; and was engaged and responsive throughout the trans housing campaign. Further, she agrees that Mayor Breed is aware of the trans community’s marginalization: she has publicly stated that trans people suffer houselessness about 18 times more (pre-COVID-19) than cisgender people (San Francisco

2019). It is an example of an initiative made possible through community organizing and coalition-partnership by local trans and LGB organizations. A limitation is that its housing services are open to all adults in need, not just individuals who identify as Transgender. In May 2019, the Mayor’s Office of Housing and Community Development passed a budget of $2 million in funding for the Our Trans Home SF campaign to help at-risk transgender individuals afford the cost of housing in San Francisco and prevent homelessness, (San Francisco Press Release, 2019). The pilot program was approved and offered a contract to be overseen by St. James Infirmary, a Black trans-led nonprofit, and began in 2020. It offered to provide housing to 13 individuals and “support hundreds of low income TGNC community members find or keep their housing through rental subsidies, housing navigation, and case management” (San Francisco Office of Transgender Initiatives, 2020). Due to the emergency created by the COVID-19 pandemic, the contract was put on hold, and St. James Infirmary launched a GoFundMe in June 2020, raising $15,000, to aid in providing safe and supportive housing for trans women and men of color (Support Our Trans Home SF Organized by Reeves, 2020). On June 27, 2020, the organization further announced on their Instagram social media account that due to health emergency, their contract funds were going to be cut by 10-15%. “At this time, we need funds to help pay for food and supplies for the house and if we can make enough to help with more long term and/or one-time rental subsidies and hotel rooms for TGNC individuals,” they stated. On August 20, 2020, Mayor Breed announced proposed a new budget of $1 million dollars annually for a 2-year contract for Our Trans Home SF to provide rental subsidies, transitional housing, and navigation services to transgender and gender nonconforming low-income community members (San Francisco Government Press Release 2020).
Government Press Release, 2020). Still, there is much work to be done and the Our Trans Housing SF is merely scratching the surface. While Victoria is extremely grateful for the opportunity it provides trans people, she stated that the funding only assists, at most, a couple hundred people; and her guess is that there are likely thousands of trans individuals who are at risk and need assistance in the area (Id).

Victoria proposed that collaboration is the best solution to bridging need-based gaps. She envisions a collaboration amongst trans coalitions, LGBT+ service providers, and activist/allies to find solutions and advocate for the city to create vast services that are set up for success. Victoria shares from experience an example of the power of community and grassroots organizing to develop solutions and respond to limited services: her own community network. Victoria has developed an independent network of people passionate about helping Translatininas who respond to their housing needs by finding them transitional or temporary housing:

I always try to find solutions, many times outside the system, because thanks to God I have a lot of friends. I have created for myself a large circle of friends and am always ready to send out an email, asking them for help, telling them about the latest Translatina girl I encountered who does not have a home, for whom I’m trying to find something temporary. I try to find solutions... [for] one month or maybe even one day. There are people who arrive [at El/La] and need [a place] to sleep for a few days or until they find something. So then I try to find a solution that… for the moment is secure and so that I can at least say to them, “You will not sleep in the streets tonight” (Personal interview, November 2019).

Victoria and her network are committed to helping Translatininas find more than just safe transitional housing; they provide them an opportunity to get back on their feet. Without these housing opportunities, the women would remain houseless, vulnerable, and at-risk.

Another barrier Victoria brought up is practitioners’ and healthcare workers’ lack of cultural competency and language abilities. Victoria shared her own experiences and observations:

[Many] doctors are not prepared to treat trans people. Often times, there are therapists who are having a trans client for the first time and they don’t know how
or what it means to have been born in a body with which you don’t identify. There are therapists here in San Francisco who are very good at working with trans people, but I think most of them need more training to be able to work with trans people because here there are a vast number of trans people who need services (Personal interview, 2019).

Due to Translatinas’ limited access to culturally responsive therapists, Victoria shared that she and her participants have had invalidating experiences in therapy: “…he or she can say, “No, I feel that you are fine,” but emotionally I am [doing] terribly because I am telling them about real situations that are happening to me… about my dysphoria... but they are [dismissing] my experiences and not validating [my feelings]” (Id).

Victoria also shared that practitioners’ and health care workers’ limited cultural responsiveness often creates more issues for trans patients by delaying their access to medical intervention for their gender dysphoria, including access to gender affirmation surgeries. Under the Standards of Care (SOC) for transgender healthcare, an individual undergoing gender affirmation surgery must undergo a psychological assessment and evaluation, and only once their surgical readiness referral letters (one or two, depending on the type of surgery) have been completed and processed by mental health providers will they be eligible to undergo gender affirmation surgery (O’Brien-Coon & Neira, 2020; World Professional Association for Transgender Care, 2012). For Translatinans who want to affirm their gender, seeing a therapist is oftentimes a barrier to obtaining the body they have dreamed of their whole lives, the body that matches the gender they identify with. “Each doctor, each therapist, decides if you are a candidate. And while the doctors don't think you’re ready for it, you will be placed on a very long waitlist… [this] puts the girls into a depressive mood,” Victoria reflected (Personal interview, 2019). While Victoria is grateful that safe services exist in the United States – a stark contrast to the often-deadly clandestine methods women in other countries resort to – she believes neither a doctor nor therapist
should determine whether a trans person is or is not ready for surgery. She simply, “cannot understand this advice from a person who does not know the realities that trans people face” (Id).

Victoria also finds the SOC requirements troubling and a double standard compared to the lack of requirements imposed upon the general population when undergoing surgery and proposes the requirements for gender affirmation surgery be changed. Currently, a cisgender houseless person needing surgery, whether for desire or need, does not have to undergo therapy or obtain a referral from a therapist(s) to undergo surgery. Similarly, trans people should be timely treated for gender dysphoria without having to jump through obstacles. The barriers imposed and often-extraordinary delays in obtaining gender affirmation surgery harm a trans person’s mental and physical health. Victoria proposes a solution is for healthcare professionals to undergo regular and on-going trainings, stating that by “train[ing] people to be able to work with [trans] mental health [patients],” practitioners will be adequately trained to be culturally-responsive (Id). This will increase mental healthcare access to the trans community (Id).

Another suggestion Victoria shared is for trans therapists to treat trans patients. For Victoria, being serviced by someone who looks and identifies like her is critical because she knows from experience how helpful and affirming it can be. She shared that her therapist at the time of the interview identified as trans. For Victoria, having a trans therapist makes her feel, “very comfortable because I feel safe, because I know that what I am telling her she understands and that she can see it from the reality perspective and from the professional perspective, and therefore she knows which path will be the best for me to take” (Personal interview, 2019). Only having trans-identified practitioners is, however, too idealistic and limited. This is because there are a “very limited” number of trans-identified practitioners as the trans community is so marginalized in all spaces, especially in higher education and academia (Id).
The final issue Victoria raised as a barrier for trans immigrants, from her perspective, is liminal legality. She explained that as progressive as San Francisco and California are, immigration status still poses a barrier to therapy and to obtain medical insurance and healthcare. One of the main ways immigration status is a barrier is because by law, an individual must have an original unexpired government-issued identification card to enroll in healthcare, even in Healthy San Francisco. But Translatinxs generally do not possess an original government-issued ID card because their documents are held by ICE. When a migrant is detained, ICE confiscates their identity documents and keeps control of it for the duration of the migrant’s proceedings. Retaining access to an individual’s documents allegedly ensures the individual does not flee the country. Victoria believes that to ensure prompt access to eminently needed services, “there must be a way for trans people to access therapy without documents because this is about our mental health” (Personal interview, 2019).

When discussing timelines to wait to access therapy, Victoria suggested that trans immigrants should not have to wait; they should be granted therapy from the moment they are released from ICE custody. Victoria explained that a trans woman’s mental health can suffer at any point, and without adequate guidance and support, life can become very difficult. Having stable and safe housing, in Victoria’s experience, is not sufficient. Triggers are encountered daily: in planning for or undergoing transitioning, in the workplace via discrimination or microaggressions, in being alone and/or isolated from one’s (chosen) family and loved ones, in the streets (societal violence), in being unemployed or financially insecure, in one’s immigration proceedings (especially if one’s case is denied), in being food insecure, and in the general challenges of navigating a new country. Swift access to mental healthcare will ensure trans migrants have access to someone who will listen to them, help manage their traumas, offer
guidance as they insert themselves into and navigate their new community, and advocate for themselves in their immigration process. Access to mental health is about wellness and dignity.

Victoria believes a city like San Francisco has a lot of potential for creating free, accessible programs for trans migrants. She believes San Francisco can and should divest resources from other organizations and programs and re-invest them into organizations and programs that serve the most vulnerable, specifically LGBT communities. Victoria would like to see a center solely for Translatinas. She states that “a space definitely is needed, one that is specific, or an area so to speak, that exists for Latina women, trans, [where they can be] comfortable in their language and obtain services in their language, where they feel comfortable and protected” (Personal interview, 2019), free from systemic oppressions.

Victoria ended her interview in a tone of urgency, sharing that the proposed interventions offered in this research project are critical to the Translatina community and that she hopes the city takes action: “We need more people focused on these topics and who are motivated to do these types of initiatives because many times, the solutions remain as ideas, they remain in the ‘we want to do this’ but then people say they… ‘can’t find how to do it,’ losing that mission and vision... [But this proposal is] essential… especially here with the Translatina community, [the situation] is very dire” (Personal interview, 2019).

**Pau Crego, City Employee**

Pau Crego is a community organizer, health instructor, and published author, and he has extensive experience in the policy and non-profit sectors. He identifies as a transgender man. Currently, he is a city employee and the deputy director of the Office of Transgender Initiatives (OTI). Pau is also a stellar Translatina advocate and previously held the role of Case Manager at El/La. Pau’s work at the Office of Transgender Initiatives, his advocacy, and proximity to the trans
community throughout his career but also as the director of the Trans Migrant Fellowship have exposed him to the barriers and scarce resources Translatinas face in San Francisco. His experiences are unmatched for the purposes of this thesis. I was honored he accepted the opportunity to meet with me and participate in this research. No payment was provided for participation.

