

BARRIERS TO HEALTHCARE IN THE TRANSGENDER POPULATION

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BARRIERS TO HEALTHCARE IN THE TRANSGENDER POPULATION

A Project

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Division of Social Work

Abstract
of
BARRIERS TO HEALTHCARE IN THE TRANSGENDER POPULATION

By
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This research project addresses the current barriers to health care from the perspective of the transgender population in the Sacramento area. This study involves a sample of 34 transgender participants, eighteen years of age or older, who were surveyed about their experiences when utilizing health care services. These participants were members of four separate transgender support groups in the greater Sacramento area. Transgender people face a number of barriers to accessing adequate health care. This study revealed some key issues calling immediate action on the part of medical and mental health providers as well as the social work profession. FTM were found to have significant amounts of barriers to access of culturally competent health care than the MTF population. This study also found that partial gender presentation participants had significantly less barriers to health care than the full-time identified participants. There is a need for further research to learn more about the experiences of transgender persons.

_____, Committee Chair
Teiahsha Bankhead, Ph.D., L.C.S.W.

Date

DEDICATION

To all of the transgender person's who have struggled to obtain adequate health care and to those that have lost their lives due to discrimination and inequality. This is also dedicated to all of the transgender people that have entered my life and have had the courage to be who they truly are. They have all taught me a great deal about struggle, beauty, and courage. Thank you for letting me apart of your journey every week. You have all touched me in ways that I will never be able to truly express. In the word of Harvey Milk, "All men are created equal. No matter how hard you try, you can never erase those words."

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Chapter 1

THE PROBLEM

In response to Robert Eads' tragic death in 1999, Leslie Feinberg, an activist and celebrated transgender author, agreed to go public on the crisis in transgender health care (Wilcox, 2001). Robert Eads was a transgender male that died of ovarian cancer when over two dozen physicians refused to treat him due to his transgender status (Wilcox, 2001). This is what she wrote:

I'm sitting in a cardiologist's waiting room filling out my intake forms. The tip of my pen hovers above the ubiquitous binary boxes. Female or male? I am transgender. Which box do I check to get the medical attention I need so badly right now? I consider all this and decide to check the "F" box, hoping the doctor will take my birth sex into account in listening to my cardiac symptoms.

One of the two women at the front desk takes the clipboard and flashes me a generous smile. "Have a seat, sir." Minutes later she calls out, "Miss Feinberg, do you have insurance?" I stand up; she looks bewildered. To her credit, she recovers quickly. She goes out of her way to be warm to me.

I sit back down and leaf through a magazine. The other woman at the front desk explodes in derisive laughter. She comments out loud about a patient's records: "Do you know what's on this *man's* chart? This man had a *breast* biopsy!" She snorts and snickers in a mean-spirited way. Everyone in the waiting room can hear her.

Five years ago, while battling an undiagnosed case of bacterial endocarditis, I was refused care at a Jersey City emergency room. After the physician who examined me discovered that I am female-bodied, he ordered me out of the emergency room despite the fact that my temperature was above 104 degrees. He said I had a fever “because you are a troubled person.”

Weeks later I was hospitalized with the same illness in New York City in a Catholic hospital where management insists patients be put in a ward based on the basis of birth sex. They place transsexual women who have completed sex-reassignment surgery in male wards. Putting me in a female ward created furor. I awoke in the night to find staff standing around my bed ridiculing my body and referring to me as a “Martian.” The next day the staff refused to work unless “it” was removed from the floor. These and other expressions of hatred forced me to leave (Feinberg, 897, 2001).

Introduction

The term transgender is used as an umbrella term to describe people who have gender identities, expressions, or behaviors not traditionally associated with their sex at birth (Kenagy, 2005). Transgender people are often grouped by their gender group, male-to-female (MTF), and female-to-male (FTM) (Kenagy, 2005). MTFs are people who have been assigned a male gender at birth, but who identify their gender as female. Conversely, FTMs are people who have been assigned a female gender at birth, but who identify their gender as male (Kenagy, 2005). These two gender identities have been widely used by transgender people and in transgender literature (Kenagy, 2005, Feldman

& Bockting, 2003, Burdge, 2007), but this language is constantly evolving to include many queer identities (Kenagy, 2005).

Studies have shown that the transgender population is one of the most oppressed and vulnerable to discrimination (Burdge, 2007, Kenagy, 2005, Rachlin, Green, & Lombardi, 2008). This is because they step outside the social constructed gender binary (Burdge, 2007). It is the obligation of social workers to serve oppressed and vulnerable populations, eliminate discrimination based on sex, and seek social change to ensure the well-being of all people (NASW Code of Ethics, 2000).

Transgender individuals tend to be heavily stigmatized in Western society for their gender nonconformity (Bockting & Cesaretti, 2001). Many issues face the transgender population such as finding or keeping a job, being denied health benefits, experiencing lack of access to social services, harassment, and lack of acceptance in religious venues (Bockting et al., 2001). The negative view of transgenderism has not always existed. In many cultures such as, Native American and Southeast Asian, transgender members are powerful and revered (Bockting et al., 2001). These cultures were able to develop a more pluralistic view of gender instead of the dichotomous view that western cultures have developed.

The dichotomous view has been attributed to the stigmatization and segregation of transgender people. This segregation has contributed to the medicalizing and pathologizing of the transgender population. Since the 1990's transgender health has been shifting toward the rediscovery of gender diversity and a reclaiming of spiritual aspects of the transgender coming out process (Bockting et al., 2001). Transgenderism

is found throughout history and across cultures most often in connection with spirituality and religious beliefs (Bockting et. al, 2001).

This researcher has worked with the transgender population and has seen the devastating effects that barriers to health care can have. Many of the people she has worked with do not have access to transgender-specific health services, such as, hormone treatment, knowledgeable providers, and sex reassignment surgery (SRS). Many of them have gone into debt, lost jobs, and family in order to create bodies that are congruent with their minds. There have been very few of this researcher's clients that have been able to complete their transition due to the barriers to services. The lack of completion leaves this population struggling to find an identity that lies somewhere in between the gender binary. This struggle has caused some to become depressed, quit jobs, and consider suicide. This researcher is interested in discovering specific challenges that this population faces when trying to access the care that all humans deserve.

Background of the Problem

The literature on transgender health experiences is limited in scope and quantity. Feldman and Bockting (2003) report that as many as thirty to forty percent of transgender persons in the United States do not have a regular physician and often rely on emergency room and urgent care physicians for primary health care needs. Many transgender persons simply live with untreated or under-treated chronic conditions such as hypertension and diabetes (Williams & Freeman, 2007). Fear of revealing their transgender identity may prevent adequate health screenings, such as for breast or prostate cancers. Treatable health conditions may increase in severity unnecessarily, due

to the reluctance of transgender people, young and old, to either put themselves in further abusive situations or be forced to confront prejudice in the health care system (Williams et al., 2007). This may be especially true for transgender elders who were part of a generation that was raised to passively accept the authority of medical professionals.

Transgender people face a number of barriers to accessing adequate health care. Violence, harassment, and discrimination are common experiences among transgender people, and they lay the groundwork for particular challenges to health care access. Social and economic marginalization resulting from the pathologization of transgender persons creates a barrier to health care and health insurance access which is more prevalent in the transgender population than in the lesbian, gay, and bisexual (LGB) population (Williams et al., 2007). Transgender people of color may be the most at risk for inadequate health care and health insurance coverage due to compounding sources of stigmatization and discrimination related to racism, transphobia, and poverty.

Underinsurance and lack of health insurance appear common, due to the amount of joblessness and poverty in transgender populations, particularly among people of color and youth (Williams et al., 2007). Those that have health insurance often experience barriers to accessing their health benefits. One study details how insurance companies rely on non-medical and non-fiscal criteria to exclude transition-related medical treatment from being covered under public or private insurance benefits (Williams et al., 2007). Most health insurance policies exclude coverage for transgender-specific health procedures, such as hormone therapy and sex reassignment surgery (SRS).

As a result, some transgender people may use unregulated or “off-label” medications, often obtained and used without medical supervision, and at times administered with shared needles, increasing risk of HIV and hepatitis infection (Feldman & Bockting, 2003). There is widespread use of injectable silicone, as an inexpensive alternative to hormones, in the transgender population. MTFs inject silicone into their cheek bones and breast area for an increased feminine appearance. This can cause severe illness and possible infection if the silicone gets into the blood stream or is injected with a dirty needle. Hormone therapy has the possibility of many drug interactions, making unsupervised self-treatment dangerous, especially for people being treated for illness or injuries by doctors who are unaware of the hormone therapy. Hormone therapy is associated with a higher risk for diabetes, cardiovascular disease, and liver abnormalities.

Testosterone therapy for female-to-male (FTM) transgender men has been associated with an increased risk of heart disease, loss of bone density, endometrial cancer, and higher blood cell count, which can be life threatening (Williams et al., 2007). Male-to-female (MTF) transgender women taking estrogen may face risk of increased type II diabetes, increased cholesterol, blood clots, loss of bone density, neovaginal cancer, and prostate cancer (Feldman et al., 2003). Transgender elders may be at higher risk than those who are younger due to longer duration of hormone use, which may complicate the normal effects of aging such as cardiac or pulmonary problems. Little research has been conducted on the risks or benefits associated with hormone use among transgender youth.

Current public policies have sanctioned and institutionalized the exclusion of transgender people from access to adequate health coverage and care. The Americans with Disability Act (ADA) was explicitly amended, “denying protection for conditions related to gender dysphoria” (Williams et al., 2007). Due to this institutional, policy sanctioned bias; insurance companies have routinely denied transgender consumers coverage for many transgender-specific health procedures.

The effects of the ADA exclusion clause is seen throughout the health care system as a whole. Many insurers apply the SRS exclusion clause to deny transgender persons coverage for back pain, intestinal cysts, and even cancer under the idea that any medical care transgender persons need is an excludable gender related condition (Williams et al., 2007). Insurance companies have denied transgender consumers coverage for routine medical treatments, including office visits, blood tests, physical exams, sinus medication, and emergency room visits, based on the exclusion of SRS (Williams et al., 2007, Kenagy, 2005, Feinberg, 2001).

Discrimination against transgender persons is not limited to insurers in the health care system. Some physicians refuse to treat transgender patients and those that do often times persist in referring to them by their non-identified pronoun. Transgender health care consumers describe doctors, nurses, and emergency medical technicians as responding with discomfort or disgust to their identity, telling jokes, insulting clients, and providing inadequate care (Williams et al., 2007).

Some hospitals prevent transgender patients’ physicians from administering procedures to their patients. Doctors have been reported for refusing to administer

gynecological care for FTM transgender people, including treatment for cervical cancer or abnormal vaginal discharges (Williams et al., 2007). Transgender individuals who have repeatedly been barred from receiving medical care and been treated disrespectfully by health care professionals often delay seeking necessary care which puts them at unnecessary risk.

Effective communication is further complicated by cross-cultural issues of all types, including differences between non-transgender and transgender communities, as well as racial, ethnic, and cultural differences between health care providers and transgender health care consumers. When health care providers are willing to treat transgender persons, consumers are often required to educate their providers regarding culturally appropriate care. In some cases transgender patients find themselves educating their providers about specific needs and concerns related to transgender health care provision.

Some gains have been made in transgender health policy and not all transgender people find access to adequate health care impossible. In 1999, the American Public Health Association passed its first resolution on transgender health issues in order to improve the treatment experienced by transgender persons seeking healthcare (Lombardi, 2001). Many individuals report that their doctors and employers have successfully advocated against insurers' denial of health coverage, and a minority of health insurance providers cover medical care needs of transgender people, including some transition-related treatments (Williams et al., 2007). Surveys at one university sexual health clinic found consistently high rates of transgender patient satisfaction, comparable to the

satisfaction rates of other health clinic patients (Bockting, Robinson, Benner, & Scheltema, 2004). This was due to establishing partnerships with transgender community organizations and the clinic themselves founded a community advisory board. The clinic then began the satisfaction survey process to ensure transgender clients were able to voice their concerns.

Transgender people also appear to be at higher risk for some mental health concerns. One study (Clements-Nolle, Marx, Guzman, & Katz, 2001) assessed HIV risk qualitatively among 392 transgender individuals and found that about one-third of them had attempted suicide. These findings were significantly higher than the general population and also higher than estimated rates for lesbians and gay men (Williams et al., 2007). Almost two-thirds of the MTF and fifty-five percent of the FTM participants were clinically depressed at the time of the study. Transgender persons are at a higher risk for compromised mental health as a result of discrimination, shame, isolation, and sexual identity conflict.

Accessing mental health care is also a unique challenge for many transgender people. Mental health clinician bias has been problematic to transgender clients. Some counselors have exerted bias in counseling that includes pressuring clients into decisions regarding gender, trying to talk clients out of gender reassignment or transition, pushing clients prematurely to come out and identify as their internal gender, or pathologizing transgender identity as internalized homophobia (Williams et al., 2007).

Receiving effective mental health care is also complicated for many transgender individuals due to the dual role that many mental health professionals have in their work

with transgender clients. Mental health professionals have held roles as gatekeepers to gender-transition treatments including hormone therapy and sex reassignment surgery (SRS). This has undermined the potential for forming a trusting therapeutic relationship for many transgender people and at times created hostility toward mental health professionals as a whole (Bockting et al., 2004).

