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Factors Affecting Health Care Access among Transgender People in the United States

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Abstract

Transgender people experience pervasive interpersonal and structural discrimination within the health care system, which impact their ability to access appropriate and inclusive health care. Their invisibility is sustained by a cultural milieu wherein non-trans identities are privileged and an assumption is made that all people are cisgender. Transgender populations consist of a diverse spectrum of gender and other intersecting identities. Yet, there is a paucity of research about how each subgroup experiences discrimination, especially if they belong to more than one marginalized community. More specifically, transgender men have been underrepresented in research and little is known about the factors which affect their ability to access care. Guided by the theoretical framework of intersectionality and two conceptual models of health care access, the aims of this study are to: (a) compare barriers to health care among transgender men versus transgender women and non-binary/gender queer people; (b) examine factors which may increase the risk of experiencing health care discrimination or potentiate the ability to access care; and (c) examine the interaction of gender identity with other factors that can influence health care access in the United States.

It was hypothesized that transgender men were more likely to experience barriers to health care access than transgender women and non-binary/gender queer people. Additionally, it was hypothesized that racial minority group status and living in poverty were risk factors while having health insurance and disclosure of trans identity were protective factors in the ability to access health care. It was further hypothesized that transgender men's disadvantage would be greater among racial minority group members and those living in poverty, and that the gender identity divide would be smaller among

those who had health insurance or had disclosed their trans identity. Logistic regression analyses were conducted using a non-elder, adult subsample of the 2015 U.S. Transgender Survey (*N* = 14, 540) which was implemented by the National Center for Transgender Equality. Results found that transgender men experienced greater disadvantage than transgender women in many dimensions of health care access. Living in poverty was a risk factor, while having health insurance was observed to be a protective factor in health care access in the United States. Disclosure of trans identity served as a protective or risk factor, depending on the outcome being examined. Moreover, a significant interaction was observed with gender identity by disclosure. There was evidence to suggest that transgender men who did not disclose their trans status experienced greater vulnerability in health care access. The results of the present study can be used to illuminate the inter and intragroup differences within the transgender population in their health care access and to extend the current knowledge base about the experiences of trans men. Social workers and other health care professionals need to increase their understanding about the complexities and multiplicities of gender, and to develop cultural competency in serving the transgender population.

Key words: transgender, trans men, health care access, health care discrimination, intersectionality

Dedication

To all the resilient transgender individuals who have endured adversity in pursuit of an authentic life.

To all transgender people who are unable to live publicly for any reason.

To all the fierce advocates who work tirelessly in the quest for social justice and equity.

Acknowledgements

Most major achievements are reached as a result of great effort and sacrifice made by unsung heroes. I would like to acknowledge the people who have been instrumental to my success, for they are my heroes from whom I draw inspiration.

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I am indebted to Dr. Kevin Gorey for his mentorship throughout my doctoral education. Because of his steadfast encouragement during this journey of inquiry and discovery, I have learned such valuable lessons—not just about research but also about myself. During moments when I was paralyzed by self-doubt, his words of wisdom sustained me and served as a mantra: 1) tell the story, 2) be passionate, and 3) synthesize original thought with scientific evidence. This dissertation is one way for me to tell the story, with the hope that this work can be used towards advancing equity for sexual and gender minority populations. He has provided me with a transformative learning experience.

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I hold immense gratitude and esteem for the National Center for Transgender Equality who shared their 2015 U.S. Transgender Survey dataset with me. Indeed, this was a precious gift. I will endeavor to inform knowledge users and policy makers of my research findings as part of the advocacy efforts to advance the rights of transgender people.

To the thousands of transgender individuals who generously volunteered to participate in the 2015 U.S. Transgender Survey, thank you for sharing your experiences with us.