Pau and I met in November 2019 in a public cafe at Civic Center Plaza, per his request. We began our interview by discussing the purpose of my research, our common interests, and our experiences working with the immigrant and LGBT community. Similarly to my prior interviews, Pau and I built rapport and trust based on our common goals, interests, and experiences, allowing us to feel more at ease and have a free-flowing conversation (Fayan, 2006).

Pau established from the beginning of our conversation that in his work witnessed experience, the Translatina community is one of the communities in most need. Despite the high need Translatinas have, they face scarce resources, lack access to mental health services, language barriers, and limited knowledge and skills pertaining to their rights. Understanding Translatinas’ and trans needs, Pau is fully committed in his work through the EmergeSF Fellowship, formerly the LGBT Immigrant Fellowship, which he leads, and the Our Trans Home SF campaign, to build and empower the trans community. His goals are parallel to those of the Office of Transgender Initiatives: “[At OTI] we are working on policies that are beyond our office like city and county policies, [and] we do a lot of community involvement” (Id). It was evident throughout our conversation that he and his team carry a heavy load and that he wears many hats at OTI.

Based on his activism and work, Pau has observed that the main barriers for Translatina wellness are accessibility, representation, and limited data; they need support in all of this to be successful post-migration. The Trans Migrant Fellowship was created to eliminate some of the
accessibility and representation gaps trans people in San Francisco face, and to empower and provide them equity. To do this, the fellowship provides its participants with opportunities for professional development, including refining or establishing their careers, mentorship, English as a Second Language (ESL) classes, and connects them to services to rebuild their lives. The fellowship also introduces them to the community and provides spiritual guidance and opportunities to develop their mental wellness. He explained how the pilot greatly informed him about current Translatina’s needs, specifically their limited understanding of employment rights, experiences with financial hardship, and mental health needs:

… Our pilot, which was last year… [focused] on Translatin… we’re open to folks who are LGBT [immigrants] but… the majority of the people who do this are Translatin so… we pay them for 20 hours a week during 5 months to work on their professional development. That includes taking ESL classes if that’s what they want to do, so last year… we had 3 people, they each had their own plan, one was from Colombia and her work plan was to take English classes because… she wanted to work on [that] and… to figure out how to validate her architecture license here. The second was a person who wanted to work on her small business and her English, so she worked with MEDA to develop her [business] model. And the third was a woman who worked on her portfolio. So in addition to their individual work plans, they attended sessions, which we provided them, so we focused on a range of skills like some of them were just work skills like PowerPoint, like administrative skills, and then some of them were an overview of the education system in the U.S. and economic development stuff, like what is a credit score, how do you get a credit score... So all three of them started doing lending circles with the Mission Asset Fund to work on their credit score. This time around… we’re going to have 8-10 hours a week of internship which will be around the census and engaging folks around the 2020 census… the main components are: the internship, the weekly or bi-weekly sessions, and then if they want, the English classes… it’s also paid, which is a very important piece for me because I know that people would not participate otherwise, and compared to other programs like [Luchadoras] at El/La¹⁷, it’s a very generous stipend (Personal interview, 2020).

¹⁷ Here, “Luchadoras” refers to El/La Para Translatin’s Luchadoras Leadership Development Program (El/La Para Translatin, 2020). Part of the program involves training Translatin to be known advocates in the community and empower other women (Hing, 2014). The goal is for them to be trained to facilitate violence-prevention conversations, think about different ways to do outreach, run small support groups, and practice advocacy at higher levels like at City Hall (Id).
It’s clear that Translatinatas need, want, and deserve opportunities to develop themselves and their careers in the United States, but there remain many barriers to doing so. The fellowship responds to these barriers and should be expanded to impact a much greater number of trans women, which will require a more expansive city investment.

Pau shared that another critical barrier and component to responding to Translatina needs is accurate, expansive data on city-wide trans demographics. Victoria Castro also shared this issue as a barrier. “I think especially with trans communities we have such little data, so anything that kind of brings together the need for mental health services and can compile some data to make that case is super important,” he said, adding that projects like mine are “super important to move policy forward” (Id), but it doesn’t always work out due to timing, limited knowledge, or insufficient resources. Until the city has compiled more data, he told me, we will be unable to express the urgency and need for city-funded mental health services for Translatinatas. In the meantime, he calls for legal aid centers and law firms that represent trans asylum seekers to hire in-house therapists to provide clients holistic psychological and emotional support as they navigate immigration law.

A third barrier Pau raised that prevents Translatinatas from accessing and benefitting from city services is government departments’ limited training on trans issues. “I think… training different departments on trans issues… is a key piece for the city services to be accessible but also to hire trans individuals into the city,” he shared (Personal interview, 2019). The need for training of city and service providers is a barrier Victoria Castro also brought up during our interview.

I next brought up to Pau the limited funding that Translatina services in the city face, and which Victoria, Jesica, and my clients have experienced and observed. I asked him if the city could divesting resources from other departments and organizations, including from the police, and
reinvest them into the trans community for services, including mental health. Pau told me that the
situation is complicated for equitable, political, financial reasons:

... Those [funding] decisions are [made by] the mayor, the supervisors, the Director of Public Health… [they] could say, ‘We’re going to allocate this money to this,’ but since they’re already so under resourced, what usually happens is that the supervisors say, ‘We’re going to add money to DPH’s [Department of Public Health’s] budget to address this issue.’ So, the decision-making really falls on the board and the mayor’s office… Hopefully, our advisory committee would be able to do some more advocacy towards pushing for the mayor to allocate some funding for this specifically, and then what department it goes to just depends on a variety of different things. It’s most likely DPH but it depends, it could get sent out to an agency like Instituto [Familiar De La Raza]18… it is a very political process because you know then in theory another community is getting less funds for something because money could be reallocated from a lot of places but it depends on how it's reallocated... Either way that is basically what happens because the budget does not increase that much every year. And then there’s state money that comes in, and that’s how Our Trans Home SF was paid for (Personal interview, 2019).

The last issue the trans community faces that Pau and I discussed is access to gender-affirming care, including psychological and medical. Based on his work and observations, he knows that the Department of Public Health has a program called Gender Health SF. San Francisco residents with Medi-Cal, Healthy San Francisco, or the San Francisco Health Plan can access gender-affirming surgeries through that program. Pau echoed Victoria’s concerns over delays in accessing surgery, informing me that therapists often “hold off on signing the recommendations” (Personal interview, 2019). Some of the reasons therapists delay recommendations includes the candidate not having stable housing, but he stated even then, he cannot justify. “… Other [non-

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18 Instituto’s La Clínica (“The Clinic”) program addresses the social, emotional, and spiritual needs of the Chicano/Latino community. Services focus on a range of behavioral health issues, including severe and persistent mental illness, trauma-related conditions, family and intergenerational conflicts, as well as adjustment problems related to immigration, and reunification. La Clínica offers individual, family, group, and couples therapy; and case management and medication services for children, youth, adults and their families. All services are provided to San Francisco residents without private insurance and are on a sliding scale depending on income. La Clínica provides services at no fee, at low fees, and accepts insurances including Medi-Cal, Healthy Families and Healthy Kids. Instituto’s Si A La Vida (“Yes to Life”) program offers holistic wellness services for LGBT+ Latinos living with HIV. In addition, they offer Transgender Wellness Services that include PrEP navigation services HIV testing & counseling, weekly support groups, case management, peer counseling, and community engagement activities.
trans] people who need medical procedures are not required to have stable housing right? Like homeless people get medical procedures all the time and they go to a type of residence or [the city] has a backup for them,” he shared (Id).

Pau first realized delays for gender-affirming surgery referrals were an issue while working at El/La. His Translatina participants expressed the delays they experienced, including how it negatively affected them and their perception of mental health. Instead of viewing the referral and surgery access process as supportive and positive, they viewed the various referral requirements, delays, and assessments as a barrier to their obtaining the gender-affirmation care they have sought for years, possibly even their lifetimes. Pau told me that he believed “a lot of trans people relate to therapy through that lens [of therapy as a requirement for gender affirmation procedures], and it’s something that’s a requirement versus something that’s not necessarily a choice,” by “choice” meaning needing surgery to affirm one’s gender, to treat one’s gender dysphoria. A solution Pau suggest is for “trans people [to] reclaim therapy by accessing gender-affirming care more accessible,” and for mental health practitioners to be culturally-responsive (Id).

If he were wealthy, Pau’s dream would be to put his money into the community by investing in a building to offer stable and safe housing for the trans migrant community.

**International Trans-Supportive Policy Interventions to Learn From**

The next section includes examples of resettlement services, including mental health, for refugees and asylum seekers – including those who identify as LGBT – available in Norway and Germany and led by non-profit organizations and state governments. Their intervention models, approaches, and success are significant and provide inspiration and opportunities the City of San Francisco should strive to adopt, as will be discussed in the following sections. The author acknowledges that Norway and Germany have different social and racial contexts in comparison
to the United States, and therefore a comparison might seem inadequate. For instance, regarding social progress, Norway and Germany placed in Tier 1 of the 2020 Social Progress Index ratings, whereas the United States placed in Tier 2 (Social Progress Imperative, 2020). Each country was also scored out of 100 based on an average for three broad social dimensions: Basic Human Needs, Foundations of Wellbeing, and Opportunity (Id). Norway was 1st place overall and scored 92.73, Germany was 11th place and scored 90.56, and the U.S. was 28th place and scored 85.71 (Id). Racially, racism is worse in the United States than in Europe (BBC, 2018). Regarding quality of life, Norway scored 91 out of 100 for its great political stability, while Germany scored 84 and the U.S. scored 67 (World data, n.d., a; World data, n.d., b). On the subject of health, Norway scored 91, Germany 96, and the U.S. 74 (Id). Finally, regarding civil rights, Norway scored 99, Norway 94, and the U.S. 81 (Id).

Despite the social and racial progress disparities, there are equitable factors between the countries. All three countries are similarly advanced, developed, and have similar high incomes and standards of living. In 2019, Germany’s gross national income was reportedly $57,411 dollars per capita, Norway’s was $70,327, and the United States’ was $66,022 (OECD, 2021a). Comparing net national income, in 2020 the reported net national income in the United States was $55,069 dollars per capita, in Norway it was $53,179, and in Germany it was $44,734 (OECD, 2021b).