Statement of the Problem

There exists a deficiency of research soliciting MTF and FTM transgender persons regarding barriers to healthcare and access to transgender-specific care. Transgender persons just like everyone else, require adequate care to ensure healthy physical, psychological, and social development. Furthermore, there is a gender bias in current transgender health research. To date MTF transgender women are overrepresented in the current literature (Rachlin et al., 2008; Hussey, 2006; Clements-Nolle, 2001), and the experiences and needs of FTM transgender men remain relatively unknown (Hussey, 2006).

Purpose of the Study

This research project seeks to understand the current barriers to health care from the perspective of the transgender population in the Sacramento area. This project also seeks to have a mixed representation of MTF and FTM transgender participants. There is insufficient research on the topic of transgender experiences with accessing health care and much relies heavily on MTF participants. This study will help gain a unique understanding of the differences as well as similarities in both populations. Information

gained in this study may indicate where strengths lie in access to health care and where improvement may need to be made.

The knowledge gained from this study has the potential to help on three different levels. On the micro level, health and mental health practitioners may understand the unique experiences that this population currently experiences and subsequently provide more competent services. On the meso level, practitioners may train all staff regarding proper care of transgender consumers. On the macro level, a standardized health care policy may be influenced for the treatment of transgender consumers; as well as standardized education for health and mental health providers on transgender-specific care.

Theoretical Framework

Social construction theory is based on our environment and how we define ourselves, objects, and others through interaction with an emphasis on language (Greene, 2008). This theory has an interesting approach because it works to reduce stereotypes and it purports that personal meanings and views stem from the reality of individual life experience (Greene, 2008). Gender is a social construct that holds power over every individual in society. The traditional dichotomous gender paradigm or gender binary is oppressive, especially to transgendered people whose sense of gendered self is different than the gender assigned at birth (Burdge, 2007). Gender is present from the moment our genitals are discernible which often begins in utero or before birth. This is the first question many ask parents-to-be and it is the first question answered by the doctor who tells parents the gender even before saying the baby is healthy. Our gender is

constructed by the colors we wear and the toys that we play with as infants. Cooper (1999) argues that these gender labels will be used to define the child and will have monumental implications for the course of the child's life. The existence of transgendered people casts doubt on a gender binary model. Gender is constructed not only as a reflection of one's internal self, but also as a social process (Burdge, 2007). Gender is a powerful social construction in which a person can be held accountable for their actions as a man or a woman. According to West and Zimmerman (1987) we have no choice but to "engage in behavior at the risk of gender assessment" (p. 136). This assessment determines whether we are rewarded or punished in ways such as verbal or physical harassment. Individuals learn at an early age that they must master gender successfully and go on to be enforcers of the gender divide. This process relies on individuals to present their genders clearly so that privileges can be granted accordingly. Transgender people disrupt this process and therefore are victimized or not accepted into binary social process. The novel *Stone Butch Blues* (Feinberg, 1993) demonstrates that gender is a social construct and is evident in the brutal and humiliating punishments to which the protagonist Jess Goldberg and other transgendered characters are subjected to for failing to conform to the gender norms properly.

Queer theory is a useful postmodern concept that aims to eliminate the dichotomous gender construct (Burdge, 2007). Any activist or person who tries to change the gender binary system will face numerous awkward and possibly dangerous social moments (Burdge, 2007). "Challenging oppressive gender structures and making

gender rights a priority are critical steps toward universal freedom from punishment for gender nonconformity” (Burdge, 2007, p.247).

Leslie Feinberg’s novel *Stone Butch Blues* is one of the first works of contemporary fiction about a transgendered person (Moses, 1999). In the novel she exposes the social construction of fixed gender and is the first to embrace transgender as an identity. She also challenges the American Psychiatric Association’s official construction of gender identity disorder (GID) which is a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition). This diagnosis, which was introduced in 1980 after homosexuality was removed from the DSM, acts as the institution of medicine attempting to enforce the gender binary. The GID diagnosis fuels gender stereotypes by pathologizing behaviors and attitudes that violate the rigid gender dichotomy (Burdge, 2007). Unfortunately, transgendered people requesting sex reassignment surgery must be diagnosed with GID in order to be eligible.

There has been a movement to challenge the binary of sex and gender as well as to demedicalize the idea of GID because of the continued discrimination, harassment and ridicule transgendered persons face (Burdge, 2007). Groups have formed a community that live outside the gender binary and are considered gender- queer or gender-neutral (Burdge, 2007). Today, more transgender people are identifying with space outside the gender binary (Cooper, 1999). They consider themselves neither male nor female. More often transgender persons are coming out to their families, friends, coworkers, and faith communities rather than attempting to pass as male or female, but affirming their transgender identity (Bockting et.al., 2001). In intimate relationships, sex, and gender

roles do not always conform to conventional heterosexual pattern, but include exploration and discovery of gender-creative roles (Bockting et al, 2001).

Self-affirmation of one's identity as transgender alleviates shame and is experienced by many as liberating. The pressure of trying to conform to how a man or woman is supposed to look and act can be exhausting and uncomfortable. Shame and stigma can be transformed into pride and discovery of gender diversity that does not require a medical explanation (Bockting et al, 2001). Health and mental health professionals are shifting from encouraging gender-variant individuals to adjust to one of two gender options to supporting self-identification as a transgendered person (Bockting, Robinson, Benner, & Scheltema, 2004).

Definition of Terms

Gender: One's social or personal status as male or female.

Gender identity: One innate sense of maleness or femaleness or both, as well as how those feelings and needs are internalized and presented to others.

Gender variant: One's public presentation of maleness or femaleness differs from public perception of one's biological maleness or femaleness. Presentation may include aspects of both masculinity and femininity.

FTM: refers to individuals assigned 'female' at birth whose current gender presentation may be construed as male.

Gender Presentation: refers to transgender persons dressing in their preferred gender part-time or full-time. For example, a part-time MTF may dress as a male and as a female, but a full-time MTF will only dress as a female. For the purpose of this study,

the terms part-time and full-time will be used to describe the amount of time transgender live in their preferred gender identity.

Homophobia: Although implied in the direct translation of the word, homophobia seldom refers to a phobic or fearful response. Often, though, it is used to indicate anti-homosexuality prejudice.

LGB: Represents lesbians, gay males, and bisexuals when addressed as a group rather than as individual sexual minorities.

MTF: MTF refers to individuals assigned male at birth whose current gender presentation may be construed as female (Bettcher, 2007).

Transgender: Transgender is an umbrella term that refers to a diverse group of individuals that cross or transcend culturally defined categories of gender, irrespective of their sexual orientation. The umbrella includes transsexuals, cross dressers, bigender persons, drag queens, drag kings, gender queer, gender variant, gender non-conforming, female masculinity, and queer (Bockting, Robinson, Benner, & Scheltema, 2004; Kenagy, 2005; Burdge, 2007).

Transphobia: Comparable to homophobia, but specifically referring to anti-transgender prejudice.

Sex/ Biological Sex: One's biological maleness or femaleness established by medical assessment of genitalia in utero and at birth.

Assumptions

All transgender persons deserve access to health and mental health care in order to support health and wellness. Any person identifying as transgender should have

access to transgender-specific care without discrimination or humiliation. Services must reflect knowledge about gender identity issues and be socially informed, transgender-sensitive and responsive. All transgender persons are entitled to receive culturally sensitive care and access to medical care that addresses all aspects of care related to general health and mental health as well as transgender-specific care.

Justification

Conducting this study of transgender adults will aid health and mental health providers with knowledge of barriers to the access of health care in the Sacramento area. Findings may be utilized by health and mental health professionals and advocacy organizations, to provide competent, transgender-specific care as well as inform public policy. Findings may provide empirical support for transgender persons in their own self-advocacy efforts with health and mental health providers.

Limitations

This project will study barriers to health care in the transgender population; however, health care providers will not be surveyed or interviewed. This project will be limited to transgender adults; transgender youth will not be surveyed. This study is limited to transgender persons residing in the United States. The majority of persons participating will be from the Sacramento area, such that, the results cannot be generalized to other countries or geographic areas. The participants will be recruited through local support groups; therefore, transgender persons not involved may not be accounted for.

Chapter 2

LITERATURE REVIEW

Introduction

Transgender is an umbrella term that refers to a diverse group of individuals that cross or transcend culturally defined categories of gender, irrespective of their sexual orientation (Burdge, 2007; Kenagy, 2005). The umbrella includes transsexuals, bigender persons, drag queens, drag kings, gender queer, gender variant, gender non-conforming, female masculinity, and queer (Bockting, Robinson, Benner, & Scheltema, 2004). For this research, the categories of interest will be: transgender, transsexuals, male-to-female, female to male, gender queer, gender variant, gender non-conforming persons.

The stigmatization of transgender identity and behavior leads many individuals to maintain traditional gender roles while keeping their transgender identity closeted (Feldman & Bockting, 2003). Individuals may be uncomfortable with their bodies, added with a lack of access to sensitive and knowledgeable providers can result in avoiding medical care. An estimated thirty to forty percent of transgender persons in the United States do not have a regular physician and often rely on urgent care and emergency room physicians for their immediate health care needs (Feldman et al., 2003).

After a comprehensive review of the literature, it was discovered that transgender persons have a wide range of health and service needs. These health issues include violence, suicide, HIV/AIDS, and barriers to health care access (Kenagy & Bostwick, 2005). Kenagy et al. (2005) conducted a needs assessment of 111 transgender individuals to fill a gap in knowledge about health needs. Kenagy et al. (2005) found

that transgender people are at risk for HIV and AIDS through unprotected anal and vaginal sex, unclean needles, as well as high levels of HIV infection among male-to-female transgender (MTF) (Kenagy et. al, 2005). Violence and suicide are also health-related issues of particular concern to transgender people. Research shows that transgender people are subjected to varying forms of violence including physical abuse (Kenagy et. al., 2005). In San Francisco a quantitative needs assessment found that, thirty-two percent (N = 515) of transgender individuals surveyed had attempted suicide as had one-third of transgender individuals surveyed in Philadelphia (N = 176); sixty-seven percent of those that had attempted suicide stated that the attempt was due to consequences of discrimination due to their transgender identity (Kenagy et al., 2005). Discrimination is the cause of many health-related issues in the transgender population.

Another health-related issue facing the transgender community and the focus of this research study is barriers to health care. Studies all with the purpose to fill a gap in research, such as the previously discussed a needs assessment of 182 transgender individuals in Philadelphia, and a quantitative study of 523 transgender individuals in San Francisco, have found that transgender people experience discrimination due to their gender identity and a lack of cultural competence when trying to access health and social services (Kenagy et al., 2005; Kenagy, 2005; Clements-Nolle, 2001). Some health care providers have offered their services contingent upon transgender people wearing clothing appropriate to their birth assigned gender to the provider's office, such as a MTF will be required to dress in male clothing in order to receive services (Kenagy et al., 2005).

Transgender persons may also present with mental health challenges; such as, anxiety, depression, and suicidal ideation (Bockting et.al., 2004). Many request assistance with the process of coming out as a transgender person, which may lead to gender role transition and medical intervention to feminize or masculinize their bodies through hormone therapy and/or sex reassignment surgery (SRS) (Bockting et al., 2004). Transgender persons may present with adjustment problems related to their identity; such as, rejection by family, impact on sexual functioning and relationships (Bockting et al., 2004).

For transgender care, compassion and technical competence are particularly important given the negative experiences from providers reported by transgender patients in these areas. Transgender patients are among the most socially stigmatized of gender minorities, facing discrimination in health care coverage and insensitivity from ill-informed health providers (Bockting et al., 2004). Transgender-specific health care is rarely a covered benefit. Few providers and staff are knowledgeable about transgender health or trained to respect transgender patients' gender identity. This lack of training; such as, the importance of using an appropriate pronoun and special needs for confidentiality; for example, knowing whether to use a patient's female or male name during phone calls to third parties creates barriers.

Most transgender patients are open about their identity (Feldman et. al, 2003), although at doctor's visits they may appear in clothes, cosmetics, and hairstyles that conform to their birth sex. Transgender patients who are making the transition to living in the identified gender role may present with some elements of each gender. Patients

may also vary their presentation from visit to visit (Feldman et al., 2003). Patients often use two names: a birth name and a chosen name that they use when they are presenting in the preferred gender role. Although multiple names can pose a problem for clinical records, they represent a vital part of the transgender person's identity and should be accommodated whenever possible.

Demographics

There are no concrete statistics on the number of transgender people in the United States. Some estimates on the number of transsexual people, which ignore the broader transgender population, range anywhere from one-quarter percent to 1 percent of the U.S. population. These estimates are dated and likely underestimate the transgender population because they do not account for people who have not yet undergone SRS. The most-cited estimates have been based on counts of people who have undergone sex-reassignment under the care of certain European clinics (HRC, 2007).

History

Christine Jorgensen's sex reassignment surgery (SRS), performed in Denmark in 1953, sparked the U.S. public's first mass media experience involving transgenderism (Williams & Freeman, 2007). At this time, there was a lack of knowledge of gender identity issues, most of the heterosexual public assumed that sex reassignment surgery was related to homosexuality. It was believed to be a last resort for men who love men in order to be stealth about their homosexuality. The U.S. medical community divided over the issues surrounding SRS which served to further pathologize and marginalize transgender people. The conservative faction of the American Medical Association

(AMA) endorsed a law against SRS stating the old English common law that outlawed the maiming of any man who might become a soldier (Williams et al., 2007). The result was that some desperate men took matters in their own hands and performed their own castrations (Williams et al., 2007).