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Table of Contents

List of Tables

List of Abbreviations

Abbreviation	Full Text
ACA	Patient Protection and Affordable Care Act
ACS	American Community Survey
AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychiatric Association
BRFSS	Behavioral Risk Factor Surveillance System
CI	Confidence Interval
CSWE	Council on Social Work Education
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency Department
GD	Gender Dysphoria
GID	Gender Identity Disorder
GIDC	Gender Identity Disorder of Childhood
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICD	International Statistical Classification of Diseases and Related Health Problems
LGB	Lesbian, Gay, and Bisexual
LGBT	Lesbian, Gay, Bisexual, and Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
MOHLTC	Ministry of Health and Long-Term Care
NASW	National Association of Social Workers
NCTE	National Center for Transgender Equality
OHIP	Ontario Health Insurance Plan
OR	Odds Ratio
RR	Relative Risk
SES	Socio-economic Status
SO/GI	Sexual Orientation and Gender Identity
STI	Sexually Transmitted Infection
TGNC	Transgender and Gender Non-Conforming
UCSF	University of California San Francisco
U.S.	United States
USTS	U.S. Transgender Survey
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health

Chapter 1: Introduction

Transgender people are a medically underserved population who experience pervasive discrimination in the health care system (Giblon & Bauer, 2017; Rodriguez, Agardh, & Asamoah, 2017). They are the most disadvantaged group among sexual and gender minority populations. Compared to their lesbian, gay, and bisexual (LGB) counterparts, transgender people experience more prevalent health care discrimination, which adversely impacts their health and well-being throughout the life course (Fredriksen-Goldsen et al., 2011; Lambda Legal, 2010; Macapagal, Bhatia, & Greene, 2016). Disclosure of their trans identity to a health care provider or their recognizability as a trans individual is positively associated with perceived discrimination in health care (Cruz, 2014; Macapagal et al., 2016; Rodriguez et al., 2017). Consequently, many transgender individuals avoid or delay health care or selectively disclose their trans identities to health care providers (Bauer, Scheim, Deutsch, & Massarella, 2014; Bradford, Reisner, Honnold, & Xavier, 2013; Fredriksen-Goldsen et al., 2011; Giblon & Bauer, 2017; Grant et al., 2011; Institute of Medicine, 2011; James et al., 2016; Lambda Legal, 2010; One Colorado, 2014; Reisner, White, et al., 2014; Stotzer, Ka‘opua, & Diaz, 2014). Delaying health care because of fear of discrimination is associated with poorer physical and mental health among transgender adults (Seelman, Colón-Diaz, LeCroix, Xavier-Brier, & Kattari, 2017). In addition to overt discrimination, ranging from being denied care to being physically or verbally abused, structural barriers (e.g., lack of providers with adequate knowledge to serve trans patients; employment and income inequities resulting in health insurance inadequacy) exist, which impact transgender people’s ability to access appropriate health care, contributing to adverse health

outcomes. Furthermore, chronic stress from internalized stigma and discrimination can generate cognitive, affective, and behavioral effects which result in negative health consequences (Institute of Medicine, 2011; Meier & Labuski, 2013; Miller & Grollman, 2015). These include anxiety, depression, substance abuse, suicidality, and Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) (Davidson, 2015; Fredriksen-Goldsen et al., 2011; James et al., 2016; One Colorado, 2014). Transgender people's disadvantage is also manifest in their level of preparation for end of life. Compared to sexual minorities, transgender people were less likely to have completed advance directives, leaving them more vulnerable to receiving substandard end of life care (Kcomt & Gorey, 2017).