Specifically in San Francisco, the German and Norway case studies are translatable because the social contexts are also similar at the San Francisco city level. Given that the financial comparison is important to determine whether a similar financial investment would be suitable or possible, it’s important to consider the GDPs or both San Francisco and Berlin. San Francisco’s GDP is 3.45 times Berlin’s, with GDPs of $501 billion in 2019 (JPMorgan Chase
Institute, 2019), and GDPs of $145 billion, respectively (European Commission, 2021). The studies demonstrate actions that San Francisco can take to provide services to Translatinas, specifically funding for trans refugee/asylee center where trans migrants can access medical, psychological, and social services, and a shelter where they can safely sleep.

Aiming to adopt Germany’s and Norway’s approaches to LGBT refugees would help the United States progress socially and racially, and in San Francisco specifically, it is translatable.

**Redress for Torture Survivors: Lessons from Norway**

As the literature and prior case studies evidence, access to psychotherapy, psychiatry, and rehabilitation is critical to assist trans migrants re-enter society and function as individuals. The Norwegian government, through the protocols it has signed on to both through the European Union’s welfare healthcare for “disabled” persons (with mental health considered a disability) and the United Nations’ protocols, particularly the Istanbul Protocol, funds and cooperates with local governments and organizations to create mental health clinics for torture survivors and traumatized migrants and refugees. These efforts are valuable given that immigrants make up 17% of Norway’s population. In Oslo, Norway’s capital, 36% of the population are immigrants and second-generation immigrants (Søegaard, Kan, Koirala, Hauff, & Thapa, 2020). Additionally, the number of refugees and asylum seekers have increased significantly since 2015, in which they received more than 31,500 asylum seekers (Donahue, 2016). Comparably in the United States, in 2018, immigrants made up 13.7% of the population (Budiman, Tamir, Mora, & Noe-Bustamante, 2020).

Regarding healthcare generally, asylum seekers and refugees are entitled to receiving essential healthcare upon arrival in Norway (Norwegian Directorate of Health, 2020). If the asylum seeker or refugee needs medication, they will receive healthcare “as soon as possible” (Id). They are also entitled to professional medical assistance if they have experienced “war, conflict, torture,
violence, abuse or female genital mutilation, and are suffering problems as a result of this” (Id). Anyone who has “suffered torture, violence or abuse, and need to talk to someone about what [they] have been through,” or who has “… major sleep […] or substance abuse problems,” can receive mental health services (Id).

In addition to extending medical and mental healthcare to asylum seekers and refugees, the Norwegian government offers specialized clinical services to refugee survivors of trauma throughout Norway. Municipalities or Regional Centres on Violence and Traumatic Stress (RVTS) exist throughout Norway and are responsible for working with the local government and mental health professionals to provide the specialized services:

[The Psychosocial Centre for Refugees, established at the University of Oslo in 1990] worked at a national level, aiming to provide assistance to professionals as well as to refugees in various parts of the country. Reception of large numbers of refugees and the policy of dispersed settlement for refugees led to resettlement all over Norway. This created a need for regional teams as well. The need for services in different locations grew, and three regional psychosocial teams were established in 1990… a proportion of the time was to be used for clinical programmes, with priority given to the treatment of severely traumatised refugees as well as clinical investigations and theoretical studies in this field. Furthermore, the information gathered served as a source for policy-making and facilitating psychosocial services adjusted towards this group at the municipality level; and the information provided by the study was noted as valuable by the White Paper on health services to refugees (Sveaass, Lie, and Hauff in Overland, Guribye, & Lie, 2014, p. 34-36).

The refugee psychosocial centers first opened in 1986, in response to refugees and migrants from Vietnam, the middle east, and then the Former Yugoslavia – particularly Bosnia-Herzegovina – resettling in Norway (Sveaass, Lie, and Hauff in Overland, Guribye, & Lie, 2014: 33). The creation of the centers is the result of government, local government, and societies’ efforts to provide services to traumatized refugees: the Ministry of Health recognized the trauma field in Norway as a public health responsibility and the Ministry of Social Affairs responded by funding and creating “projects” to assist in local university’s psychiatric clinics.
Despite the centers and the greatly available medical and mental healthcare to assist asylum seekers and refugees in Norway, there are shortcomings that have resulted in some of the projects to close. The first issue is due to funding. The increasingly conservative, xenophobic, and Islamophobic governments in Europe and Scandinavia have disregarded the clinics as unnecessary or unworthy (Vaage, 2018), cutting funds. Another issue is due to cultural differences and lack of cultural competency, resulting in patients being misunderstood and not properly supported (Id).

There are also barriers to accessing mental health services. On the patient’s part, there is often stigma for being referred to mental health services; lack of trust of their practitioner and authority; and concerns about xenophobia, lack of knowledge about the healthcare system, language, and acculturation (Vaage, 2018). On the practitioner’s and healthcare system’s ends, there is lack of knowledge about migration and the refugee experience; lack of cultural responsiveness; inability to communicate via common language and apprehension of utilizing an interpreter due to confidentiality or competency; and lack of knowledge related to acculturation, financial strains, and additional structural barriers (Id).

To ensure equal and competent health services for refugees, various health professionals throughout Norway are working diligently to create organizations and trauma centers that respond to the current needs and shortcomings. Practitioners Steel, Silove, Phan and Bauman, created an organization called “Restore” that develops refugee clinics focused on reducing refugees’ mental and physical disabilities after exposure to extreme trauma (Sveaass, Lie, and Hauff in Overland, Guribye, & Lie, 2014: 36). Sveass and Vaage, mental health practitioners in Norway who work and advocate for refugees, dedicate their work to educating the government and practitioners about how access to mental health can help refugees rehabilitate and integrate into society post migration. Sveass and Vaage believe that for any refugee/asylee to succeed, they must not be limited or
troubled by chronic struggles with suicidal ideation, PTSD, anxiety, or depression. “Rehabilitation after torture is a multi-faceted and potentially long-term process,” they write (Vaage in Overland, Guribye, & Lie, 2014: 26; Sveaass in Overland, Guribye, & Lie, 2014: 63-64). They view rehabilitation as requiring a holistic effort to successfully help survivors of torture reconnect and immerse themselves in meaningful ways into their new society (Id). They believe that for a refugee survivor to connect and immerse into their lives post-migration, they must “regain hope and a sense of control over their own lives” (Id). Sveaass and Vaage also believe that a key to helping refugees regain this control, practitioners and governments must move away from pathologizing and from viewing/labeling the survivors as “sick” (Id).

Other successful and notable efforts are at the trauma clinic at the prestigious Sorlandet Hospital (SPST) in Kristiansand and at the Transcultural Psychiatric Out-patient Clinic for Refugees and Asylum Seekers at Stavanger University Hospital, which opened in 2014 (Vaage, 2018). The Transcultural Psychiatric Out-patient Clinic aims to provide competent health services for refugees, asylum seekers and undocumented individuals, increase accessibility of services, and increase quality of assessment, diagnostics, and treatment (Id). Specifically, the Transcultural Center works to increase accessibility in the following ways: omit the word “psychiatry” to reduce stigma, work with anyone who meets the definition of refugee or asylum status, meet patients where they feel safe, and make services free (Id). Their transcultural approach includes viewing the therapeutic relationship as building a relationship, which results in trust, and as an opportunity for cross-advocacy (Id). As cross-advocates, they connect with the patient’s lawyers and immigration officers (Id). They also work based on an “explanatory model-approach,” requires that they collaborate with the patient to find solutions (Id), empowering the patient.
Redress for LGBT Refugees in Germany: Lessons for An Intervention

Elsewhere in Europe, specifically in Germany, efforts are underway to assist LGBT refugees. As of 2016, there are various LGBT refugee centers and housing projects offering a variety of services to the LGBT refugee/immigrant community. Their mission is to offer necessary services to LGBT refugees, including mental healthcare. Berlin is home to the first of the centers. In 2016, Schwulenberatung Berlin, an LGBT organization founded in the 1980s, opened an LGBT refugee center and shelter to provide a safe space for LGBT refugees and asylum seekers given the continued discrimination and abuse within German society\(^\text{19}\) and in non-LGBT shelters. “Some of the residents say Schwulenberatung is the first place they feel safe and accepted,” said Stephan Jäkel, the refugee manager at Schwulenberatung Berlin, who also advocated for and founded the LGBT refugee shelter (Toesland, 2018).

Schwulenberatung Berlin’s LGBT refugee center and shelter have proven widely successful. Part of their success is due to their expertise in LGBT and refugee issues, and their commitment to ongoing learning about the issues at hand, increasing accessibility to marginalized communities, and engaging the community. Since the center’s opening, it “[has] become a highly professional and skilled team of doctors, educators, health scientists, pedagogues, psychologists, psychotherapists, social scientists and social workers, administrators, as well as many volunteers and freelancers. Some of us have a migration or refugee background,” states their website (Schwulenberatung Berlin, 2021). Two on-site psychotherapists who specialize in refugee trauma provide LGBT refugees one-on-one therapy, group counselling, and long-term support in all

\(^{19}\) In the first half of 2019, there were 57 violent crimes against LGBT people and 188 non-violent crimes (Silk & Douglas, 2019). The Lesbian and Gay Association (LSVD) believes the numbers are not accurate as most hate crimes go unreported (Id). In the 2019 ranking of hate crime and hate speech in Europe compiled by ILGA (International Lesbian, Gay, Bisexual, Trans and Intersex Association), Germany had fallen from third to 23rd in the EU for hate crime and hate speech (Id).
matters including but not limited to “coming out,” mental health, alcohol and drug use, addiction, HIV/AIDS (*Id*). Some services are also extended to partners and families (Schwulenberatung Berlin, 2021, Toesland, 2018). Services are offered in several languages, including Arabic, English, French, Greek, Polish, Slovak, Spanish, Czech, Russian, and Turkish (Schwulenberatung Berlin, 2021). The center also employs two lawyers who are on site and offer affirming legal aid to refugees and asylum seekers (Toesland, 2018). Finally, individuals can access medical care and advice at the center, and a shelter houses 120 refugees (*Id*). All services are free.