The first report of transgender-specific health care provided in the U.S. dates back to 1964 and since 1966, this care has included sex-reassignment services (Hastings, 1969). Consistent with binary conceptualizations of sex and gender that prevailed at the time, the success of sex reassignment surgery was measured in terms of how well transsexuals adjusted socially, emotionally, sexually, and economically as a member of the other sex (Hastings & Markland, 1978).

As the visibility of the transgender population grew in the late 1970s health care providers and social service agencies became more aware that transgender issues and concerns presented a growing challenge. Little information was available regarding transgender health and unique needs for specialized care. As a result, health care providers and social service agencies sought answers within the more widely examined gay, lesbian, and bisexual (GLB) research (Williams et al., 2007). Many early conclusions about transgender health and health care were based on the assumption that the transgender community was simply a subset of the larger gay, lesbian, bisexual, and transgender (GLBT) community with similar health issues. These early efforts, however well intentioned, failed to reflect actual transgender health needs and concerns.

In the 1980s, the approach to transgender care shifted toward greater attention to treatment of co-existing psychological problems often compounded by living with a

stigmatized identity (Bockting et al., 2004). In the 1990s, the paradigm shifted from helping individuals to adjust within the two binary options of male versus female toward fostering coming out as a transgender person as patients more openly affirmed their unique gender identities in the context of a gender-diverse, increasingly visible transgender community (Bockting et al., 2004).

Today, the transgender population is growing both in numbers and visibility, and includes an age range broader than in decades past (Williams et al., 2007). Youth are expressing non-conforming gender identities at a younger age, and transgender adults are living openly into old age (Williams et al., 2007). Transgender issues have increasingly become part of the public discourse and more information on gender identity is available to the public (Williams et al., 2007). New media technologies have provided unprecedented access to information and insights about transgender persons and the rapidly evolving ways in which gender is expressed. An explosion of resources on transgender issues over the Internet has allowed those seeking more information and support to be connected with one another.

Transgender-Specific Health Issues

There is a high rate of HIV infection in the transgender population, particularly male-to-females (MTF) (Kenagy et al., 2005). Kenagy et al. (2005) found that over one-fifth of MTFs self-reported that they were HIV positive. It also discovered that fifteen out of sixteen people who reported that they were HIV positive were MTF people of color (Kenagy et al., 2005). This finding reflects the overall picture of persons with HIV in the U.S., which is people of color and women continue to be disproportionately

affected by the disease. Female-to-male transgender (FTM) are also at risk for HIV infection from high rates of unprotected sex (Kenagy et al., 2005). Research findings show the need for access to all levels of health care in this population (Kenagy et al., 2005; Kenagy, 2005; Feldman et al., 2003). Other major health concerns were also discovered in the literature.

Suicide is another major health concern among transgender people. High levels of suicidal ideation and attempted suicide were found in the transgender population (Kenagy et al., 2005; Kenagy, 2005; Feldman et al., 2003). Kenagy et al. (2005) found that sixty-four percent of respondents said that they had thought about attempting suicide. Sixty-percent of those that had suicidal ideation did so because they were transgendered. Twenty-seven percent of respondents reported attempting suicide and fifty-two percent of them said they had attempted because they were transgender (Kenagy et al., 2005).

Transgender health care involves addressing both general medical conditions and concerns related to cross-gender hormone therapy (Feldman et al., 2003). Because many transgender persons do not have a primary care physician, many may have poorly controlled chronic conditions, such as hypertension and diabetes (Feldman et al., 2003). In addition, due to fear of revealing transgender status and a perception that they are not at risk, they may not be receiving regular screening for certain cancers, including breast or prostate cancer. FTMs who use hormones, but decide not to undergo a hysterectomy continue to be at risk for endometrial cancer, just as MTFs taking estrogen remain at risk for prostate cancer (Hussey, 2006). It is important to note that the need for sex specific (biological sex at birth) health care does not change with one's gender identity.

Health maintenance for transgender patients should be based on age, family, and personal risk factors, as well as the organ systems present and possible complications from cross-gender hormone therapy (Feldman et al., 2003). Physical exams should be structured based on the organs present rather than the perceived gender of the patient. Transgender persons who have undergone sex reassignment surgery are often unaware of the residual breast or prostate tissue, and this can lead to diagnostic delay (Feldman et al., 2003). Prostate exams should be performed in postoperative male-to-female patients because prostate tissue remains after SRS. There have been a few cases of prostate cancer reported in postoperative MTF patients (Feldman et al., 2003). If there is any significant breast tissue, the patient needs routine breast exams. This includes female-to-male patients who have residual tissue post mastectomy. If the uterus and cervix are present, pelvic exams and Pap smears need to be done on a regular basis. In female-to-male patients who have not had penetrative intercourse, these may be deferred (Feldman et al., 2003). Physicians should be alert for the signs and symptoms of polycystic ovarian syndrome, as an increased incidence has been reported among female-to-male transgender patients (Feldman et al., 2003).

Hormones

The goal of care for transgender persons, as stated in the *Standards of Care for Gender Identity Disorders* of the World Professional Association for Transgender Health (WPATH), is “lasting personal comfort with the gendered self to maximize overall psychological well-being and self-fulfillment” (Meyer, Bockting, & Cohen, 2007). Health care professionals can facilitate the real-life experience, hormone therapy, and sex

reassignment surgery (SRS). Many transgender persons, including those who may not wish to pursue surgical interventions, seek hormone therapy to bring their appearance into alignment with their gender identity (Sanchez, Sanchez, & Danoff, 2009). The *Standards of Care for Gender Identity Disorders* include a psychological and medical evaluation before hormone treatment, with continued medical supervision during hormone use by a physician experienced in caring for transgender patients (Sanchez et al., 2009).

Transgender hormone therapy is a medical intervention strongly desired by many transgender persons. In addition to the physical changes hormone therapy induces, the act of using hormones can be an affirmation of gender identity. Studies of presurgical transsexuals indicate improved psychological adjustment and quality of life with hormone therapy (Feldman et al., 2003). The use of feminizing or masculinizing hormones means that physicians need to pay particular attention to cardiovascular and other risks. Other documented side effects include depression, mood swings, elevated liver enzymes, migraines, and decreased insulin sensitivity (Sanchez et al., 2009). It is important for primary care physicians to coordinate care with the hormone provider. The two are often separate.

Despite recommendations, available data suggest that many transgender persons are uninsured and that a smaller proportion of transgender persons than of the general population access medical care (Sanchez et al., 2009; Feldman et al., 2003). Transgender persons may have difficulty identifying competent and compassionate providers with transgender patient experience. As a result of these barriers, transgender persons may

obtain hormones from nontraditional sources, including friends, street vendors, the Internet, and pharmacists in the absence of a prescribing physician (Sanchez et al., 2009).

The prevalence of unsupervised hormone usage reportedly ranges from twenty-nine to sixty-three percent with urban groups of male-to-female transgender persons, causing possible significant health risks (Sanchez et al., 2009). A study of sixty-seven transgender women in Thailand, found that only fifty percent of this sample had ever discussed hormone treatment with a medical doctor (Winter, & Doussantousse, 2009). A review of endocrine treatments at Johns Hopkins University found that many clients use high-dose hormone regimens and utilize multiple hormones without medical supervision in the belief that this will achieve faster results (Sanchez et al., 2009). One serious potential risk is that of HIV infection from needle sharing from injecting hormones. Particularly among transgender women of color, due to poverty and lack of insurance there is a widespread use of injectable silicone as a cheap alternative to hormone therapy (Williams et al., 2007; Xavier, 2000; Clements-Nolle et al., 2001). Injectable silicone is used to enhance facial features and enlarge breasts in the MTF population. Continued use of injectable silicone can lead to illness, disfigurement, and possibly death (Williams et al., 2007). A review of US based HIV prevention literature found an average HIV prevalence of twenty-eight percent among male-to-female transgender persons (Sanchez, et al., 2009). In addition to health care barriers transgender persons also experience barriers to mental health care.

Mental Health

Accessing mental health care is also a unique challenge for many transgender people (Williams et al., 2007). Mental health professional bias has been detrimental to transgender clients (Williams, et al., 2007). For example, some counselors have been shown to exert bias in counseling that includes pressuring clients into decisions regarding gender, trying to talk clients out of gender reassignment, pushing clients prematurely to come out and identify as their internal gender, or pathologizing transgender identity as simply internalized homophobia (Williams et al., 2007).

Mental health services for the transgender community are particularly important and should include periodic depression screening and assistance in connecting clients with transgender support services. Although studies are limited, one study suggests that transgender patients do not appear to have higher rates of mental illness compared with the general population (Feldman et al., 2003). However, depression is not uncommon among transgender clients. Clements-Nolle et al. (2001) conducted a needs assessment of 515 transgender respondents in a San Francisco study, thirty to forty percent reported taking medication for a mental health conditions, and thirty-two percent reported prior suicide attempts. Mental health professionals also play a gate keeping role in the lives of their transgender clients.

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for the Treatment of Gender Identity Disorders require that the transgender-specific medical interventions of hormone therapy and SRS be recommended by a mental health provider after a thorough psychological evaluation and, in most cases, a period of

psychotherapy (Bockting et al., 2004). Although designed to ensure quality care and outcome, this gate-keeping role also creates an inherent barrier by making it difficult to establish a trusting and productive therapeutic relationship.

The Standards of Care are regarded as authoritative by providers but as restrictive by many clients. The guidelines have given rise to small groups of perceived experts within specific areas whose services are sought by all transgender persons wishing to medically change their gender. Those living in isolated areas may not have easy access to such experts and may find other ways to go about their transition that may not be healthy. Current constraints on access to medical care related to gender changes may place people at risk by forcing them to seek unsafe methods of making these changes such as, using hormones bought off the streets and sharing needles while injecting hormones (Lombardi, 2001).

Barriers to Access

Transgender persons often report hesitation to go to the hospital or call an ambulance for fear of being discriminated against or refused treatment (Rachlin, 2008). Uncertainty of knowing whether a situation will be safe and fear of discovery as a transgender person may prevent individuals from accessing care. Leslie Feinberg, an FTM, reported being ordered out of an emergency room with a temperature above 104 degrees after a physician expressed discomfort over treating a transgender person (Feinberg, 2001). Another example is presented in the life of Robert Eads, an FTM transsexual who died of ovarian cancer when his attempts to find a medical provider

failed because the doctors did not want to treat a transgender/transsexual patient (Rachlin et al., 2008).

In addition to the lack of reliable health care, culturally sensitive health care is even less available. Experiences of dehumanization, refusal of treatment, offensive statements, and inappropriate intake forms have been documented, creating a transphobic atmosphere in clinical settings (Mizock & Lewis, 2008). Transgender individuals report difficulty deciding on the timing and process by which to disclose their gender identity to doctors, partially due to concerns with health insurance coverage, prejudice, and discrimination on the part of the medical providers and staff at medical facilities (GLBT Health Access Project, 2000).

Transgender individuals are often likely to experience some form of discrimination or violence in their lifetimes (Lombardi, 2001). The fear of discrimination and stigma often keeps transgender people from seeking health care for themselves, and when they do, this fear keeps them from disclosing relevant information to the provider with whom they are receiving care (Hussey, 2006). Often times a transgender person is reluctant to seek care due to the insensitivity of the provider (Lombardi, 2001).

Transgender individuals' access to health care is affected by the lack of provider knowledge about transgender people and their specific health care needs. JSI Research and Training Institute (2000) conducted a series of 4 focus groups with the purpose of discovering the health care needs of thirty-four transgender adults and youth in Massachusetts. Qualitative findings suggested that many providers lack the knowledge

to treat routine health care issues having to do with transgender people (Hussey, 2006). These health care issues included hormone use and monitoring, HIV prevention, and preventive gynecological care. The lack of understanding of transgender patients points to the need for health professional to be educated and made aware of the lives and health care issues of their transgender patients

The results from JSI Research and Training Institute's (2000) focus groups in Boston suggested that transgender people often encounter providers who will deny them treatment or provide sub-standard care as a result of lack of knowledge about transgender specific health concerns (Hussey, 2006). The focus groups found that insensitivity, ignorance, fear, and discrimination are the norm for this community when its members try to seek health care (Hussey, 2006).

Studies show that transgender people experience difficulties accessing health care services. One study found that two-thirds of their sample had health insurance, but respondents of color were less likely to have coverage (Kenagy et al., 2005). Sanchez et al. (2009) conducted a quantitative study with the purpose of investigating the utilization to health care by 101 transgender participants. Sanchez et al. (2009) found that twenty percent of transgender individuals born in the United States currently lack health insurance.

Transgender persons may also be underserved by their insurance because most health insurance coverage in the United States excludes hormones, surgery, or any related services associated with transition or change of sex or gender. When a patient's

transgender status is known, even unrelated services may be denied coverage, while coverage for conditions such as hormone replacement therapy (HRT) is available for non-transgender persons (Rachlin et al., 2008). There are unique differences in transgender-specific care for the MTF and FTM populations.

FTM

FTM transgendered individuals face unique challenges in obtaining health care. FTMs have remained absent in mainstream discussion of health disparities in the transgender population, which has contributed to an even smaller number of informed providers (Hussey, 2006; Rachlin, Green, & Lombardi, 2008). In 2003 FTM Alliance of Los Angeles conducted a survey of fifty-one FTM, with the purpose of discovering barriers to healthcare in this population. FTM Alliance of Los Angeles (2003) needs assessment found forty-two percent of their sample reported having difficulty accessing care. Other findings were, fifty-three percent reported being denied services because of their transgender status, and sixty-four percent did not disclose health information to their health care provider. Overall, seventy percent were dissatisfied with their regular provider's knowledge of transgender issues. Another study examining the quality of life among FTMs, found that hormone use was associated with better quality of life compared to FTMs not using hormones (Rachlin et al., 2008). The need for access to knowledgeable providers in order to have quality of life is imperative for this population.