The transgender population is often subsumed within the greater lesbian, gay, bisexual, and transgender (LGBT) community to promote advocacy and research efforts supporting sexual and gender minorities. This aggregation has served the political cause of sexual and gender minorities by increasing awareness of their marginalization, but it has also created confusion and tension. LGBT communities are not monolithic. Although transgender individuals may share similar challenges and experiences of oppression as their lesbian, gay, and bisexual (LGB) counterparts, transgender populations have different needs, which should be acknowledged. Fundamentally, gender identity (e.g., cisgender, transgender, gender non-conforming, etc.) differs from sexual orientation (e.g., lesbian, gay, bisexual, pansexual, etc.) (Acquaviva, 2017; Institute of Medicine, 2011; Meier & Labuski, 2013; Moolchaem, Liamputtong, O'Halloran, & Muhamad, 2015; Teich, 2012). Research with aggregated LGBT samples often underrepresents the transgender subsample (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009;

Boehmer, 2002; Meezan & Martin, 2007). Researchers have been challenged in their ability to access the transgender population. Much of the extant research has focused predominantly on trans women, with underrepresentation from trans men, gender non-conforming people, and trans people of color (Meier & Labuski, 2013; Shires & Jaffee, 2015; Winter et al., 2016). The transgender population consists of a diverse spectrum of identities. Yet, little is known about how each subgroup experiences discrimination, especially if they belong to more than one marginalized community (Institute of Medicine, 2011). The intersecting identities of trans persons should be considered in understanding their experiences of marginalization (Erich, Tittsworth, Colton Meier, & Lerman, 2010; Erich, Tittsworth, & Kersten, 2010). The paucity of research about the transgender population has left practitioners and health care systems ill-equipped to meet their needs. Thus, the aims of this research are to:

1. Compare barriers to health care among transgender men versus transgender women and non-binary/gender queer people
2. Examine factors which may increase the risk of experiencing health care discrimination or potentiate the ability to access care
3. Examine the interaction of gender identity with other factors that can influence health care access.

Background

Definitions. *Is it a boy or a girl?* This is an oft-asked question from expectant parents. Indeed, moments after it is born, a baby is sexed and gendered. Its legal status is defined by the completion of the birth certificate as the parents check the Male or Female box. Perceived as "ontologically opposite," the male/female binary model permeates all

our social institutions and "formulates the first assumption of a person's identity" (Gonzalez-Salzberg, 2014, p. 799). Our understanding of the transgender experience emerges from the oppositional male/female binary model, wherein those who challenge this fixed, dualistic understanding of sex and gender are relegated to the margins of society (Ansara, 2015; Gonzalez-Salzberg, 2014; Simmons & White, 2014).

Although the terms *sex* and *gender* are often used interchangeably in Western society, researchers often draw a distinction between them. In general, sex is characterized by physiological or biological evidence at birth (i.e., the genotype of chromosome pair and the phenotype of genitalia and reproductive organs), whereas gender is a social construct which is influenced by a geographical, cultural, and historical context. Gender refers to the role-based distinctions associated with being a man or woman and consists of the behavioral, psychological, or cultural traits associated with it. *Gender identity* is a person's internal perception of being a man or woman (Acquaviva, 2017; Farmer & Yancu, 2015), or being between or beyond these genders (Diamond, Pardo, & Butterworth, 2011; Teich, 2012). Gender identity can be fluid, may change over time, and exists on a spectrum (Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015; Diamond et al., 2011; Farmer & Yancu, 2015; Meier & Labuski, 2013; Simmons & White, 2014). *Gender dissonance* or *gender incongruence* occurs when a person's assigned sex at birth does not match their gender identity or affirmed gender (Simmons & White, 2014; Winter et al., 2016). *Gender dysphoria* is a term used to describe the internal distress that some individuals may experience because of their gender incongruence. This dysphoria can be a source of great suffering. Not every individual who experiences gender dissonance will necessarily experience gender dysphoria (Byne,

Karasic, Coleman, Eyler, & Kidd, 2018; Carmel, Hopwood, & dickey, 2014; Serano, 2007; Zucker, 2015). *Gender expression* refers to the way people dress, behave, and outwardly express their internal sense of masculinity or femininity based on cultural expectations which can be influenced by gender stereotypes (Acquaviva, 2017; Winter et al., 2016). *Gender non-conformity* refers to behavior and appearance which do not conform to socially constructed expectations for a given gender (Acquaviva, 2017). Gender non-conforming individuals do not necessarily experience gender dissonance and may not consider themselves transgender (National LGBT Health Education Center, 2016).