Opening the center and obtaining funding was the result of cross-collaboration, advocacy, and a humanitarian crisis. In Germany, between 2015 and 2016, nearly 1 million people applied for asylum (Keita & Dempster, 2020) – more asylum applications than the United States ever has in one year. “The government was not even able to register them or give them a roof over their heads, with some refugees having to stand waiting in queues for four weeks just to register,” Jäkel added (Toesland, 2018). The situation was similar to today’s reality at the U.S.-Mexico border, where refugees are forced to wait for months on a quota list, living in precarious and dangerous conditions. In 2016, 72,000 refugees applied for asylum in Berlin, causing a housing and humanitarian crisis (Toesland, 2018). In 2015, to respond to the extreme need for LGBT refugee services, housing, and safe spaces, Schwulenberatung Berlin, advocates, and allies advocated relentlessly for the center. At first, “the Senate of Berlin said ‘OK, we hear you, but we… cannot focus on a single minority,’” Jäkel recalled (Toesland, 2018). Finally, as a result of Jäkel’s and the community’s advocacy, the Senate and the State of Berlin, along with the European Commission, funded Schwulenberatung Berlin’s LGBT refugee center, the first of its kind.

The funding of the center up to par with Germany’s solidarity and humanistic efforts of inclusion and support for refugees. Germany has a State Office for Refugees and provides all
refugees with universal healthcare. Most notably, all asylum seekers with a pending asylum application are entitled to full-coverage medical care, which covers gender affirmation surgeries. Germany’s policies close the gaps of Norway’s universal healthcare shortcomings.

In 2016, the city of Berlin took Germany’s leadership in inclusion and support for refugees even further by publishing a 109-page Information Package for Refugees to “welcome” them into the city and make their arrival “easier” (Senate Administration for Labour, Integration and Women, 2016). The city’s Senate Administration for Labour, Integration and Women is responsible for issuing the package.

The document opens with an address from Michael Muller, Berlin’s mayor, who reassures the new arrivals that Berlin loves diversity, referring to Berlin as a “city of immigrants for the past 300 years” (Senate Administration for Labour, Integration and Women, 2016). He promises that his goal and that of Berlin government’s is to support refugees “… in order to soon be able to stand on your own feet again,” and reminds them that the government is eager to help them accomplish that (Id). The rest of the package is divided into various sections where resources are detailed. One of the sections proudly shares that in Berlin, “Particularly vulnerable refugees receive more protection and help” than anywhere else (2016). A section informs asylum seekers registered in Berlin about the healthcare available to them. It explains that, “Should you suffer under mental illnesses (e.g., anxiety, depressions) owing to your war or flight experience and need psychological or psychiatric treatment…” medication and therapy are available. It even states the state covers costs for translators needed for any legal, medical, or mental healthcare processes (Id). Another section lists “vulnerable” individuals in order of urgency according to Berlin’s government. The fifth group (after pregnant and single women and unaccompanied minors) are “lesbians, homosexuals, bisexual, transgender, and intersexual persons” (Id).
Ever since Schwulenberatung Berlin’s LGBT refugee center and housing project opened in 2016, other similar centers and shelters have opened throughout Germany providing safety and accessibility to LGBT refugees throughout Germany. For example, the organization Rainbow Refugees opened one LGBT center and shelter in Frankfurt and two in Dusseldorf (Bierbach, 2020). Additionally, according to the Queer Refugees Germany project, there now exist 72 organizations throughout Germany offering counseling services for LGBT+ refugees, and all are members of the Lesbian and Gay Federation in Germany (Queer Refugees Germany, 2021).
CHAPTER V: ANALYSIS AND DISCUSSION

My research inquiries were to see what services Translatininas in San Francisco most need and what barriers exist in San Francisco preventing Translatininas from accessing those services. Translatina immigrants are a vulnerable and forcibly displaced group with generally shared experiences based on their gender identity and immigration status. The literature evidences that throughout their lives, Translatininas will experience trauma, abuse, discrimination, cissexism, houselessness, unemployment, and police brutality, among other trauma-inducing realities. As they attempt to rebuild their lives, rehabilitate, and insert themselves into their new communities post-migration into the United States, they deserve to access resources and services including mental healthcare to help them develop, empower themselves, and thrive. To advocate for Translatininas and their rights and amplify their voices, I pursued this study and center this thesis as a radical intervention aimed to disrupt San Francisco policies and discourse.

I first heard about Translatininas in San Francisco having limited access to mental health services while working as a paralegal in 2015. While working on cases with Translatina clients, all of whom had experienced some level of torture, persecution, abuse, or event that had led them to experience trauma, my clients expressed their desire to access therapy to help them move forward in their lives. Despite living in the “safety” of the United States, they told me that they continued to struggle due to their intersectional identities as immigrants, Latinas, and trans-identified people. Some of them struggled with suicidal ideation, others experienced houselessness, and others suffered domestic or intimate-partner violence. The immigration process further retraumatized and victimized them, rendering them unable to overcome their trauma, heal, and move forward. All of them had already met with a mental health professional who would prepare an expert mental health status report in support of their case. My clients were diagnosed
with various disorders, including anxiety, depression, and PTSD. Usually following their psychological evaluations, they shared feeling as if a great weight had been lifted off their chest and asked me for therapy referrals. I referred them to both private practitioners and non-profit organizations, some which I found online via county resources for LGBT people. None of the clients I referred were able to access therapy for various reasons, including: organizations/clinicians were saturated or not taking new clients, services were not available in Spanish and interpreters were not offered to them (all my Translatina clients were native Spanish speakers), services were costly or unaffordable, services were offered as group therapy, or the services welcomed all Latinx people, women, and/or LGBT Latinxs.

Since my clients were unable to find a space that centered Translatinas only, they were concerned that they would not feel safe, be understood, validated, or supported. Their concerns about not feeling safe in spaces inclusive of people with different gender or sexual identities were valid considering how those groups have historically discriminated or harmed trans women. My clients’ concerns about working with a therapist who may not look like, identify as, or speak the same language as my clients was also valid. Their inability to find therapeutic services to help them overcome and heal their traumas frustrated and caused them further stress and trauma.

I have further observed, through personal observations as a trans and immigrant rights advocate, how the Translatina community remains vulnerable and marginalized despite the City of San Francisco’s attempts to protect and integrate LGBT+ migrants. San Francisco must support and fund policy and resources for Translatinatas if it truly hopes to integrate, support, develop, protect, include, and empower Translatinatas as they rebuild their lives in the United States. Obtaining mental wellness will help Translatinatas realize their own potential, cope with the normal stresses of life, work productively and fruitfully, and contribute to their community (WHO, 2018).
To best inform and guide academia and policy, I present the findings through the lenses of transfeminism, liberation psychology, and wellness studies, all which are theories that bring to the forefront solutions from the participants directly. These three fields are critical in challenging the systematic oppression Translatinاس face and challenge us to develop methods grounded in producing equity and liberation, and to combat the discrimination, oppression, and injustices trans women face daily.

Through transfeminist theories, we can analyze and respond to the intersections of cissexism and gender-based violence that contribute to trans women’s vulnerability to mental and physical health issues, including depression, anxiety, suicide, and the harm, violence, and/or lack of protection they experience in their home countries. Transfeminism is critical because it advocates for the liberation of all women.

The psychological frameworks include mental wellness and liberatory psychology, which can arguably best help Translatinас and the practitioners working with them to navigate social inequalities and work towards their gender liberation. Through a liberation psychology perspective, Translatinас approach trauma-healing by first undoing their internalized oppression and empowering themselves to name the source of the oppression (Glassgold, 2016). This allows them to view the oppression as a social issue, interrupting the cycle of oppression. Such a liberatory approach helps free them from internalized oppression and helps them develop critical analyses, engage in social change, and thrive in wellness. One of this thesis’ participants, Victoria Castro, is the embodiment of an empowered Translatina who has liberated herself and is now working to change society through her work at El/La, where she advocates for and raises awareness about Translatinас’ rights and health, assists Translatinас to empower themselves, and runs a grassroots
mutual aid network of people who provide Translatinas temporary housing as they transition out of detention or houselessness.

Through a wellness lens, a healthy lifestyle and human rights may be promoted. The WHO states that achieving wellness can help reduce mental health illnesses such as anxiety or panic disorders, depression, and suicidality, houselessness, substance use, and even physical ill-health (WHO, 2018). Further, the WHO advocates that an individual who has access to mental wellness can earn a living, enjoy life, and navigate their hardship in a healthy way, and obtain dignity (Id). Specifically for Translatinas, obtaining wellness will help them navigate their transition in post-migration, rebuild their lives, and earn a living. As a society, wellness may reduce gender discrimination, promote healthy lifestyles, and improve human rights (Id).

Applying my own suggestive methods for intervention, the findings of this study centralize the voices of two Translatinas and a trans advocate who describe serious issues on the ground Translatinas in San Francisco face. I inquired from my participants to share from their perspective the current barriers, why they believed the barriers existed, and what solutions they proposed to overcome the barriers. The participants’ raw and powerful interviews provide insight into the(ir) realities and the barriers that Translatinas experience in accessing mental health resources. All three participants contend that there is a need and a desire from the Translatina community to obtain mental health services and achieve mental wellness, but the resources to achieve this are limited or non-existent. They advocate for and suggest intervention policies the city should develop in San Francisco in their commitment to trans equity.

Based on the participant’s experiences and suggestions, San Francisco has significant pro-trans policies and legislation to enact before it can applaud its commitment to “vulnerable people” including the trans community (San Francisco Government Press Release, 2019). San Francisco
leadership must re-evaluate local policy, policy-making processes in place, and the city’s commitment to the trans migrant community. It must also develop and fund pro-trans migrant policies and services. The ones suggested herein are from participant’s perspectives.

To develop Translatina equity and wellbeing and fund pro-trans migrant (and Translatina) policies and services, San Francisco and its policymakers must engage in productive allyship and solidarity by engaging and centering Translatina voices to create solutions for them. The historical disregard, silencing, and violence the trans and GNC community has faced from academia and policy has forced them to advance their liberation from the margins. Engaging Translatinases in conversation about their realities, needs, and dreams will provide policymakers with appropriate solutions to respond to Translatinases’ needs and demands and will help them achieve liberation.