Another concern regarding health care access was the difficulty FTMs experience when going in for physical or preventive care. Undergoing a physical may be difficult for FTMs because some female medical procedures such as pap smears and

mammograms are included in the exam. FTM concerns regarding these services are likely to include finding a medical setting and a provider that will treat them with respect. Respect can consist of addressing them as male even though their body may be female, and their provider should use language that validates their identity. It is also important for the office staff to address patients in their chosen name and pronoun regardless of what name and gender appears on their insurance documents (Rachlin et al., 2008). Other studies found that negative experiences in health care settings may lead transgender persons to forego seeking similar services in the future (Kenagy et al., 2005). For FTMs who do not identify with their female body, the idea of being treated as female can be emotionally difficult and a deterrent to obtaining a physical. Poor experiences or even negative associations with the health care system may cause FTMs, in particular, to avoid not only physicals but, other necessary routine care. This could potentially contribute to increased morbidity that is otherwise preventable or treatable. Such findings continue to highlight the need for training of health care professionals on how to provide competent care to transgender individuals.

Gynecological health care is one specific health need that is seldom addressed for FTMs. FTMs who are taking testosterone carry an increased risk for endometrial hyperplasia, which is abnormal thickening of the lining of the uterus, which in turn may cause endometrial carcinoma (Lee, 2000). Another serious gynecological risk to FTMs is ovarian cancer. Ovarian cancer is the fifth most common cause of cancer-related death, and the most common fatal gynecological malignancy (Hage, Dekker, Karim, Verheijen & Bloemena, 2000). It is suggested that long term exposure to increased levels

of androgens (male hormones) pose an increased risk of ovarian cancer to FTMs (Hussey, 2006). For FTMs, a diagnosis may be delayed even longer than in women in general due to reluctance to seek regular gynecological check-ups (Hage et al., 2000).

The findings together demonstrate that FTM transgender people face barriers to care, have need for a range of service needs and have major health concerns such as HIV, suicidality, violence and barriers to service access. There are also barriers in the MTF population.

MTF

Sanchez et al. (2009) conducted a quantitative study of 101 MTF to discover the potential barriers to health care. Poor, uninsured, foreign-born MTF transgender persons who lack stable housing are less likely to have access to regular medical care (Sanchez et al., 2009). Cost of care, poor access to medical specialists, and poor access to health care providers who are knowledgeable about and friendly toward transgender individuals are identified as barriers to care. MTF transgender participants were more likely to have a medical evaluation than found in previous studies before starting hormone therapy and to obtain hormone therapies from traditional sources (Sanchez et al., 2009; Kenagy, 2005; Clements-Nolle, 2001). They are also more likely to participate in risk-reduction behaviors, such as smoking cessation and obtaining syringes from traditional sources than previous findings (Sanchez et al., 2009; Kenagy, 2005; Clements-Nolle, 2001). MTF transgender persons both with and without regular medical care used hormone regimens that were not consistent with the current *Standards*

of Care for Gender Identity Disorders, placing these patients at increased risk of adverse effects.

Studies in the U.S. consistently report high prevalence rates of HIV infection among MTFs: Kenagy et al. (2005) found that over one-fifth of respondents (n=111) were HIV positive by self-report and Clements-Nolle (2001) found that thirty-five percent of the MTF participant (n=137) were HIV positive. A quantitative study of 332 transgender MTF to discover HIV related risk, estimates HIV prevalence in the MTF population to range from eleven to seventy-eight percent (Nemoto, Operario, Keatley, Han, & Soma, 2004). Despite findings, research indicates that MTFs have a low perceived risk of HIV and STD transmission, and continue to engage in high risk activities including unprotected sex, sex while under the influence of alcohol or drugs, and sharing needles (Nemoto, Sausa, Operario, & Keatley, 2006). Qualitative research has explored the social and ecological context for HIV vulnerability among MTF transgender persons, revealing that socioeconomic and psychological adversity contribute to high prevalence of HIV related risk behaviors (Nemoto et al., 2004). However, few evidence-based transgender-specific HIV interventions exist and few comprehensive studies on transgender health care exist in the literature.

Gaps in the Literature

According to *Healthy People 2010*, biases against gender identity differences must be addressed to ensure access to quality health care and related services, eliminate health disparities, and increase quality of life and years of healthy life for all Americans (Sanchez et al., 2009). This goal requires the collection of accurate information among

individuals marginalized by their gender identity. Although there is some data documenting the health care needs of transgender persons in the United States, the literature does not provide sufficient data on transgender individuals' access to medical care, availability of culturally competent providers, and access to supervised hormonal regimens to assist the transition to their self-identified gender.

The literature discusses needs of the transgender community (Sanchez et al., 2009; Kenagy, 2005; Kenagy et al., 2005; Williams et al., 2007), but little focuses solely on the health care needs of the population. The current research is lacking the voice of transgender consumers and quantitative research methods, which presents a gap in the relevance of these articles. Much of the literature briefly mentions the need for accessible health care pertaining to other main topics, but with little discussion of the experiences of transgender persons. Research has been conducted in the last ten years and there have only been a few studies specifically pertaining to health care access in the transgender population. It has just been recognized that there is a need for transgender-specific care, but due to the stigmatization the research is severely lacking. In the past transgender care was generalized from LGB research. The research on LGB issues continues to be considerably larger than the amount of transgender research. Much of the research has been conducted in urban areas where there are some transgender specific resources available.

There is a lack of research that addresses current gaps in care, such as, assisting transgender persons with obtaining health insurance and access to caregivers who are knowledgeable about and friendly toward transgender individuals who will help them

access and employ hormone therapies safely. To achieve this goal, continued research and training of future health care providers should include cultural competency education that will improve attitudes toward transgender patients as well as increased knowledge of transgender healthcare needs. Research has shown that medical students who experience increased clinical exposure to gay, lesbian, and transgender (GLT) patients perform more comprehensive histories, hold more positive attitudes, and possess greater knowledge of GLT health care concerns than do students with little or no clinical exposure (Sanchez et al., 2009). This study seeks to address this gap by surveying self-identified transgender individuals regarding their experiences seeking health care.

Summary

Transgender individuals face many difficulties in their life due to stigmatization. Barriers to health care continue to be a problem that this population faces. The transgender population has a variety of health and service needs which include: violence, suicide, HIV/AIDs, and barriers to health care access. Risk of HIV infection continues to be a significant need for reliable and competent access to health care. Transgender persons are also at higher risk of suicide due to discrimination, isolation, and stigmatization.

Access to mental health also creates challenges; such as, finding an experienced clinician to provide documentation in order to obtain hormones, culturally competent and sensitive providers, and practitioners experienced or trained in transgender issues. The high risk of suicide attempts emphasizes the need for competent practitioners to serve the transgender population.

Hormone therapy can be particularly dangerous if the appropriate care is not taken; such as, taking a proper history and continue routine blood tests to insure safety. Transgender persons on hormones should be closely monitored if they have a chronic condition, such as hypertension or diabetes. Many transgender individuals are unaware that they need to continue regular screenings for their biological sex. The need for competent practitioners to ensure that transgender patients receive appropriate care without discrimination or stigmatization is imperative.

Chapter 3

METHODS

Introduction

This chapter describes the research design and the methodology used for this study. The study population, important concepts, and the methods used for obtaining the sample are discussed. This chapter also includes a description of the data, collection instruments and a plan for analyzing the data. This chapter concludes by describing the precautions that were taken in order to protect the human subjects.

Research Question

This study investigates the following research question: What are the barriers to health care in the transgender population?

The three areas of particular interest are: care providers' cultural competence, health care accessibility, and care providers' knowledge.

Research Design

The design of this quantitative study is a cross-sectional survey. The researcher used a criterion sample of transgender adults, and a convenience sample of those adults who utilize local support groups. Convenience sample is appropriate due to the difficulty in locating the transgender population due to stigmatization and a variety of other factors. This study attaches numerical values to the answers from a forty question instrument, in order to statistically analyze the data (Marlow, 2005). Quantitative research is empirical in that it utilizes experience and observation as a route to knowledge. The research was cross-sectional because the subjects were surveyed at one point in time (Marlow, 2005).

The population for this study will be adult transgender persons that have utilized health care in the last year to insure that the information received is on current experiences. The age range for this study will be eighteen and older based on the perceived ability that they will be able to comprehend and express their perceptions of accessibility to health care. There is no age cap based on the fact that all transgender individuals that wish to be on hormones will do so for life even after sex reassignment surgery (SRS). The target sample size is thirty transgender people due to the difficulty accessing this population. The researcher contacted facilitators from four transgender support groups in the Sacramento and obtained permission to administer the survey to participants. The disadvantage to this method is that the sample participants will be connected in some way and it is difficult to know how large the current transgender population is in order to determine if this is a representative sample.

Study Population

Criterion sampling was used to find study participants. The criteria were that the study participants be self-identified as transgender, at least eighteen years of age, and utilized health care in the last year to insure that the experiences reported are current. Convenience sampling was also utilized, as evidenced by the researcher surveying those persons who were in the support groups that the researcher was permitted to attend.

Study Sample

The sample population was self-identified transgender adults whom attend local support groups. A total of thirty-three transgender persons were surveyed. The sample surveyed included MTFs and FTMs from various ethnic backgrounds. The participants

ranged in age from 21 to 69. All members of the sample lived in the greater Sacramento area.

Instrumentation

The survey used for the research study contained a total of forty questions (See Appendix A). The first four questions were multiple choice and open-end, and dealt with demographic information about the participants. The next three questions addressed health care coverage and usage in the past year. The remaining thirty-one questions were regarding experiences with health care and the final question was an open-ended question. The participants were asked to complete the survey to the best of their ability without assistance from the researcher.

Utilizing close-ended questions makes it easier for the gathered data to be analyzed. However, close-ended questions do not allow for answers that the researcher did not consider ahead of time. The researcher also included an open-ended question for the respondents to have an opportunity to add any additional information. While an open-ended question is more difficult to code for the purpose of analyzing the data, it does allow for any possible answers that the researcher did not include (Marlow, 2005).

Measurement

This study measured the barriers to health care experienced by the transgender population within the last year. Cultural competence of providers, accessibility of health care services, and the knowledge of the practitioners were measured. The study also measured the difference between the experiences of MTF and FTM transgenders as well part-time and full-time identified participants.

Data Gathering Procedures

Data was collected from transgender adults during local support group meetings. Prior to administering the survey the researcher contacted the group facilitators, and requested permission to attend their group and administer the survey. The researcher then attended those meetings to obtain consent and administer the survey.

When administering the survey, the researcher introduced herself and the survey. The researcher briefly explained the consent form and survey, and asked for participation, while emphasizing that participation was completely voluntary. The researcher then passed out the consent forms and surveys. The participants spent between ten and twenty minutes completing the consent form and survey. Upon the completion of the survey or decision not participate in the survey, the researcher collected the consent to participate forms and surveys. This way the researcher did not know who had completed the survey and who had chosen not to participate. The completed surveys and consent to participate forms were stored in separate envelopes to avoid any identification of participants.

Data Analysis

The goal of the research study is to determine barriers transgender individuals face when utilizing health care services in order to create awareness among health care professions. The proposed research question will be studied through quantitative survey research design which will investigate cultural competency, knowledge of transgender care, and accessibility of health care services to the transgender population. Data will be coded and entered into the Statistical Package for the Social Sciences (SPSS) for computer analysis. Univariate statistics will be utilized within this study to obtain

percentages and means. Descriptive statistics will also be used to identify health care issues experienced by people in the transgender population.

Descriptive statistics will provide an overview of the sample characteristics (such as the total number, age range, mean age of participants, gender distribution) and responses from the questionnaire. As drafted, the questionnaire will produce ordinal level data. This means that the median and mode of responses will be reported. Tables will be utilized to present a graphical summary of the data.

Protection of Human Subjects

Prior to administering the survey, the Human Subjects Application was submitted for approval to the California State University, Sacramento Division of Social Work Committee for the Protection of Human Subjects. The survey was approved as “minimal risk.” The anticipated risk to the human subjects was no more than what is normally encountered in daily life or during routine physical or psychological examinations. Risk to the human subjects was minimized by asking the human subjects about their experiences in accessing health care, and not directly asking the human subjects about their own reasons for accessing health care.

Each participant of the study was given a consent form (See Appendix B). This form explained the purpose of the survey, the procedures, risks, benefits, compensation, and their right to not complete the survey. The consent form also indicated that confidentiality would be strictly upheld in order to protect their privacy. The participants consented by signing or initialing the consent form.

Confidentiality was upheld by not collecting names or other identifying information. The completed consent forms were stored separately from the completed surveys in a locked cabinet in a secure location at the researcher's home. The researcher and the researcher's thesis advisor were the only people who had access to the completed surveys during the completion of the project. The data will be destroyed approximately one month after the project is filed with Graduate Studies at California State University, Sacramento.

Summary

The purpose of this study is to discover the specific barriers that the transgender population faces when accessing health care services. A convenience sample was used in order to locate this difficult population through receiving participants through four local support groups. The thirty-three transgender individuals were self-identified and at least eighteen years of age. The instrument used for this study was a survey created by the researcher and it consisted of forty questions. Data was collected during the four individual group meetings, consent forms were obtained, and resource sheets distributed to the participants. Confidentiality was insured by keeping completed questionnaires and consent forms separated. SPSS was employed to analyze the data collected from the instrument.