The term *transgender* is an umbrella term for people whose gender identity and/or gender expression differs from the one assigned to them at birth (Carabez et al., 2015; National Resource Center on LGBT Aging, 2012). Transgender people are "a diverse group of individuals who cross or transcend culturally defined categories of gender" (Bockting, 1999 as cited in Institute of Medicine, 2011, p. 26). Not all transgender people decide to alter their bodies hormonally and/or surgically (National Resource Center on LGBT Aging, 2012). The term transgender—containing the prefix *trans* which means "across" or "over"—reflects the cultural normativity of the gender binary which regards male and female as the socially intelligible categories defining one's identity (Diamond et al., 2011; Teich, 2012). The word trans is also used as a shorthand to refer to the same communities or individuals. In contrast, the term *cisgender*—containing the prefix *cis* which means "on the same side"—refers to non-trans identities or people whose gender identity aligns with their biological sex (Simmons & White, 2014). Reporting a sense of wrong embodiment, many transgender individuals experience a dissonance between their

biological sex and psychological gender and seek to bring them into alignment. Yet, there are other transgender people for whom the experience of gender identity is more fluid or ambiguous and feel that they are *both* male and female, or *neither*. These individuals may express themselves with various forms of gender blending and bending, exhibiting the range of identities that fit under the transgender umbrella and troubling the hegemonic notion that there exist only two genders (Diamond et al., 2011).

Gender transition is a complex and multi-faceted process. The journey to undergo a social, medical, and/or legal transition holds personal significance for each individual (Acquaviva, 2017; Diamond et al., 2011). Transgender people can live part-time or full-time in their affirmed gender. They may dress themselves and behave in a manner that represents their gender identity (through clothes, hairstyle, speech, mannerisms, etc.). They may change their name or use different pronouns which reflect their affirmed gender. Some trans people choose to bring their biological sex into alignment with their gender identity through a medical transition process by undergoing gender-affirming hormone replacement therapy (e.g., androgen blockers and estrogen for a natal male; testosterone for a natal female) and/or gender-affirming surgeries (e.g., penectomy, bilateral orchiectomy, vaginoplasty, or breast augmentation for a natal male; hysterectomy, bilateral salpingo-oophorectomy, vaginectomy, metoidioplasty, phalloplasty, scrotoplasty, or mastectomy for a natal female) (Carabez et al., 2015; Hardacker, Chyten-Brennan, & Komar, 2019; Houlberg, 2019; Peate, 2008; Zucker, 2015). Those who receive hormone treatments must do so for the rest of their lives to maintain the masculinizing and feminizing effects of testosterone and estrogen respectively (Peate, 2008). The term *top surgery* refers to surgeries to change the chest

(i.e., breast augmentation or mastectomy) and *bottom surgery* refers to surgeries to change the genitals (e.g., penectomy, vaginoplasty, phalloplasty, etc.). Other surgeries include facial surgery and tracheal surgery (to remove the Adam's apple in natal males) (Simmons & White, 2014). Some may prefer to modify only selected parts of their body (e.g., facial hair or breasts) rather than full sex reassignment surgery (Diamond et al., 2011). For many, pursuing a medical transition process is influenced by their ability to access or afford treatment (Grant et al., 2011). Some transgender individuals may take steps to legalize their affirmed gender identity by changing their name and gender markers on legal documents (such as birth certificate, passport, driver's license, etc.). The decision to embark on a social, medical, and/or legal transition process is highly individualized, and each aspect of the gender transition process represents a trans person's movement towards lived authenticity (Carabez et al., 2015; Diamond et al., 2011).