**Need/Desire for Translatina Mental Health Wellness**

Consistent with the literature, this thesis’ participants revealed that the community in most need in San Francisco is the Translatina community and that one of the primary services Translatinases must access is mental health. Although the City has made attempts to assist trans people by adopting the Our Trans Home SF initiative and investing $2 million in it and creating projects for trans youth (San Francisco Government, 2019), the trans community remains in great need. Victoria Castro shared this need in her interview, stating that “... The city does not provide us services, and the few [resources] it brings us are already saturated, already full, there is an enormous waitlist” (2019). Jesica Reyes experienced the same issues and delays as Victoria did when she sought legal, medical, and psychological aid. All other available city-wide programs that include trans people are services for the general LGBT community and/or LGBT immigrants (San Francisco Government, 2019). With such limited resources and services where must trans migrants and Translatinases turn to for support?
All participants agreed that accessing free mental health services is a critical resource Translatinases need and which they should be entitled to receive post migration. Considering all the traumatic experiences and hardship Translatinases have survived, access to free and on-going psychological services can help them cope through the arduous process of regulating their immigration status and help them achieve an optimal state of wellness. In this way, they can learn the best tools to help overcome societal and internalized transphobia, navigate through the continuum of violence they may encounter. Pau Crego, from his experiences as a Translatina ally, an activist, a member of the LGBT community, and city employee, knows that trans people in San Francisco have unmet mental health needs. To assist Translatinases develop wellness, Pau dedicated one of the EmergeSF Fellowship sessions to wellness. He wishes there was a space for therapy in the fellowship but stated the fellowship cannot support mental health because it is out of its scope. Victoria, who has been both a participant at the only Translatina organization in San Francisco and is now a service provider at the same organization, knows from experience and from her participants’, that the only way Translatinases will be able to find stability, success, and happiness is by working with a professional who can help them navigate difficult situations that would otherwise jeopardize their mental health. Jesica views therapy as a mechanism to keep going, adapt, and survive.

Both Jesica and Victoria, knowing the importance of mental health for her wellbeing, have sought therapy in the United States but shared common struggles accessing it. While they were in immigration custody, they both attempted to speak to a therapist but ICE denied Victoria’s request. Today, Victoria receives therapy through her private health insurance, which is part of her employment benefits. While Jesica was granted a therapist, the ICE practitioner she met with discriminated against her and verbally abused her, causing her greater distress. As a result of this
incident, Jesica felt fearful of the authorities. The experience made her realize she was in country where, contrary to her beliefs, cissexism and discrimination existed. Following Jesica’s release from detention, she felt hopeful she would find therapy to help her overcome her pre- and post-migration experiences. Given the unavailability of services, she was unable to secure therapy, legal aid, and medical care for months. This caused Jesica to feel as though she were, “adrift, in crisis, going back and forth” post-detention.

**Barriers to Translatinás Obtaining Mental Healthcare**

According to the three participants of this study, the main barriers that exist in San Francisco to developing resources and to obtaining resources are as follows: limited data on trans people in San Francisco, limited resources for trans migrants, liminal legality, and a limited number of culturally responsive, gender-affirming, and Spanish speaking practitioners.

**Limited Data on Trans and Translatinás in San Francisco**

A substantial barrier to developing services for the trans community is the little data collection on trans people at the national, state, and city levels. The limited data and its effects – under resourced and under-funded services – pose great challenges for Translatinás. The limited data was a theme that all three participants raised during our interviews, discussing the various ways in which lack of data on trans and Translatinás affects or affected them, people they know, or participants they have assisted.

Reflecting on personal experiences, Victoria and Jesica shared that they struggled accessing or were entirely unable to access resources because services are under-funded or unavailable. As the literature demonstrates, services and their availability and accessibility are directly correlated to funding and data about the community. In Jesica’s experience, the issue is
that organizations do not have enough funding to hire sufficient staff and create services to respond to the community’s needs. She urged government leaders to prioritize Translatina mental healthcare access via policy and funding. How can the government determine the funding and number of services needed? With accurate data.

Victoria mentioned that she has seen first-hand the barriers that limited data on the trans community through her work at El/La. One of her greatest frustrations has been her inability to reach, engage with, and provide access to more participants. She is certain that with accurate data collection, El/La’s outreach and impact would significantly increase, greatly impacting Translatinas’ lives in San Francisco. As of November 2019, El/La had registered about 320 participants, which Victoria knows is only a small fraction of the Translatina population in San Francisco; in her outreach efforts, participation in community events, and her daily interactions with the community, Victoria has encountered over 1,000 Translatinas. Without accurate data, “we cannot know the number of resources that are needed,” Victoria explained, referring to the needs at El/La and city-wide. She calls for government action through mobilization, initiative, and taking trans people, especially Translatinas, into account (Personal interview, 2019). For the government to obtain accurate data, Victoria stressed the need for city employees to be trained in cultural sensitivity, be fluent in Spanish, express real interest in the community, and fulfill their promises and commitment to investing in the community. Doing so, Victoria believes, will give hope to trans people and encourage them to engage and collaborate.

The largest U.S. Trans Survey to date was conducted in 2015. The survey documented 27,715 responses from self-identified trans people ages 18 and older (James et al, 2016a). Roughly 30% of all respondents lived in the Western region of the United States, home to California (Id). Of the survey’s 27,715 respondents, 16.6% identified as Latinx. Out of the Latinx respondents,
35% identified as non-binary, 33% as trans men, 31% as trans women, and 1% as “crossdressers” (Id). Of the Latinx respondents, 92% of the respondents were U.S. citizens, 7% were reportedly naturalized citizens, and 2% identified as undocumented. Given that only 16% of all respondents identified as Latinx and 2% of all Latinx respondents were undocumented, the data collection is not representative of Translatinats or trans asylum seekers.

The invaluable data the 2015 U.S. Trans Survey provides includes the hardship and barriers that all trans people in the United States face daily (James et al, 2016a). The survey highlights the hardship trans people face – widespread mistreatment, discrimination, and inequity – from various groups, including society, employers, and doctors. Specifically regarding the barriers trans Latinx and undocumented respondents face, the survey revealed key findings that portray disturbing realities. For starters, 24% of undocumented respondents reported they had been physically assaulted in the year before completing the survey, Translatinats reported a 12% greater likelihood of being physically attacked because of their gender in comparison to trans men, and 42% of the Translatinats experienced intimate partner violence in their lifetimes (James et al, 2016b). Overall, 31% of trans Latinx respondents reportedly experienced houselessness at some point in their lives, and 14% of them experienced houselessness in the year prior to the survey because they were transgender (Id). Another issue is healthcare access, with only 37% of trans Latinx respondents reported they had health insurance (Id). Despite being insured, those with healthcare reported they could not afford a doctor and had not sought care when needed because of costs or because of fear of having a negative experience due to their gender identity (Id). According to the survey, “32% of Latino/a respondents who saw a health care provider in the past year reported having at least one negative experience related to being transgender, such as being refused treatment, being
verbally harassed, being physically or sexually assaulted, or having to teach the provider about
transgender people in order to get appropriate care” (Id).

Trans Latinx people’s experiences in the United States differ greatly than those of non-Latinx trans respondents, non-undocumented trans respondents, and the general U.S. population. For instance, the unemployment rate among the Latinx respondents was 21% – four times higher than the rate in the U.S. population, about 5%, and three times higher than the rate among non-trans Latinx people in the United States, about 7% (James et al, 2016b). Regarding mental health, 45% of trans Latinx respondents experienced serious psychological distress in the month prior to completing the survey, in comparison to only 5% in the general U.S. population (Id). Out of all the trans Latinx respondents, 40% have attempted suicide in their lifetime – nearly nine times higher than the general U.S. population rate and the rate among Latinx people in the U.S. (Id).

Despite the report’s limited data specific to TransLatinas, asylum seekers, and undocumented trans Latinx people, it remains an invaluable contribution evidencing trans realities throughout the United States. The report also corroborates this thesis’ participant’s statements that data on trans people and TransLatinas is limited (Id).

Another helpful and important trans data source that was also published in 2015 is the national poll conducted by Growth from Knowledge. Growth from Knowledge is a data and analytics company that conducted a national poll of 1,020 trans-identified people (Combs et al., 2018; Flores et al., 2018). One of the most significant findings is that based on responses, the company estimated that about 0.6% of the U.S. population identifies as transgender, or about 2 million (Id).

A final source establishing trans demographics in the United States is Flores et al.’s 2014 research (2016a). Their data program, called the Behavioral Risk Factor Surveillance System,
estimated that about 1.4 million trans adults lived in the United States. Of those, 21% identified as Latino or Hispanic and 16% as Black (Id). Surprisingly, the racial diversity among Flores et al.’s respondents was more diverse than the non-trans Black and Latinx population in the United States (Flores et al., 2016b), and even more diverse than the non-trans Black and Latinx population in California. Out of the trans-identified respondents from California, 45% identified as Latinx, but official government data estimates that 34% of all California (non-trans) identifies as Latinx (Id).

Locally in San Francisco, just as Victoria and Pau stated in their interviews, data on the trans community is surprisingly scarce and underdeveloped. The first data collection on sexual orientation and gender identity (SOGI) people occurred in 2016, when then-Supervisor Scott Wiener launched a local data collection project. Supervisor Wiener, an openly-gay-identified man, sought to improve data collection about local LGBT+ communities to measure equity and inclusion in city services (Crego & Farley, 2019). Despite the efforts, data on trans and gender non-conforming people (TGNC) remains scarce due to including inequity, lack of training, a need for service improvement, and complicated data systems (Id).

As evidenced by the findings and analyzed herein, population data about how TGNC people in the U.S., including their demographics such as race, education, employment, housing, or immigration status, is underrepresented at macro and micro government levels. The underrepresentation is a substantial barrier to responding to TGNC needs, as accurate data is needed to create policy, fund resources, and increase pro-trans legislation. Inaccurate data contributes to the erasure of TGNC people, further marginalizes the TGNC community, and fuels anti-trans legislation. While it is difficult to estimate the number of TGNC and non-binary people who live in the United States, the estimates point to over 2 million people who identify as transgender alone. As long as data about trans, GNC, and non-binary people remains
underrepresented, there will continue to be a massive barrier to creating policy that appropriately and sufficiently responds to the community’s needs. Policymakers must prioritize efforts to increase data collection about trans, GNC, and non-binary people, and to create resources, services, and laws to respond to their needs and protect them.