Chapter 4

RESULTS

Introduction

This project sought to answer the question “What are the barriers to health care in the transgender population?” This project was interested in examining three areas of particular interest: care provider’s cultural competence, health care accessibility, and care providers knowledge. Questionnaires designed by the researcher (see Appendix B) were distributed to thirty-five transgender persons associated with four different support groups in the Sacramento area. Thirty-four questionnaires were completed and returned to the researcher. Therefore, a 97% response rate was achieved in the research. The data will be analyzed and presented within four separate categories: respondent demographics, cultural competence of care providers, health care accessibility, and care provider’s knowledge of transgender-specific care. The survey consisted of thirty-nine quantitative questions and one qualitative question. For the purpose of this study “strongly agree” and “agree” responses will be collapsed and interpreted; where applicable, as “yes” and “disagree” and “strongly disagree” will also be collapsed and interpreted as “no”.

Respondent Demographics

The first questions presented to participants on the questionnaire asked about demographic information in order to learn how each participant self-identified and to gather health care data. Thirty-four, transgender individuals over the age of eighteen consented to participate in the project. Based upon information shared in survey, it appeared likely that one respondent lived outside of the Sacramento, California area, but

resided within the state of California. Data is provided in percentages. Correlation of percentage to respondents is 3% to 1 respondent.

Gender. The gender of participants was asked in six categories: “Transgender”, “Male to Female” (MTF), “Female to Male” (FTM), “Female”, “Male”, “Genderqueer”, and an “other” for respondents to fill in. The multiple categories for gender were provided to permit the greatest latitude to the respondent. For the purpose of analysis, the categories were collapsed into five major categories: “Transgender”, “MTF”, “Genderqueer”, “FTM”, and “transsexual”. There was a wide range of responses with the majority choosing either “Male-to-Female” 47% or “Female-to-Male” 41%. Six percent, chose “Transgender”, 3% chose “Genderqueer”, and 3% wrote in “Transsexual” (see Figure 4.1). There were some responses where respondents chose more than one gender identity. Of those were: two persons identified as “FTM” and “Male”, one identified “Transgender” and “Tranny Boi”, one identified “FTM” and “Genderqueer”, one identified “Transgender” and “FTM”, one identified “Transgender”, “FTM”, “Male”, “Genderqueer”, and “Queer²”, three persons identified “Transgender” and “MTF”, one identified “Transgender”, “MTF”, and “Female”, and one identified “Transgender”, “MTF”, and “Non-Op Transsexual”.

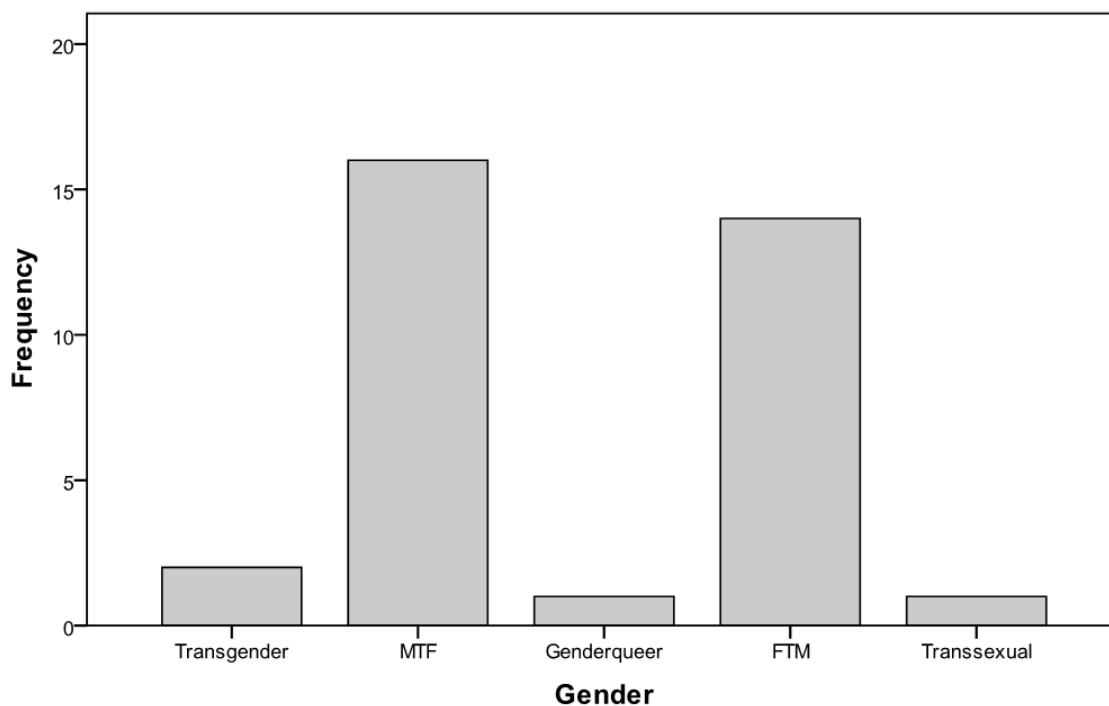


Figure 4.1 Gender identity

Preferred gender presentation. The preferred gender presentation represents the amount of time respondents present themselves to the public as their preferred gender.

The majority of respondents were presenting full-time 79%. Twenty-one percent responded that they were presenting in their preferred gender part-time.

Ethnicity and age. The majority of respondents identified their ethnicity as Caucasian, 82%, while 12% identified as Latino, 3% African American, 3% Asian, and 3% Celtic. Age of respondents ranged from 21 to 62 years old. Categorically, 32% were 21-29 years old; 21% were 30-39 years old; 15% were 40-49 years old; 26% were 50-59; and 6% were 60-69 years old. The mean age of respondents was 40 years old.

Health care data. Respondents were asked what type of health coverage they had and the majority of respondents, 50% were covered by their employer. Categorically, 21% were covered by self or partner, 15% were covered by medical or medicare, 6% were covered by school, 3% were covered by their parents, 3% were uninsured, and 3% did not respond (see Figure 4.2). Respondents were asked the number of times they accessed healthcare in the last year. The majority of people 71% fell between 1 and 8 times, with a range of 1 to 30. The final demographic data question asked respondents about their primary physician; this revealed that 65% saw a general practitioner, 18% saw a specialist in transgender care, 12% responded “other”, and 6% did not respond.

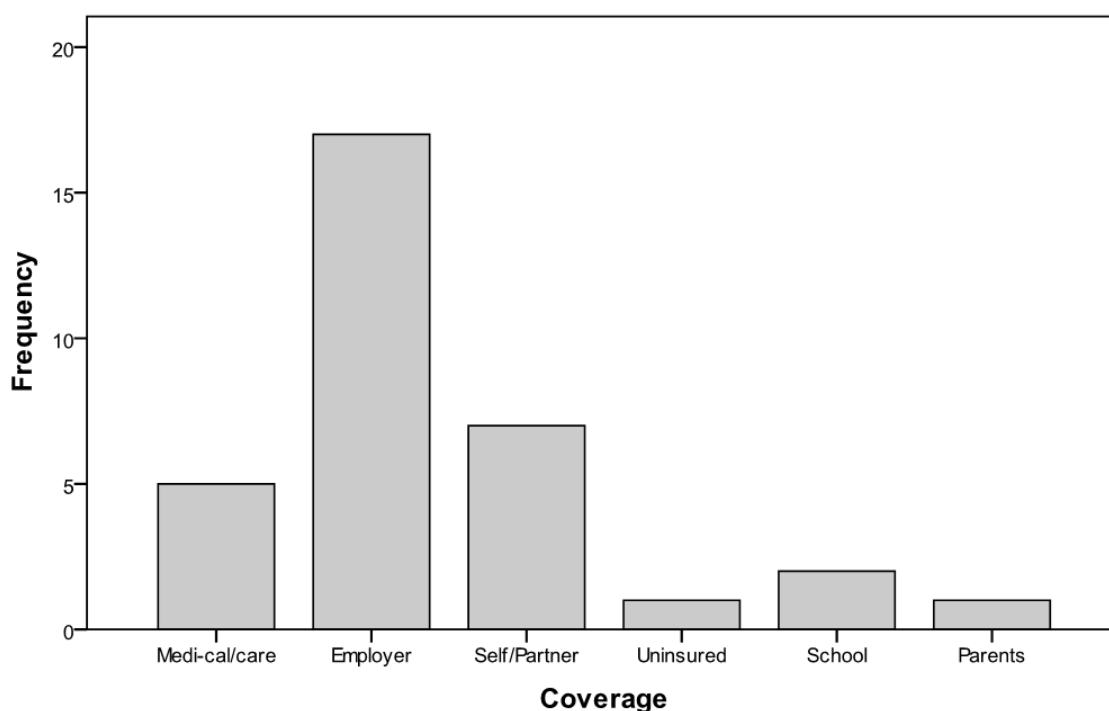


Figure 4.2. Health Insurance Coverage

General information questions. Respondents were asked two general information questions about what types of gender-confirming steps they had taken. Respondents were asked if they had any gender-confirming surgery; 41% responded “yes” and 58% responded “no”. Seventy-nine percent agreed that they were taking hormones and 21% were not at the time the survey was conducted.

Cultural competence of care providers

After providing basic demographic information, participants answered questions regarding the cultural competence of their care providers. Respondents were asked three questions regarding disclosing their transgender identity. When asked whether respondents felt comfortable disclosing their transgender identity to health care practitioners, 29% reported they “strongly agreed”, 50% reported they “agreed”, 15% reported they “disagreed”, and 6% reported they “strongly disagreed”. More FTM respondents, 36%, than MTF, 13%, disagreed that they felt comfortable disclosing their transgender identity when accessing health care. Conversely, 44% MTF and 14% FTM responded that they strongly agree that they are comfortable disclosing their transgender identity (see Figure 4.3).

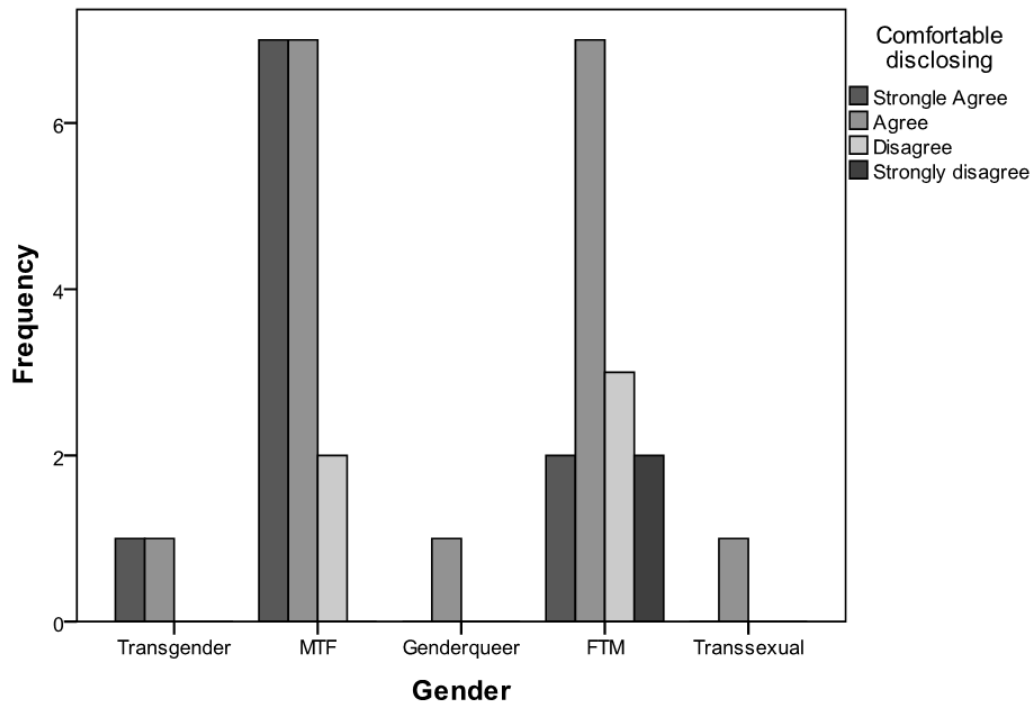


Figure 4.3. Comfortable disclosing transgender identity to health care practitioner.

When asked if the respondents disclosed their gender to health care professionals, 91% responded “yes” and 9% responded “no”. Both MTF and FTM had disclosed their gender with 7% of FTM and 13% of MTF not disclosing. Nine percent of respondents that were part-time in gender presentation had not disclosed their transgender identity where 0 of full-time respondents had not disclosed (see figure 4.4).