**Liminal Legality**

Cecilia Menjivar (2006) uses the term “liminal legality” to express the state of “legal limbo” that immigrants in the United States find themselves in when their “legality” is uncertain. Liminality, Menjivar describes, is characterized by its ambiguity, as it is a state of being neither documented nor undocumented (*Id*); people who are undocumented, those with DACA or TPS, or who have pending applications for relief. Migrants who live in liminality are denied rights and marginalized (*Id*), with the existence or nonexistence of status shaping their social and cultural identity, welfare, assimilation, and belonging. Although Menjivar’s research focuses on Guatemalan and Salvadoran migrants, liminal legality is relevant and applicable to Translatinass: Translatina immigrants, already a marginalized group, experience liminality both in their immigration status and in their identity as legal documents often do not match their gender identity or chosen name, creating a double liminal legality.

Translatina migrants’ double liminality means there is a high likelihood they will be unable to enroll in healthcare and be issued an identity document that reflects their gender and name, creating a barrier to their obtaining mental healthcare and thus wellness. In their interviews, both Victoria and Jesica discussed experiencing liminality and the barrier it posed to their accessing healthcare. After ICE released them from immigration custody, ICE held their original identity documents. The withholding of an individual’s identity documents, from national identity cards, to passports, to birth certificates, is common practice under the presumption that an immigrant will
not flee the country without their identity documents. While ICE is supposed to return an immigrant’s documents when their proceedings are complete, often they lose the documents.

Victoria and Jesica experienced delays accessing health insurance without their original identity documents, still in ICE possession, because the San Francisco requires an applicant to presenting an original and valid legal ID document to apply for healthcare (City and County of San Francisco, Office of the County Clerk, 2020). The document must bear the applicant’s name, date of birth, and photo (Id). The same requirements apply to obtain a driver’s license and a San Francisco City identification card (Id). This means that, when ICE keeps possession of a Translatina’s original documents, a Translatina could be without an identity card, a driver’s license, or healthcare for an unknown length of time. Although critics might argue that a solution for this could be for a Translatina to obtain an original document from their consulate, doing so may complicate their immigration case. This is because an asylum applicant could be deemed as availing themselves to their home country, the country they are claiming to be unable to protect or even persecute them if they apply for a document from that country. Additionally, applying for a document from their consulates means exposing their location to the very government they fled. Some consulates even refuse to issue identity documents to an immigrant who has no legal status in the United States or one who has applied for asylum. Thus, expecting an asylum seeker to approach the government they fled and ask them for an ID is potentially asking them to “choose” between risking future protection to obtain healthcare and other necessary services.

Identity documents are necessary for more than just accessing healthcare, meaning that without them, it is almost impossible to live a “normal” life. Identity documents are needed to navigate everyday matters, from obtaining employment or benefits, traveling, verifying their identity, opening a bank account, and even more mundane transactions like purchasing goods. The
liminality that arises from not having an original and valid ID creates an enormous issue for any person, but especially Translatinas, as an ID is a means for them to validate their gender identity and name.

Further, having a valid identity document that reflects a Translatina’s gender identity and preferred name is also a matter of personal and psychological safety. It is triggering and can be dangerous to an individual if their ID document does not reflect their identified gender and name. Cissexist or transphobic people may also discriminate against, mistreat, harass, or abuse a Translatina whose gender presentation or name are different than those reflected on their ID. The 2015 National Transgender Discrimination Survey revealed that trans people endure widespread abuse for presenting an ID that does not match their presenting gender identity: 32% of respondents were denied benefits or services, or experienced verbal or physical assault (James, 2016).

Unfortunately, it might not be possible for a Translatina to possess a gender and/or name affirming identity document prior to migrating to the United States, as only four Latin American countries have name- and gender-affirming policies in a fast, easy and inexpensive manner.20 A hope many trans migrants have upon migrating to the United States is being able to obtain an identity document that accurately reflects who they are. Instead of achieving this being an easy, straightforward, and cost-free process, the process in San Francisco (depending on the document sought) is costly and lengthy, and requires a court order and/or a physician’s letter (UCSF Transgender Care, 2019). This is an uphill battle for Translatinas who have no health insurance, are unable to afford the legal process, do not speak the language to understand the process

20 As of the writing of this paper, only four Latin American countries (Argentina, Colombia, and Chile, in addition to Mexico City’s Federal District) have policies to allow name and gender reaffirmation in legal documents in a fast, easy and inexpensive manner (Godoy, 2015, Human Rights Campaign Staff, 2020). Countries like Peru, Bolivia, and Uruguay allow it only through a complex, costly and time-consuming process involving court appearances, psychological evaluation, or approval by an “inter-disciplinary committee” (Berezowsky Ramírez, 2018).
requirements or to advocate for themselves, and who do not have an original unexpired identity document from their home country or one that already reflects their identified name and gender.

Without a doubt, identity documents are essential to Translatina immigrants and the City of San Francisco should do everything in its power to eliminate current barriers to accessing gender and name-affirming documents, and to ensure this is an expedited process. Trans migrants already endure the barrier of liminal legality and they should not also have to endure having an ID that does not accurately reflect their affirmed gender and name. The City of San Francisco can ensure that trans migrants do not have to endure double liminality and also assist them by providing them with basic identity rights and protection by revising its document requirements for obtaining the SF City Card and San Francisco healthcare. The suggested policy would consist of issuing trans migrants identity documents without requiring an original valid one from the applicant, and that these documents be free. Additionally, the City should create a no-cost, expedited process for trans migrants obtaining name and gender changes. These changes would aid trans migrants in obtaining healthcare and a city identification document reflective of their true selves in an expedited manner. All this would help to Translatinas access medical and/or mental health more quickly, and also to protect and validate them.

**Need for Practitioners with Cultural Responsiveness/Competency**

Another recurring theme that the participants identified as a barrier to Translatinas obtaining psychological healthcare was the lack of cultural responsiveness/competency from practitioners. To be culturally responsive and competent, a practitioner must first have cultural humility, which is defined as “a lifelong commitment to self-evaluation and critique, to redressing power imbalances . . . and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations” (Tervalon & Murray-Garcia,
Cultural humility and competency are critical when working with trans, GNC, or non-binary-identified clients because a non-culturally-responsive therapist could invalidate their client’s feelings/struggles, engage in therapy that is oppressive, pathologizing, or unsafe, or trigger their client’s traumas and worsen their gender dysphoria. Further, practitioners working with Translatinhas have a lot of power not just in helping them heal from past traumas and achieve wellness, but they also have the power in a Translatinhas’ access to medical treatment for dysphoria.

Lack of cultural responsiveness remains an issue in the field of psychology. Historically, psychology and therapy have oppressed and pathologized LGBT+ individuals, and it was not until very recent in 2015 that the DSM-5 removed gender identity disorder from the list of mental health disorders (DSM; American Psychological Association, 1980, in Singh, 2016). Mental health professionals and scholars have widely noted that psychological trainees who work with TGNC clients do not obtain sufficient, adequate, or on-going competency trainings (Singh, 2016). Others have noted that the inadequate training situates TGNC clients in a position of having to educate their mental health providers about trans people, their pronouns, struggles, and dysphoria, impacting TGNC clients’ ability to feel safe while accessing services and with their therapists (Id). In her interview, Victoria shared her experiences being treated by doctors and practitioners who lack cultural humility and responsiveness. “Many times,” she said, “there are therapists who are having a trans client for the first time and they don’t know how or what it means to have been born in a body with which you don’t identify” (Personal interview, 2019), which caused her practitioners to invalidate her, reject her wishes to undergo a gender-affirming procedure, and use her emotional labor to educate them on what it means to be transgender.
In regard to recommendations for surgery, a practitioner who is not culturally-responsive may impose their own views on surgery onto their patients by telling them they do not need a type of surgery or they may not recommend or delay a Translatina’s referral to surgery. Victoria shared that in her own experience, her practitioner told her many times that she was not “ready,” and she had to wait years for a referral to a gender-affirming surgery she had always dreamed of. She did not agree with the therapist’s wishes to delay her surgery, but she believed the therapist knew best. However, her feelings regarding surgery referrals were more frustrated when it was Victoria’s participants at El/La who experienced the delays. Victoria told me that often, her participants open up about their frustrations with their therapists for the delays caused in their accessing surgery. While Victoria’s participants hope to get recommended for gender-affirming surgery, the therapists or doctors impose their own personal views on them because they don’t understand dysphoria. She shared the example of a participant with nose dysphoria, but whose doctor told her, “Well, you look fine to me” (Personal interview, 2019). She reflected that it was unjust and frustrating for her and her participants to have doctors and therapists impose their own views and perceptions on them: “There is a different between [saying] ‘you look good’ and considering what is making me feel masculine or… different and what I want to transmit or how I want to see myself… so train people so that they can see the difference” (Id). The lack of understanding and invalidation, caused by inadequate culturally responsive training, makes women wait for their therapist to clear them for surgery, but the delays make the women depressed. Victoria believes that this could be overcome by changes in training and the policies that require referrals for surgery.

From a pro-trans and GNC rights perspective, practitioners working with trans and GNC-identified clients must be upheld to high cultural competency and responsiveness standards. To
ensure that trans and GNC people are treated with sensitivity, humanity, and respect, the City of San Francisco must provide mandatory cultural competency and responsiveness training to employees. Without humility and competency, practitioners may not comprehend how to engage in liberatory psychology and help their TGNC and NB clients identify sources of oppression, heal from their traumatic experiences, or feel empowered and develop their own agency.

Pau’s experience as a Translatina service provider and ally has made him aware of the delays Translatinas face when obtaining gender-affirming procedures and echoes Victoria’s concerns that these are caused by therapists who may often lack cultural responsiveness. He recalls how during his time working at El/La, his participants’ surgeries were delayed because their therapist did not recommend them for surgery in what the participants perceived a timely manner, causing Translatinas to negatively perceive mental health and view it as a barrier to obtaining the affirmation they have sought for years, possibly even their lifetimes.

The issues Pau and Victoria raise are also supported by the 2015 U.S. Trans Survey. The survey’s trans Latinx respondents reported that in the year before completing the survey, more than a quarter of them had not seen a doctor when they needed to because they feared mistreatment due to their transgender identity (2016). Of all trans Latinx respondents, 25% stated they had sought coverage for transition-related surgery in the year before the survey but were denied coverage. More concerning is that 32% stated they had a negative experience from their healthcare provider because of their identity (Id). The negative experiences included verbal, physical, or sexual assault, and having to educate their provider about trans people (Id).

Singh (2016) believes that a successful way to provide therapists with culturally competence training is through a liberatory approach. Singh argues that liberation psychology’s framework of identifying oppressive systems can aid therapists in deidealizing psychology and
naming oppressive histories and power structures within mental health (Id). By exploring their relationship to this historically-oppressive-to-LGBT-people field and revealing them to TGNC patients, the practitioner and patient work on exploring trust issues and approaching counseling from a gender-affirming perspective as allies rather than as gatekeepers (Id). In moving towards a liberatory allyship role, practitioners can develop individualized treatment for Translatinas, advocate for them, and serve them better; they can develop and engage in social change on behalf of Translatinas and in collaboration with them (Id). By transforming the way psychologists work with Translatinas, they would help develop a trusting relationship, provide them counseling over periods of time that are not restrictive over the patient’s access to gender affirmation treatment, reduce the stigma on mental health, and attain wellness.

Although some individuals and communities may argue that the word “competence” is problematic and “binary” (Chavez, 2012, 2018, in Greene-Moton & Minkler, 2019), health professionals and the International Organization for Migration (IOM) support the idea of a practitioner being culturally “competent” (Cerezo, Galceran, Soriano, & Moral, 2014; Taylor-Ritzler et al., 2008, in Greene-Moton & Minkler, 2019). Competency, they argue, contributes to individual and community control over decision making and increases participation in decision-making processes (Id). In their 2019 article, Greene-Moton and Minkler conclude that racial, social, and health equity depend on this ability to move past seeing “competency” as an “and/or” binary. They argue for pursuing both cultural competency and cultural humility, calling it the path of “both/and” (Id). Doing so, they argue, will enable us to work across a wide range of barriers and divides and work collectively toward “racial, social, and health equity and the more just and habitable society and planet on which our work and our future depend.”
Practitioners serving trans people in San Francisco must be both culturally competent and culturally humble – they must be culturally responsive – to recognize that both are a lifelong journey without an endpoint, especially when working with BIPOC trans people. The power dynamic is harmful to a trans person’s psychological and physical healing process but training and approaching TGNC psychology through a liberatory practice can provide psychologists with the opportunity to transform psychological practice and mental health institutions by helping practitioners achieve their own gender liberation. Doing so will allow the practitioners to maintain an interpersonal stance that is other-oriented and to interact effectively with people of different cultures, (legal) statuses, genders, and sexual orientations. Embracing the path of “both/and” will help practitioners treating TransLatinas to remain humble and aware, learn from and build partnerships with TransLatinas, reduce power differentials, and better advocate for TransLatinas at the interpersonal, community, and policy-level. When served by culturally responsive practitioners, TransLatinas will be able and comfortable to develop trust with their practitioners. TransLatinas will experience therapy and wellness as a choice and a positive experience, rather than a requirement and an obstacle to obtaining gender affirmation surgery. By extension, the Department of Public Health, organizational leadership, and city leaders should also receive ongoing cultural responsiveness trainings to best create policy and work with the communities in need, and to develop and provide resources and services that reduce inequity for the trans committees.
CHAPTER VI: CONCLUDING REMARKS AND POLICY RECOMMENDATIONS

Despite policy improvements, inclusion, and visibility of transgender people over the last several years, trans rights were significantly threatened, endangered, and revoked during the recent Trump Administration. Even during a Biden Administration, trans migrants remain incarcerated, heavily criminalized, and without necessary services. There is still much work ahead to ensure that transgender people, especially trans migrants and Translatinas, can live without fear of discrimination and violence (James et al., 2016a). Trans people deserve and need equal rights, protection, and equity. Accessing free and quality mental healthcare is one of the most important systems of support for trans people.

This thesis demonstrates that Translatinas face numerous barriers in achieving mental health wellness. These barriers include accessibility issues, including a shortage of Spanish-speaking practitioners, limitations imposed by a Translatina’s liminal status, and a shortage of resources leaving organizations and clinics with limited or no capacity to provide services or accept new patients. Other barriers reflect insufficient culturally-responsive services and practitioners, which can cause trans migrants to develop stigma against mental health services and to consider therapy a hurdle to obtaining gender-affirmation surgery. Finally, there are barriers around data limitations and inadequate/insufficient training on trans issues within city departments that leads to lack of active support and promotion of trans rights, though they should be enacting policies and legislation to assist and protect their most vulnerable communities.

In response to the above barriers, this thesis calls on the City of San Francisco’s mayor, Board of Directors, Director of Public Health, LGBT activists, psychologists, social workers, legal practitioners, and society as a whole to collaborate to develop the resources and training, and to implement mental health services and bridge the accessibility gap for the Translatina community.
San Francisco’s government has a responsibility to develop cost-effective public health and intersectoral strategies and interventions to promote, protect, and restore the mental health of Translatina migrants. Efforts should consider divesting resources from other services, such as the police, to fund mental health services to the Translatina community and help them obtain mental health wellness.

The WHO constitution states that: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2018). Achieving mental wellness will help Translatinatas live a life in which they have dignity, equity, are empowered, and ensure they not only survive but thrive. Mental wellness will also help Translatinatas as they integrate into society, rebuild their lives, continue their transitioning, and redefine their own humanity. It will also help reduce their mortality and morbidity, and disability for people with mental disorders (Id).

When advocating for trans migrant’s rights, the focus is often on access to legal representation and regularizing their immigration status, leaving their mental health and medical needs aside. Translatinatas generally flee abuse and leave behind situations, people, and possibly entire lives of hardship and injustice. The United States is where they experience validation, support, freedom, liberation, protection, and respect for the first time in their lives. “For some, this may be the first time that [sexual and gender minority asylum seekers] are able to talk about their needs without fear of reprisal or being stigmatized,” (Alessi and Khan, 2017: 386). They yearn for the opportunity to live with dignity, be treated humanely, and exist in safety, having the opportunity to walk down the street safely embodying and representing the person they identify with, the person they have the right to be. The United States’ anti-immigrant policies often harm and further retraumatize Translatinatas during and post migration. Furthermore, the U.S. is not equipped to provide Translatinatas the tools they need to thrive, re-immersing themselves, and rebuild their lives.
As the literature and findings show, Translatinastas need and deserve free gender-affirming mental health services. Accessing therapeutic services would give them an opportunity to effectively integrate, survive, ensure stability, thrive, and obtain ultimate wellness. Mental health is “fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world” (Id). Psychologists and experts advocate that positive medical, psychological, educational, and employment support “… [would] facilitate participation in multiple transnational, political, economic, and social spaces that generate new claims of belonging and formations of citizenship” (Genova, 2002: 427), and allow LGBT asylum seekers, asylees, and refugees to liberate and develop themselves. Otherwise, they remain exploitable, liminal, and vulnerable (Genova, 2002: 438). As part of a vulnerable community, a Translatina’s ability to obtain mental health wellbeing can help her realize her own abilities, cope with the normal stresses of life, allow her to work productively, and to contribute to her community (Id).

The examples of activism and government intervention adopted in Germany and Norway have redefined policy efforts and closed the gaps for refugees, providing them basic human rights services. Accessing such services has extremely beneficial societal, psychological, and political benefits, including the opportunity to achieve wellbeing. The case studies and literature show that government-funded mental health services offered to forced immigrants helps integrate, support, and empower them. The analysis here does not romanticize Norway’s or Germany’s efforts to aid LGBT refugee integration but presents it as evidence of what should be expected from developed, wealthy governments, both local and federal. The WHO (2018) also advocates for governments to intervene. This is especially encouraged for places like San Francisco, a city that prides itself as
progressive and one that has historically acted as a haven for LGBT people everywhere. San Francisco should fund the local non-profit organization El/La Para Translatinhas to provide free in-house culturally responsive psychological services for Translatinhas.

Recommendations to the City of San Francisco Government

1. Prioritize a census coalition to accurately collect the population data and demographics about trans and nonbinary people, especially immigrants, in San Francisco;

2. Increase the number of EmergeSF Fellowships and staff, to help a greater number of LGBT immigrants develop professionally and financially, learn English, and receive guidance;

3. Divest millions of dollars from overly-funded programs, such as the San Francisco Police Department, and invest in the Translatina community through pro-trans/GNC policy and resources;

4. Invite the organization El/La Para Translatinhas and dialogue with them about the possibility of supporting their organization to expand as the center for Translatinhas in San Francisco, offering a multitude of wellness services, including mental health services, legal aid staff, medical care providers, and a safe drop-in center where workshops, food, social events, and accompaniment are offered;

5. Engage trans/GNC and trans-migrant practitioners and experts to train City of San Francisco employees, including the Department of Public Health, on trans/GNC issues, healthcare, and cultural responsiveness, and mandate periodic on-going trainings;

6. Hire additional trans/GNC employees to expand the Office of Transgender Initiatives to increase their impact and reach;

7. Re-evaluate and reduce the medical requirements for gender-affirmation surgery;

8. Expand San Francisco City ID access for trans/GNC migrants by removing the requirement that they must have an original valid government identification card with a photo to obtain a San Francisco ID. This will facilitate their obtaining timely access to health insurance; and

9. Hire into the Department of Public Health BIPOC psychologists and clinicians who represent the populations served and are fluent in the various languages and dialects trans immigrants speak, including but not limited to Spanish, Portuguese, Mam (and other indigenous) languages.