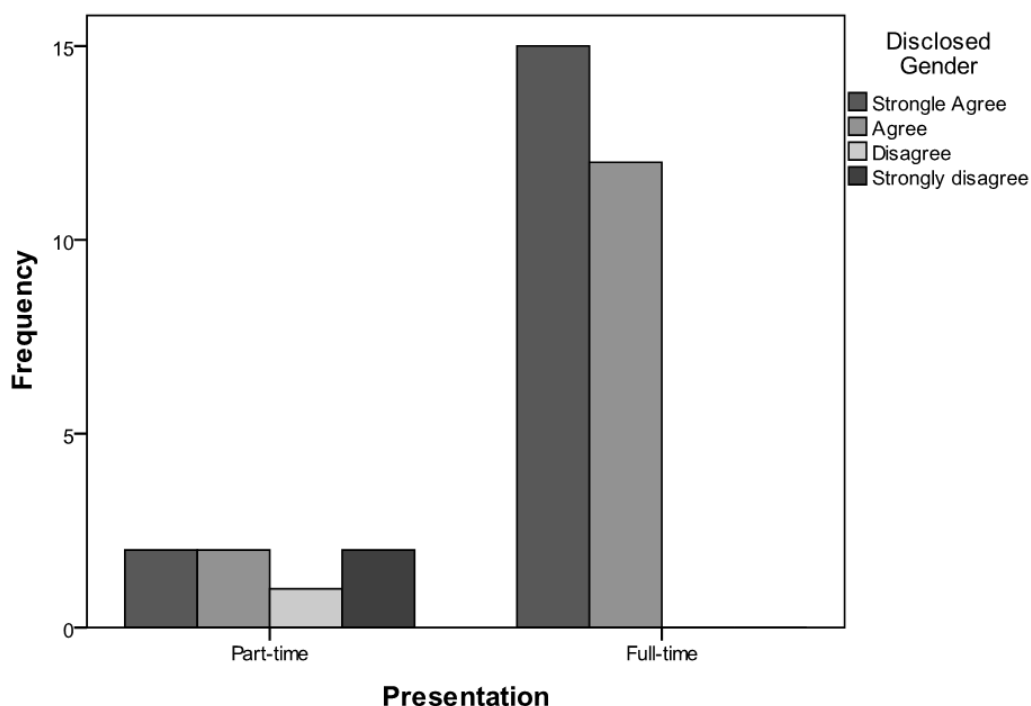


Figure 4.4. Disclosed gender identity.

When asked if respondents' physician was aware of their transgender identity they responded almost identical to disclosing gender to physician. The responses were: 89% responded "yes", 9% responded "no", and 3% did not respond.

There were six questions regarding the treatment of respondents when utilizing health care. When asked if they were treated with dignity and respect when accessing health care 32% strongly agreed, 56% agreed, and 12% disagreed. Six percent of MTF and 21% of FTM respondents were not treated with dignity and respect. In response to this question the preferred gender presentation responses were 3% part-time and 9% full-time disagreed that they were treated with dignity and respect.

Respondents were asked if they avoid seeking medical care due to a negative experience and the majority (80%) disagreed. Responses were: 15% strongly agreed, 6%

agreed, 47% disagreed, and 32% strongly disagreed. FTMs reported a higher rate of negative experience (36%) compared with 13% of MTFs. Of the respondents that agreed to having a negative experience, all (21%) were full-time in their preferred gender presentation.

Identifying transgender individuals by their preferred gender pronoun is an important aspect of culturally competent transgender care. When asked if health care providers use respondents preferred pronoun, 73% responded “yes”, 24% responded “no”, and 3% did not respond. Twenty-one percent of FTMs and 25% of MTFs responded that their physician did not use their preferred pronoun. Six percent of respondents that dressed part-time and 24% of full-time respondents disagreed that their health care provider used their preferred pronoun.

When respondents were asked if they were asked inappropriate questions by their practitioner 30% responded yes, 65% responded “no”, and 6% did not respond. FTMs were asked inappropriate questions more often (50%) compared to (19%) for MTFs. Respondents with part-time gender presentation had not been asked inappropriate questions by their physicians compared with 29% of full-time respondents.

Respondents were asked if they felt respected when utilizing health care. Responses were: 24% strongly agreed, 56% agreed, 15% disagreed, and 6% strongly disagreed. Six percent of MTFs did not feel respected compared to 43% of FTMs. Respectively, 3% of participants that have a part-time preferred gender presentation and 18% full-time did not feel respected when utilizing health care.

In the literature, transgender patients felt discomfort in a variety of health care settings. The final question respondents were asked about their experiences was where they had experienced discomfort. Twenty-one percent of respondents experienced discomfort in the emergency room, 21% in the waiting room, 29% by front desk staff, 26% in gynecology/prostate care, 26% while having a physical examination, 47% replied that they had not experienced discomfort, and 9% did not respond.

When asked if respondents had been diagnosed with Gender Identity Disorder (GID), 64% responded “yes”, 30% responded “no”, and 6% did not respond. Sixty-nine percent of MTFs and 64% of FTMs agreed that they had been diagnosed with GID. Of those that responded, 74% of full-time presenters and 29% of part-time agreed that they had been diagnosed with GID.

Accessibility of Health Care

Respondents were asked several questions about their experiences with the accessibility of health care. When asked about whether the participants had been denied health care, 3% reported that they “strongly agreed”, 18% reported that they “agreed”, 47% reported that they “disagreed”, and 32% reported that they “strongly disagreed”. Of this sample, 15% of the FTM and 3% of the MTF participants reported that they had been denied health care. Twenty-six percent of full-time respondents reported that they were denied health care compared to no part-time respondents (see Figure 4.5).

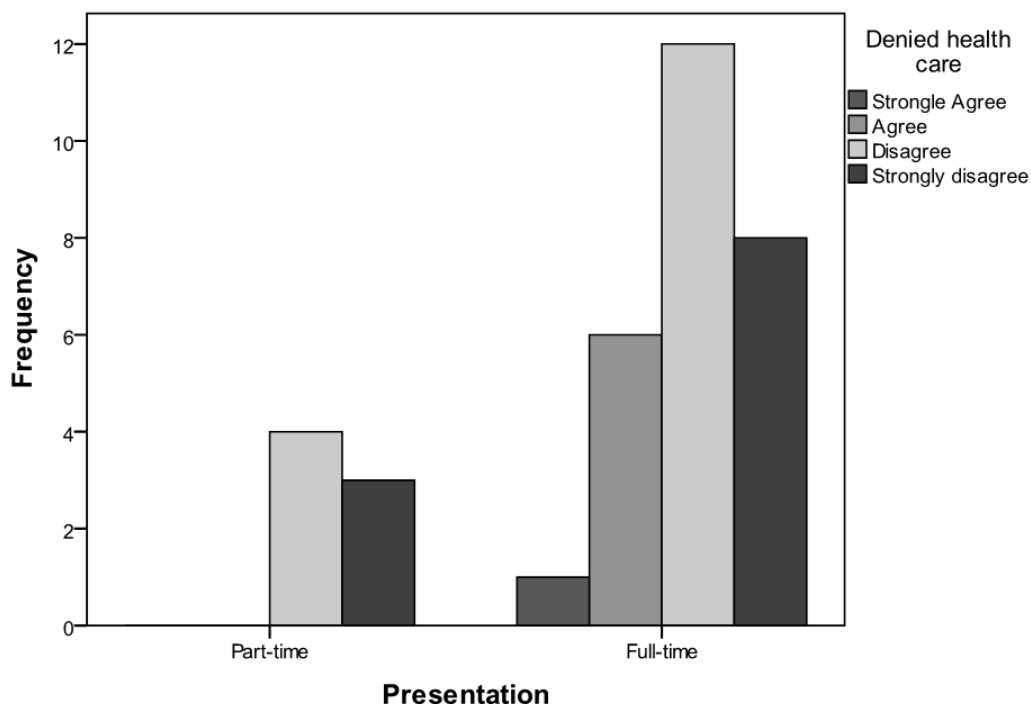


Figure 4.5. Denied health care.

When asked if their medical records reflected their preferred gender identity participants responded: 59% responded “yes” and 41% responded “no”. MTF (56%) and FTM (64%) agreed that their medical records reflected their gender identity. Seventy-one percent of part-time respondents and 33% of full-time respondents disagreed that their medical records reflected their preferred gender identity.

Respondents were asked if there were practitioners knowledgeable in transgender health care within twenty miles of their residence. Six percent strongly agreed, 32% agreed, 44% disagreed, 9% strongly disagreed, and 9% did not respond. Response by gender was 57% FTM and 50% MTF disagreed that there was a knowledgeable practitioner close to their residence. Fifty-seven percent of full-time respondents and

28% of part-time respondents felt that there were not any knowledgeable practitioners within twenty miles of their residence.

In the literature it was discovered that due to lack of accessibility, many transgender persons obtain hormones from sources other than licensed practitioners. Participants were asked if they were taking hormones, were they provided by a licensed physician, and responses were: 77% responded “yes”, 12% responded “no”, and 12% did not respond. Nineteen percent of MTF respondents and 7% of FTM disagreed that they received their hormones from a licensed practitioner.

Due to gender non-conformity transgender persons find it difficult to seek medical care and in turn avoid preventative care. When respondents were asked if they were comfortable seeking preventative care 67% responded “yes” and 33% responded “no”. FTM (57%) responded that they were more uncomfortable than MTF (13%) in seeking preventative care. Of those that experienced discomfort, the majority were respondents that were full-time dressers (37%) compared with 14% of part-time dressers. Many transgender persons are uncomfortable seeking preventative care for their biological risk due to not identifying as that gender. At times, this type of care can be traumatizing to individuals, therefore; many choose to forgo screenings for cancer which can be fatal. Respondents were asked if they continue with these exams. The responses are: 59% responded “yes”, 36% responded “no”, and 6% did not respond. Consistent with the literature, 57% of FTM respondents and 25% of MTF disagreed that they continued preventative care for their biological sex. More full-time (29%) than part-time (6%) dressers responded that they do not seek preventative care for their biological sex.

When asked if respondents had experienced difficulty with insurance companies due to gender non-conformity 6% strongly agreed, 27% agreed, 47% disagreed, 18% strongly disagreed, and 3% did not respond. Comparing responses by genders, 50% of FTM and 19% of MTF had experienced difficulty with insurance companies. Part-time dressers reported that they had not had difficulty with insurance companies due to gender identity, compared with 41% of full-time presenters.

Participants were then asked if they avoided insurance companies because of difficulty navigating the system due to their transgender identity. Responses were: 39% responded “yes”, 53% responded “no”, and 9% did not respond.

The next statement was “I have had no difficulty accessing health care”, 50% responded “yes”, 47% responded “no”, and 3% did not answer. More MTF (69%) than FTM (36%) responded that they had not experienced difficulty accessing healthcare. Seventy-one percent of part-time presenters and 44% of full-time responded that they did not have difficulty accessing healthcare.

When asked if it was difficult to obtain relevant information about transgender health 65% responded “yes” and 35% responded “no”. More FTM (79%) than MTF (50%) agreed that it was difficult to obtain relevant health information. Full-time presenters (53%) experienced more difficulty obtaining relevant information than part-time (12%).

Participants were asked what the biggest barriers to obtaining hormones were: 18% responded physician, 26% insurance, 24% said that this was not applicable to them,

25% responded pharmacy, 12% mental health provider, and 41% did not have difficulty obtaining hormones.

The last question regarding accessibility asked participants to rate their access to health care with 1 being no access and 5 being very accessible. Responses were: 3% answered 1 or no access, 15% answered 2, 41% answered 3, 15% answered 4, and 27% answered 5 or very accessible.

Table 1

Health care accessibility rating

	Frequency	Percent
1	1	3%
2	5	15%
3	14	41%
4	5	15%
5	9	27%
Total	34	100%

Knowledge of Transgender-Specific Care

Respondents were asked several questions about the knowledge of their health care providers regarding transgender care. When asked if participants' practitioners were knowledgeable in the Harry Benjamin Standards of Care 15% strongly agreed, 35% agreed, 27% disagreed, 12% strongly disagreed, and 12% did not respond. Participants were asked if they were required to obtain a letter for hormones which is required

according to the Standards of Care (SOC). The majority of respondents were required to obtain this letter, 56% responded “yes”, 36% responded “no”, and 9% did not respond.

There are many potentially dangerous side-effects that can occur when taking hormones, participants were asked if their practitioner explained the risk as well as benefits. Respondents indicated that the majority of physicians did: 62% responded “yes” and 24% responded “no”. When asked if participants were confident that their practitioner had a basic knowledge of transgender care 24% strongly agreed, 35% agreed, 27% disagreed, 12% strongly disagreed, and 3% did not respond. Participants were asked if they have had to educate their practitioners regarding transgender health issues, 61% responded “yes”, 36% responded “no”, and 3% did not respond.

The transgender population often times will seek out information from other transgender persons regarding hormones and other aspects of medical care. The participants were asked if they had educated other transgender persons, 71% responded “yes”, 24% responded “no”, and 6% did not respond. Participants were also asked where they received the majority of their health care information and 38% said physicians or nurse practitioners, 85% indicated the internet, 24% reported a therapist, 50% stated friends, 68% indicated support groups, and 0% emergency visits.

When accessing health care participants have received: 38% inaccurate information, 59% general lack of understanding of transgender people, 29% negative reactions by practitioners, 71% lack of information, 29% resistance to using correct pronoun, and 24% had not experienced any of these.

Participants' Recommendations for Health Care

The final question was an open-ended question that asked participants to give recommendations for culturally competent health care. Thirteen participants responded to this question. Many responded about the wish that sex reassignment surgery (SRS) was covered by insurance. "Acceptance of SRS as the standard of treatment for GID and availability of insurance for such." One respondent wanted insurance to cover hormones.

One powerful statement regarding the Standards of Care stated, "transgender/transsexual people are NOT disordered. I am perfectly healthy both mentally and physically and reject all the outdated Harry Benjamin nonsense. It is my wish that trans-people be able to control their own destinies in the future."

Several participants commented on the need for respectful reactions to treating transgender patients. "Keep your facial reactions and body language to a minimum when you react to my gender." Another participant stated that more listening and respecting the experiences of the patient. One respondent simply put "awareness".

Several participants stated that they recommended increased training for doctors and nurses. Another respondent recommended there be required transgender health continued education units for all health and mental health providers, including admin staff. One participant wished that transgender people would have a greater "ability to find a primary care physician with experience in hormone therapy."

Specifically for mental health, one participant recommended that therapists be "more informed of other practitioners where families can access group therapy for families of transgender people."

Kaiser in Vacaville was commented on by a participant. “My endocrinologist and therapist have been, though lacking in education initially, absolutely wonderful, compassionate, self-educating, and respectful.”

One participant lives in the San Francisco area where transgender health services are covered as part of their universal health care for all persons that reside within the city limits. “Honestly, I’ve had great access to excellent trans-care. The folks at Lyon-Martin began seeing me on a sliding scale (basically for free) almost two years ago and then helped me get on the Healthy San Francisco program when I moved to the city. Before I was on that program I sometimes missed my hormones for lack of money, but they’re now all covered.”

Summary

This project consisted of 34 self-identified transgender individuals with an age range of 21-62 years-old and a mean of 40 years-old. The majority of participants’ gender identities were MTF (47%) or FTM (41%) and their preferred gender presentation was full-time (79%) and part-time (21%). The majority of participants were insured (97%) with 50% covered by an employer. The majority of participants (58%) had not had any gender-confirming surgery.

The majority of participants responded that their health providers were culturally competent. 79% agreed that they felt comfortable disclosing their transgender identity to their health care practitioners. There was a higher percentage of FTM (36%) than MTF (13%) respondents that did not feel comfortable disclosing their gender identity.

The majority of participants (88%) responded that they were treated with dignity

and respect while accessing health care. More FTMs (21%) felt that they were not treated with dignity and respect than 6% of MTFs. FTMs (36%) reported avoiding medical care due to a negative experience more than MTF (13%) respondents. Of those that reported (21%) having a negative experience and therefore avoiding medical care were all (21%) full-time in their preferred gender presentation.

Respondents were asked question regarding their experiences with the accessibility of culturally competent health care. The majority (79%) reported that they were not denied health care based on their transgender identity. More FTMs (15%) than MTFs (3%) responded that they had been denied health care. Twenty-six percent of full-time respondents reported they were denied care compared with (0) part-time respondents.

Fifty-three percent of participants disagreed that there were practitioners knowledgeable in transgender health care within twenty miles of their residence. Nineteen percent of MTF and 7% of FTM respondents reported that they received their hormones from someone other than a licensed practitioner. Of the 33% of respondents that reported discomfort in seeking preventative care 57% were self-identified FTM. The majority of respondents (37%) were full-time in their gender presentation compared with 13% of part-time respondents.

Respondents were asked about their experience with insurance companies. Thirty-three percent of respondents agreed that they had experienced difficulty with insurance companies due to their gender non-conformity. Of those, 50% of FTMs and 19% of MTFs reported difficulties and the entire 33% that had experienced difficulty were full-time in their gender presentation.

Fifty-percent of respondents reported that they had no difficulty accessing health care and 47% reported that they had difficulty. Just 36% of FTMs had not experienced difficulty compared with 64% of MTFs. Part-time respondents had less difficulty (71%) compared with full-time (44%). Sixty-five percent of respondents stated that it was difficult to obtain relevant information about transgender health.

Respondents indicated that the majority of practitioners explained the side-effects of hormones. Sixty-two percent of respondents reported that their physician had discussed side-effects. Sixty-one percent reported that they had to educate their practitioners about transgender-specific care. Seventy-one percent of respondents reported that they also educated other transgender persons regarding transgender health. Eighty-five percent responded that they received the majority of health care information from the internet. Seventy-one percent reported that when accessing health care they received a lack of information.

The following chapter will recap the important findings of the study. This researcher will also discuss the implications for future research, policy, social work practice and practitioners. There will also be a discussion pertaining to the limitations of the data collection and in essence, what may be known about the non-responders.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The transgender population is an oppressed and vulnerable population and there is a gap in literature regarding this population (NASW, 2000; Burdge, 2007; Burgess, 1999). According to the NASW, where a gap is or lack of services exist and the gap contributes to distress, alienation from others, or impedes health care treatment for transgender persons then professionals need to be advocates for change (2006). There is a need for health care and mental health care providers to work to support the health and development of the transgender population.

A review of the literature, although limited, indicated that the transgender population experienced a significant amount of barriers to health care access. As many as forty percent of the United States transgender population does not have a regular physician, which causes a heavy reliance on emergency medicine and/or illness left untreated (Feldman et al., 2003, & Williams et al., 2007). Violence, harassment, and discrimination from revealing their transgender identity prevent access to necessary care. The primary objective of this study was to understand the current barriers to health care from the perspective of the transgender population, in order to learn how to better serve this population. This final chapter discusses conclusions drawn from the research and from survey participants, the limitations of this study, and recommendations for future research and for further development regarding this topic.

Discussion

This research project found that many of the participants (50%) did not significantly lack access to healthcare as the literature suggested. The study population consisted of relatively even numbers of MTF (16) and FTM (14) participants which was not generally found in the current literature (Clements-Nolle et al., 2001; Kenagy, 2005; Kenagy et al., 2005). This offered a comparative view of the two separate populations. FTM (64%) were found to have more significant amounts of barriers to access of culturally competent health care than the 36% MTF population. This phenomenon coincides with the literature. This researcher does not believe there were any outside influences that could have accounted for the difference in populations. The support groups were not mixed population support groups and there was no motivation to answer questions in any other way than through the lens of the individual experience.

FTM are typically less likely to have SRS surgery than the MTF population due to the risks, cost, and the lack of operability for urination and sexual intercourse. This may add to their general discomfort due to their genitals not matching their male identity. Another thought that is also found in the literature is the idea that MTFs are able to obtain biological sex specific (prostate exams) with a general practitioner (Hussey, 2001; Rachlin et al., 2008). FTM transgender individuals will oftentimes need to visit a gynecologist for their exam. Due to their male identity this can create some discomfort which may lead to avoiding health care altogether. This study confirmed that FTM are less likely (57%) to seek preventative care than 13% of MTF participants. Congruently, 57% of FTM participants did not obtain biological-sex preventative care such as pelvic

exams and breast exams. This puts the FTM population at significant risk even if they have had a mastectomy and/or hysterectomy due to the presence of tissues left.

In addition, 50% of FTM respondents experienced difficulty with insurance companies compared with 19% of MTFs. Also, 15% of FTM respondents were denied health care compared with 3% of MTFs. Due to negative experiences with health care, FTMs were more likely (36%) to avoid health care than 13% of MTF respondents.

Another finding that was of significance which this researcher did not find in the literature is the difference in barriers for the part-time identified participants. This study found that this group had significantly less barriers to health care than the full-time identified participants. This is believed to be from the ability of the part-time transgender persons to be perceived as the gender which they do not identify with. Nine percent of part-time respondents reported that they had not disclosed their transgender identity to practitioners compared with 0% of full-time respondents.

The study consisted of seven part-time identified persons which is not a significant number for generalization. Three percent of part-time compared with 9% of full-time respondents were not treated with dignity and respect. All part-time respondents reported that they had not avoided medical care due to a negative experience where 21% of full-time did avoid medical care. Respondents with part-time gender presentation had not been asked inappropriate question by their physicians compared with 29% of full-time respondents.

In regards to accessibility, 26% of full-time respondents compared with no part-time participants reported that they were denied health care. More full-time participants

(37%) reported feeling discomfort with seeking preventative care than part-time participants (14%). In regards to insurance, part-time respondents did not experience difficulty companies compared with 41% of full-time participants. Full-time respondents (53%) experienced more difficulty obtaining relevant information than 12% of part-time participants.

Another interesting finding is that the participants more often than not received information about health care through friends, support groups, and internet sites. They were less likely to obtain information from practitioners. Seventy-one percent of participants also found that there was a lack of information when they accessed healthcare and 59% responded that they experienced a general lack of understanding of transgender persons.

Limitations

This research is limited in sample size and scope (each participant was a member one of four transgender support groups). The research conducted in this study utilized convenience and snowball samples of adults who self-identify as transgender. Therefore, those who were not currently involved in support services were not accounted for. Those may include: transgender persons who are fully transitioned, persons questioning or at the beginning of transition, transgender persons that are not aware of support groups, and those that are not open about their transgender identity. Those who might expand upon this research may quantitatively compare doctor's ideas about their treatment and knowledge of transgender consumers with transgender persons' experiences. This may be achieved by creating a questionnaire or expanding upon this researcher's

questionnaire, which would be sent to physicians to gain understanding from their perspective. In addition, create or use the existing questionnaire to survey transgender individuals. Using statistical analysis, this may give a more accurate picture of how to best improve upon care. Although it is difficult to obtain approval, it may also be helpful to open the study for those under eighteen to participate which will help gain insight into the needs of transgender youth and health care.

Additional studies may seek out physicians that are culturally competent in transgender care and those that are not. Comparing the two groups' background to discover what is helpful in facilitating competent treatment of the transgender population. This research should pay particular attention to when their first contact with a transgender individual took place and the amount of experience they have had with the population. It would be important to discover if their individual medical schools discussed transgender-specific care. Another important aspect is the new media coverage on the transgender population (Feinberg, 2001; Williams et al., 2007). Media often times shapes an individual's views on many areas of life. A study of the media affects on the treatment of transgender persons would be a significant contribution.

Recommendations

By bringing awareness to the barriers that the transgender population faces when accessing health care, such as, lack of knowledgeable practitioners and services, policies requiring non-discrimination of transgender care, curricula in medical school teaching transgender-specific care, and practices in the literature that address these victimizations and emphasizes the need for acceptance can be created. As indicated by the research

participants there is a need for more education of medical and mental health staff regarding the care of transgender consumers. There appears to be a correlation to education and experience when providing competent care. Unfortunately, there are no requirements in medical school to learn how to treat transgender patients. Many transgender experience negative affects due to this lack of policy. Those that are willing to treat may not know how to treat such individuals and therefore may do more harm than good. By requiring such courses, this may help to eliminate some of the negative experiences of transgender individuals.

There also seems to be a lack of sensitivity coming from front desk staff when this population accesses health care. As written in Chapter one of this project, these experiences can be horrifying and permanently damaging to the individual. Policies should not stop at the practitioner, but should be provided to all medical staff that will work with this population. Sensitivity trainings should already be in place for other cultures so they should be extended to include the transgender population. The literature pointed out that professionals generalize care based on findings from the lesbian and gay population (Williams et al., 2007, Clements-Nolle et al., 2001, Kenagy, 2005), but the needs of the transgender population are unique and separate (Williams et al., 2007). Trainings and policies should deal with the unique needs of these populations separately.

Implications

Efforts must be made to combat the social stigma attached to identifying as transgender and at the same time, attention must be paid to assisting those who have been victims of oppression and discrimination. Services should be made available to this

population to prevent isolation and preventable or chronic illness. Specific efforts should be made specifically for the FTM population that appears to experience more stigma when accessing care. The MTF and FTM health needs vary greatly and continued education and research is key to ending lack of access to care.

Conclusion

This study revealed some key issues calling immediate action on the part of medical and mental health providers as well as the social work profession. There is a need for further research to learn more about the experiences of a larger sample of transgender individuals. There is also a need for more engagement of the transgender community to determine what their needs are specifically.

Although there is no simple solution to solve the problem of the lack of access to health care and transphobia in the larger society, there are measures that social workers and medical providers can take. Health care is something that all citizens should have access to and as we have seen in the most recent fight for universal health care reform many others agree. The passage of this bill did not extend benefits to transgender services nor were there any protections to ensure competent transgender care. Most feel this is a step in the right direction and this researcher tends to agree; however, universal health care should truly do what it says, be extended to all. Perpetuating the oppression of the transgender population or any other population is not ethical under the NASW code of ethics. As social workers we have the responsibility to advocate in the interest of ending the oppression of oppressed and marginalized groups which includes the transgender population.

APPENDIX A

Consent to Participate in Research

You are invited to participate in a research study that will be conducted by **Heather Waddle**, a Master of Social Work student at the Division of Social Work, California State University, Sacramento. This study will explore barriers to utilization of health care in the transgender population.

Procedures:

After reviewing this form and agreeing to participate you will be given a survey containing multiple choice and fill-in questions. The survey should take approximately fifteen (15) minutes to complete. The survey is confidential and no names will be recorded.

As a participant in the survey you can decide at any time not to answer any specific question, skip questions or stop taking the survey.

Risks:

The discussion of some of the topics on the survey may illicit some emotional responses as you recall your recent experiences utilizing health care. For this reason this research is considered minimal risk. If needed, you can seek mental health support through the provided resource handout.

Benefits:

This research gained by completing this survey may help us to understand the effect cultural competence has on utilization of health by transgender persons. In addition, by being a part of this study you may gain insight into your own barriers.

Confidentiality:

All information is confidential and every effort will be made to protect your identity. Your responses on the survey will be kept confidential. Information you provide on the consent form will be stored separately from the completed surveys in a locked cabinet in a secure location at the researcher's home. The researcher's thesis advisor will have access to the completed surveys for the duration of the project. The final research report will not include any identifying information. All of the data will be destroyed approximately one month after the project is filed with Graduate Studies at California State University, Sacramento.

Compensation:

Participates will not receive any kind of fiscal compensation.

Rights to withdraw:

If you decide to participate in this survey, you can withdraw at any point. During the survey you can elect not to answer any specific question.

If you have any questions you may contact the researcher, **Heather Waddle** (916) 410-2291 or by email at heather@agridesigns.com.

Or, if you need further information, you may contact the researcher's thesis advisor:

Teiahsha Bankhead, Ph.D., LCSW
C/o California State University, Sacramento
(916) 278-7177 or bankhead@csus.edu.