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Appendix A: Interview Guides

I. Interview Guide for Translatina Asylum Seekers

**Semi-Structured Interviews: For Translatina Asylum Seekers and Asylees**

1. Where are you from?
2. When did you enter the United States?
3. What is your current immigration status?
4. When did you apply for asylum?
5. What are the experiences of Translatina immigrants in the United States?
6. Did you receive any psychological services while applying for asylum?
7. Did you receive a forensic evaluation?
8. How do you survive from day to day despite the stress generated by the transphobic and anti-immigrant policies and gender orientation prejudice in the United States?
9. What role have organizations in San Francisco played during the course of your journey?
10. What services would you like or need to receive right now?
11. What do you think is getting in the way from those organizations providing you more/better services?
12. Have you sought psychological services in the past?
13. When you were seeking psychological services, what was the experience like?
14. Based on your perception, how is that experience similar or different from the experiences of other Translatinatins?
15. What would your life look like if you had mental health services available?
16. What about psychological services free of charge?
17. If you had all the money in the world, what services would you have liked to receive when you first arrived to the U.S.?
II. Interview Guide for Allies/Service Providers

Semi-Structured Interviews: For Stakeholders and Trans Allies

1. What is your relationship to the Trans(latina) community?
2. How long have you been involved with this community?
3. What are some of the challenges currently facing this community?
4. Historically, it seems that a lot of trans programs and funding have been created to inform, treat, and prevent AIDS. As we move past from pathologizing transgender individuals and and Do you think the city still follows this mindset for programs and funding?
5. How do you think it would benefit Trans(latinas) to receive psychological services?
6. Do you perceive any issues associated with this?
7. What are the organizations providing in-house mental health services to Translatinhas? What have been your experiences with these organizations?
8. What are some of the barriers to providing Translatinhas in-house mental health services?
9. What resources exist to better educate non-trans individuals and stakeholders, especially those providing health services, in issues surrounding Translatina injustice?
10. There are currently some initiatives proposed in San Francisco to benefit the trans community, particularly for trans housing. What do you know about these initiatives? Are you involved in any of them? (If involved: What is your expected outcome for the expansion of these initiatives?) (If not involved or aware: What do you attribute to not knowing about the initiatives — e.g. communication or a limited diffusion of information? What would you suggest could be done to improve cross-collaboration/information?)
11. In your experience, is there an issue in the City of San Francisco of a lack of funding or is there misuse of funding? Do you have any suggestions for where the city could cut funding and invest it into the trans community instead?
12. If you were mayor of San Francisco and could create funding policies specifically for the trans community, how would you allocate those resources? What services would you create and how would you maintain them in a sustainable way for the next 5 to 10 years?
Appendix B: Informed Consents

I. English Language

CONSENT FORM FOR INTERVIEW

Consent to be interviewed and have that information utilized in a research thesis:

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided (or give oral consent if unable to sign) to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form via email.

You have been asked to participate in a research study that aims to understand what mental health services San Francisco Translatinas who have been granted asylum or Withholding of Removal in the United States, or who are currently applying for asylum, need; what appropriate intervention strategies for this community in San Francisco look like; and about efforts currently underway or efforts that have failed in the past to obtain the necessary financial resources to serve this community. We want to know what needs to happen in order to establish these services — and to have the government of San Francisco fund them. The research is conducted by Valeria Vera, a graduate student in the Master in Migration Studies Program at the University of San Francisco. The faculty advisor for Ms. Vera’s research is Dr. Daniela Domínguez, PhD, a professor at the University of San Francisco.

What the study is about:
The purpose of this study is to learn what are appropriate mental health intervention strategies in San Francisco for trans Latina, those whose asylum cases are still pending, and those who have been granted withholding status. The research aims to advocate for San Francisco government-funded mental health services.

What we will ask you to do:
If you agree to be in this study, we will conduct an interview with you. The interview will include questions about your involvement and ties to the Translatina community in San Francisco, what current mental health services exist for the Translatina community, what efforts are currently underway to establish more mental health resources for said community, what barriers stand in the way from achieving these resources, and what we need to establish said resources. The interview will take about 60 minutes to complete. With your permission, we would also like to tape-record the interview.

Potential risks and discomforts:
There is the risk that you may find some of the questions about your life, experiences, activism, and mental health struggles to be difficult to reflect upon and share. You might feel strong emotions as a result of the information being discussed. These emotions might be similar to those felt when talking to a close friend or family member. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

Benefits:
The possible benefits to you of participating in this study are sharing critical information for the improvement of trans migrants and trans rights with our university, the world, and potential students. Your participation may help politicians, legislators, and organizations understand how to better serve trans immigrants. An additional benefit is your contribution to a body of research designed to better understand how to advocate on behalf of trans immigrants.
Compensation/Payment:
There is no compensation.

Privacy/Confidentiality:
Note: You may choose your identity to remain confidential (except in cases in which the law requires the authorities be notified in cases such as danger to self or to others). If so, please inform Valeria.
Confidentiality means that the researcher (or perhaps the instructor) will have a record of who participated but their personal data will be kept private. Code names will also be used.

Taking part is voluntary:
Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationship with any organization that may have referred you. If you decide to take part, you are free to withdraw at any time.

If you have questions:
Please ask any questions you have now. If you have questions later, you may contact Valeria Vera at evvera@dons.usfca.edu or at 415-737-6856. If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) at IRBPHS@usfca.edu or access their website at https://myusf.usfca.edu/irbphs.

You will be given a copy of this form via email to keep for your records.

Statement of Consent:
I have read the above information. Any questions I have asked have been answered. I consent and agree participate in this research project and I will receive a copy of this consent form.

Participant’s signature, mark, or interviewer notation that oral consent has been given

Date

Researcher’s signature

Date
II. Spanish Language

Consentimiento Para Participar en un Proyecto de Investigación Estudiantil

A continuación hay una descripción de los procedimientos de investigación y una explicación de sus derechos como participante de la investigación. Si acepta participar, le pedirá su firma o acuerdo verbal. También le daré una copia de este formulario por correo electrónico para que se lo quede.

Le hemos pedido que participe de forma voluntaria en un estudio de investigación que intenta entender que servicios psicológicos existen para las Translatin@es en San Francisco, incluyendo aquellas quienes han sido otorgadas el asilo, Rompimiento de Deportación, o quienes están en proceso aplicando para el asilo, cuales podrían ser estrategias apropiadas para intervención en esta comunidad en San Francisco, y sobre esfuerzos que están desarrollándose en estos momentos, al igual a esfuerzos que han fallado en el pasado para obtener los fondos necesarios para servicios mentales para esta comunidad. Queremos saber que necesita pasar para lograr establecer estos servicios — y para lograr que el gobierno de San Francisco los apoye financieramente. La investigación es conducida por Valeria Vera, una estudiante posgrado del programa Maestría en Estudios Migratorios en la Universidad de San Francisco. La consejera de la facultad para la investigación de la Señorita Vera es la Dr. Daniela Domínguez, PsyD., una profesora en la Universidad de San Francisco.

De qué se trata el estudio:
El propósito de este estudio de investigación es aprender sobre qué tipo de intervención de salud mental son apropiados en San Francisco para las Translatin@es, aquellas quienes son casos pendientes, y aquellas quienes han sido otorgadas remoción de deportación. La investigación espera abogar para que el gobierno de San Francisco financie servicios de salud mental para las Translatin@es, describidos previamente.

Lo que te vamos a pedir que hagas:
Si estás de acuerdo a participar en este estudio, te entrevistará. La entrevista incluirá preguntas sobre tu participación y la comunidad Translatina en San Francisco, que servicios de salud mental existen de momento para la comunidad Translatina, que esfuerzos están siendo desarrollados para establecer más recursos de salud mental para esta comunidad, que barreras existen previniendo que esos recursos se obtengan, y qué necesitamos para establecer esos recursos. La entrevista tomará unos 60 minutos para completar. Con tu permiso, también queremos pedir poder grabarla — nada en video.

Riesgos e Inconvenientes:
Existe el riesgo de que algunas de las preguntas sobre su vida, experiencias, activismo y problemas de salud mental sean difíciles de reflexionar y compartir. Puede ser que sienta emociones fuertes como resultado de la información que estás discutiendo. Estas emociones serán como aquellas que siente cuando habla con algún amigo cercano o familiar. Si lo desea, puede optar por retirar su consentimiento e interrumpir su participación en cualquier momento durante el estudio sin penalización.

Beneficios:
Los posibles beneficios para usted de participar en este estudio son compartir información crítica para el mejoramiento de los migrantes trans y los derechos trans con nuestra universidad, el mundo y posibles estudiantes prospectivos. Su participación puede ayudar a los políticos, legisladores y organizaciones a comprender cómo servir mejor a los inmigrantes trans. Un beneficio adicional es su contribución a un
cuerpo de investigación diseñado para comprender mejor cómo abogar en nombre de los inmigrantes trans.

Compensación/Pago:
No hay compensación.

Confidencialidad y Privacidad:
Nota: puede elegir que su identidad permanezca confidencial (excepto en casos en los que la ley ordene que la información sea compartida, como en situaciones de daño a sí mismo o a otros). Si no es así, por favor informe a Valeria. La confidencialidad significa que el investigador (o quizás el instructor) tendrá un registro de quién participo, pero sus datos personales se mantendrán en privado. Nombres código también van a ser usados.

Su Participación es Voluntaria:
Participar en este estudio es completamente voluntario. Puede omitir cualquier pregunta que no quiera responder. Si decide no participar, puede omitir algunas de las preguntas, no afectará su relación actual o futura con ninguna organización que lo haya derivado. Si decide participar, puede retirarse en cualquier momento.

Si tienes preguntas:
Por favor haga cualquier pregunta que tenga ahora. Si tienes preguntas o incertidumbres más adelante, puede comunicarse con Valeria Vera en eyvera@dons.usfca.edu o al 415-737-6856. Si tienes alguna pregunta o inquietud sobre sus derechos como participantes en este estudio, puedes contactar a la Junta de Revisión Institucional (IRB), al IRBPHS@usfca.edu, o puedes acceder a su sitio web en https://myusf.usfca.edu/irbphs.

Se le dará una copia de este formulario tras email para sus records.

Declaración de consentimiento:
He leído la información anterior. Cualquier pregunta que haya quedado sin ser respondida. Doy mi consentimiento y acepto participar en este proyecto de investigación y recibiré una copia de este formulario de consentimiento.

Firma del participante, marca o notación del entrevistador de que se ha otorgado el consentimiento oral       Date

Firma de la investigadora       Date