Consent to Participate as a Research Subject

I have read the descriptive information on the Research Participation cover letter. I understand that my participation is completely voluntary. My signature or initials indicate that I have received a copy of the Research Participation cover letter and I agree to participate in the study.

Signature or Initials: _____ Date: _____

If you have any questions you may contact the researcher, **Heather Waddle**
(916) 410 2291 or heather@agridesigns.com

Or, if you need further information, you may contact the researcher's thesis advisor:

Teiahsha Bankhead, Ph.D., LCSW
C/o California State University, Sacramento
(916) 278-7177
bankhead@csus.edu

APPENDIX B
QUESTIONNAIRE

Transgender Health Care Experiences Questionnaire

Dear Participant,

Please take a few minutes to complete the following questions. The questions are aimed at understanding transgender experiences in health care/mental health settings. All data will remain confidential. Your responses will be used to assess the influence of cultural competency with health care accessibility. Thank you for your participation.

Demographic Information: Circle One

1. Gender: Transgender Male to Female Female to Male Female
 Male Genderqueer Other:_____
2. Preferred Gender Presentation: Part-time Full-time
3. Ethnicity: Caucasian American Indian Other:_____
- Latino Pacific Islander
- African American Asian
4. Age: _____

Health Care Data: Circle One

5. Health Coverage by: Medi-cal/care Employer Self/Partner Uninsured
 School
6. How many times in the last year did you utilize medical care? _____
7. Primary Physician: General Practitioner Specialist in Transgender Care
 Other:_____

Please circle the answer that best represent your views.

In the last year:

8. I have felt comfortable disclosing that I am transgender to a health practitioner.

Strongly Agree Agree Disagree Strongly Disagree

9. I have been denied health care.

Strongly Agree Agree Disagree Strongly Disagree

10. I have disclosed my gender to a health care practitioner.

Strongly Agree Agree Disagree Strongly Disagree

11. I have had some gender-confirming surgery.

Strongly Agree Agree Disagree Strongly Disagree

12. I am treated with dignity and respect when accessing health care.

Strongly Agree Agree Disagree Strongly Disagree

13. My practitioner is knowledgeable in Harry Benjamin Standards of Care. (Guidelines for medical and mental health practitioners regarding transgender care).

Strongly Agree Agree Disagree Strongly Disagree

14. I am taking hormones.

Strongly Agree Agree Disagree Strongly Disagree

15. If you are taking hormones, my practitioner explained the risk/benefits of taking hormones for transgender persons.

Strongly Agree Agree Disagree Strongly Disagree

16. I am confident that my practitioner has a basic knowledge of transgender care.

Strongly Agree Agree Disagree Strongly Disagree

17. My medical records reflect my preferred gender identity.

Strongly Agree Agree Disagree Strongly Disagree

18. There are several practitioners knowledgeable in transgender care within 20 miles of my residence.

Strongly Agree Agree Disagree Strongly Disagree

19. If currently utilizing hormone therapy, my current hormone regimen is provided by a licensed practitioner and not homeopathic.

Strongly Agree Agree Disagree Strongly Disagree

20. I was diagnosed with Gender Identity Disorder.

Strongly Agree Agree Disagree Strongly Disagree

21. I was required to obtain a letter stating 'eligibility' or 'readiness' for hormones from a mental health clinician.

Strongly Agree Agree Disagree Strongly Disagree

22. I am comfortable seeking preventative medical care.

Strongly Agree Agree Disagree Strongly Disagree

23. I continue to get preventative healthcare for my biological sex. For example: FTM-gynecology; MTF- prostate exams.

Strongly Agree Agree Disagree Strongly Disagree

24. Due to a negative healthcare experience I avoid seeking medical care.

Strongly Agree Agree Disagree Strongly Disagree

25. My physician is aware that I am transgender.

Strongly Agree Agree Disagree Strongly Disagree

26. Health care providers use my preferred gender pronoun.

Strongly Agree Agree Disagree Strongly Disagree

27. I experienced difficulty with an insurance company due to gender non-conformity.

Strongly Agree Agree Disagree Strongly Disagree

28. I have avoided insurance companies due to difficulty in navigating the system as a transperson.

Strongly Agree Agree Disagree Strongly Disagree

29. I have had no difficulty in accessing healthcare.

Strongly Agree Agree Disagree Strongly Disagree

30. It is difficult to obtain accurate or relevant information about transgender health care.

Strongly Agree Agree Disagree Strongly Disagree

31. I have had to educate my practitioner regarding transgender health issues.

Strongly Agree Agree Disagree Strongly Disagree

32. I have been asked inappropriate or irrelevant questions by my practitioner.

Strongly Agree Agree Disagree Strongly Disagree

33. I have educated other transgender persons regarding health care, including: hormones, mental health, etc.

Strongly Agree Agree Disagree Strongly Disagree

34. I have felt respected when utilizing health care.

Strongly Agree Agree Disagree Strongly Disagree

35. When accessing health care I have received: (circle all that apply).

1. Inaccurate information
2. General lack of understanding of transgender people
3. Negative reactions by practitioners
4. Lack of information
5. Resistance to using correct pronoun
6. None of the above

36. I have experienced difficulty obtaining hormonal medications due to:

- | | |
|--------------|--------------------------------------|
| 1. Physician | 4. Pharmacy |
| 2. Insurance | 5. Mental health provider |
| 3. N/A | 6. I have not experienced difficulty |

37. I receive the majority of health care information from: Circle all that apply:

- | | |
|-----------------------------------|---------------------|
| 1. Physicians/ nurse practitioner | 5. Friends |
| 2. Internet | 6. Support Groups |
| 3. Therapist | 7. Emergency Visits |
| 4. Family | |

38. I have experienced discomfort in: Circle all that apply:

- 1. Emergency care
- 2. Waiting room
- 3. Front Desk Staff
- 4. Gynecology/ Prostate Care
- 5. Physical examination
- 6. N/A

39. Please rate your access to competent health care 1(no access) 5(very accessible):

- 1
- 2
- 3
- 4
- 5

40. Please explain any recommendations for culturally competent health care.

THANK YOU!!!

APPENDIX C

RESOURCES

Transgender Resources in Sacramento

Transgender Support Group- The Sacramento Gay and Lesbian Center's LGBT Community Counseling Program provides a weekly support group in a safe, culturally affirming environment for transgender adults and youth with professional facilitators trained in sexual identity and gender issues. Meets every Sunday 6:30-8:00pm in Room A, 1927 L St, Sacramento

Sacramento Gay & Lesbian Center- Counseling Program offers individual or group counseling services for transgender people under the supervision of licensed psychotherapists trained in sexual and gender identity issues. All counseling services are provided on a for-fee, sliding-scale basis. Call 916-442-0185, Ext. 101.

River Rock Counseling- River Rock Counseling is a non-profit counseling agency that was founded in 2008 to meet the community's need for affordable counseling services. River Rock offers individual, couples, and group services in a culturally affirming environment. River Rock Counseling, A Non-Profit Counseling Agency, 4944 Sunrise Blvd., Ste. J-5, Fair Oaks, CA 95628, 916-642-5410

REFERENCES

- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. Text Revision), Washington, D.C.: Author.
- Bockting, W., & Cesaretti, C. (2001). Spirituality, Transgender Identity, and Coming Out. *Journal of Sex Education & Therapy*, 26(4), 291. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient Satisfaction with Transgender Health Services. *Journal of Sex & Marital Therapy*, 30(4), 277-294. doi: 10.1080/00926230490422467.
- Bettcher, T. (2007). Evil Deceivers and Make-Believers: On Transphobic Violence and the Politics of Illusion. *Hypatia*, 22(3), 43-65. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Burdge, B. (2007). Bending Gender, Ending Gender: Theoretical Foundations for Social Work Practice with the Transgender Community. *Social Work*, 52(3), 243-250. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Burgess, C. (1999). Internal and External Stress Factors Associated with the Identity Development of Transgender Youth. *Journal of Gay & Lesbian Social Services*, 10(3/4), 35-47. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention. *American Journal of Public Health*, 91(6), 915-921. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.

- Cooper, K. (1999). Practice with Transgendered Youth and Their Families. *Journal of Gay & Lesbian Social Services*, 13(1/2), 205-224. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Feldman, J. & Bockting, W. (2003). Transgender Health. *Minnesota Medicine*, 86(1), 25-32. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Feinberg, L. (2001). Trans Health Crisis: For Us It's Life or Death. *American Journal of Public Health*, pp. 897-900. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- FTM Alliance of Los Angeles. (2004). *Results of the 2003 Health Access Survey: The Female-to Male Transgender Community Experiences Multiple Barriers to Healthcare in Southern California*. Los Angeles FTM Alliance of Los Angeles. Retrieved April 13, 2010, from <http://www.ftmalliance.org>.
- GLBT Health Access Project. (2000). *Access to Health Care for Transgendered Persons in Greater Boston*. Retrieved January 27, 2010, from www.glbthealth.org.
- Greene, R. R. (Ed.). (2008). *Human Behavior Theory & Social Work Practice* (Third ed.). New Brunswick: Aldine Transaction.
- Hage, J., Dekker, M., Karim, R., Verheijen, M., & Bloemena, E. (2000). Ovarian Cancer in Female-to-Male transsexual: Report of Two Cases. *Gynecological Oncology*, 76, 413-415. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Hastings, D.W. (1969). Inauguration of a Research Project on Transsexualism in a University Medical Center. *Transsexualism and Sex Reassignment* pp. (243-251).

Baltimore, MD: Johns Hopkins Press. Retrieved
from <http://search.ebscohost.com.proxy.lib.csus.edu>.

Human Rights Campaign Foundation (2007). *The state of the workplace for gay, lesbian, bisexual and transgender Americans*. Retrieved April 12, 2010, from
www.hrc.org.

Hussey, W. (2006). Slivers of the Journey: The Use of Photovoice and Storytelling to Examine Female to Male Transsexuals' Experience of Health Care Access. *Journal of Homosexuality*, 51, 129-158. doi: 10.1300/J082v51n01_07.

JSI Research & Training Institute, Inc., (2000). *Access to Health Care for Transgendered Persons in Greater Boston*. Boston: GLBT Heather Access Project. Retrieved April 13, 2010, from www.jsi.com.

Kenagy, G. (2005). Transgender Health: Findings from Two Needs Assessment Studies in Philadelphia. *Health & Social Work*, 30(1), 19-26. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>

Kenagy, G. P., PhD., & Bostwick, W. B., MPH. (2005). Heath and Social Service Needs of Transgender People in Chicago. *International Journal of Transgenderism*, 8(2/3), 57-66. doi:10.1300/ j485v08n0_06.

Lee, R. (2000). Health Care Problems of Lesbian, Gay, Bisexual and Transgender Patients. *Western Journal of Medicine*, 172, 403-408. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.

- Lombardi, E. (2001). Enhancing Transgender Health Care. *American Journal of Public Health, 91*(6), 869-872. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Marlow, C. R. (2005). *Research Methods For Generalist Social Work*. Australia: Thomson Brooks/Cole.
- Meyer, W., Bockting, W., Cohen-Kettenis, P. *Harry Benjamin International Gender Dysphoria Association's Standard's of Care for Gender Identity Disorders, Version 6*. Retrieved February 27, 2009, from: <http://www.wpath.org>.
- Mizcock, L. & Lewis, T. (2008). Trauma in Transgender Populations: Risk, Resilience, and Clinical Care. *Journal of Emotional Abuse, 8*(3), 335-354.
Doi: 10.1080/10926790802262523.
- National Association of Social Workers. (2000). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Nemoto, T., Sausa, L., Operario, D., & Keatley, J. (2006). Need for HIV/AIDS Education and Intervention for MTF Transgenders. *Journal of Homosexuality, 51*(1), 183-201. doi: 10.1300/J082v51n01_09.
- Nemoto, T., Operario, D., Keatley, J., Han, L., & Soma, T. (2004). HIV Risk Behaviors Among Male-to-Female Transgender Persons of Color in San Francisco. *American Journal of Public Health, 94*(7), 1193-1199. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.

- Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of Health Care Among Female-to-Male Transgender Individuals in the United States. *Journal of Homosexuality*, 54(3), 243-258. doi: 10.1080/00918360801982124.
- Sanchez, N., Sanchez, J., & Danoff, A. (2009). Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City. *American Journal of Public Health*, 99(4), 713-719.
doi: 10.2105/AJPH.2007.132035.
- Wilcox, Joyce. (2001). Editor's Note. *American Journal of Public Health*, 91(6), 897.
Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- William, M. & Freeman, P. (2007). Transgender Health: Implications for Aging and Caregiving. *Journal of Gay & Lesbian Social Services*, 18(3), 93-108.
Doi:10.1300/J041v18n03_06.
- Williams, W.L. (1986). *The Spirit and the Flesh: Sexual Diversity in American Indian Culture*. Boston: Beacon Press. Retrieved
from <http://search.ebscohost.com.proxy.lib.csus.edu>.
- Winter, S. & Doussantousse, S. (2009). Transpeople, Hormones, and Health Risks in Southeast Asia: A Lao Study. *International Journal of Sexual Health* 21(1), 35-48. Doi:10.1080/19317610802554141.
- Xavier, J.M. (2000). *The Washington, D.C. transgender needs assessment survey*. Washington, DC: Gender Education and Advocacy & Us Helping Us, People into Living, Inc. Retrieved from <http://search.ebscohost.com.proxy.lib.csus.edu>.