Identity is political. It can impact the access to and attainment of social, material, and legal resources. Often requiring pragmatic and strategic negotiations, identity is a complex phenomenon and a socially interactive process which ensues personal, interpersonal, and socio-political effects. Claiming a specific identity can result in tangible consequences such as opportunities, challenges, membership in social identity groups, and life possibilities (Pfeffer, 2014; Silverschanz, 2007). Not every person who may fit the definition of transgender identifies with that word. To illustrate, many trans older adults made their transition in a less tolerant socio-political climate when the transgender identity was pathologized. To avoid violence and discrimination after having made their social, legal, and/or medical transition, they have learned to live *stealth*

(concealing their transgender status) and may prefer to identify solely with their affirmed gender. For this cohort, the label transgender or transsexual is associated with discrimination—often resulting in negative socio-economic consequences and victimization. Being visible meant risking their lives or their livelihood (Ducheny, Hardacker, Claybren, & Parker, 2019; Witten, 2016). Furthermore, some individuals who do not live full time as their affirmed gender or who have not initiated the medical or legal transition process may feel as if they have less claim to self-identify as transgender (Simmons & White, 2014). Alternatively, those who have completed a medical or legal transition may identify principally as a man or woman and leave the transgender label behind (Hardacker, Kelly et al., 2019). Thus, much like the decision to engage in a social, medical, or legal transition process, the adoption of a transgender identity label is also highly personal.

The politics of transgender identity are complicated. Roen (2002) explained the concept of *transgenderism* as "a political movement seeking to challenge the belief that every person can be categorized simply as one of two sexes" (p. 521). Trangenderists challenge the gender binary and exalt gender fluidity and the transgression of cultural gender norms. Openly crossing these gender norms and being out as a trans person is regarded as a form of political action to transcend and eliminate gender oppression. In contrast, those who prefer to pass as their affirmed gender and to live stealth are perceived as maintaining the oppressive gender system and the invisibility of trans people through their silence. They are viewed as non-supporters of the gender revolution. In this context, transgenderists privilege crossing and coming out over passing and being silent. They posit that passing can be harmful to one's mental health; it creates a self-

consciousness in one's interactions with others and a constant anxiety about not wanting to be outed accidentally. Yet, being out also increases the risk of experiencing violence and harassment. For many trans people, their survival rests on their ability to pass. Roen (2002) also noted that these categories (of crossing versus passing) are not necessarily mutually exclusive. Many trans individuals straddle both worlds and must negotiate their identity depending on the social context (Roen, 2002).

Roen (2002) argued that transgenderism's political stance has drawn exclusionary lines among transgender people and failed to account for the socio-economic factors enabling them to be safe in their outness, or the factors enabling them to pass successfully. For example, passing is partially related to visual conformity, which is dependent on access to gender-affirming technologies. This access is influenced by sociodemographic factors such as class, race, and education. Furthermore, while passing has been devalued by some, others have held it in high esteem, privileging those who have been able to achieve visual conformity. Economically advantaged individuals (predominantly white, educated, and middle class) have had greater access to these technologies and thus have experienced greater privilege post-operatively (Meier & Labuski, 2013; Roen, 2002). This hierarchy has created another exclusionary line amongst trans communities—between those who are pre-op versus those who are post-op (Roen, 2002). This preoccupation with surgical status, along with the labeling of post-op individuals as *transsexuals*, have been deemed classist and reductionist, as most transgender individuals cannot afford the cost of medical transition procedures (Serano, 2007).

Additionally, discursive tensions exist between feminism and trans politics. In their documentary film, *Boy I Am,* Feder and Hollar (2006) portrayed the experiences of several trans men and opened the dialog about the oppositional forces between the lesbian and transgender communities. Many trans men who formerly identified as *butch lesbians* (i.e., lesbians who have a masculine gender expression) prior to their transition have found themselves being distanced from, or have disidentified themselves from, the butch lesbian community after their transition process. Some feminists have argued that the female-to-male transition process undermines the advancements made by the feminist movement and that trans men are accessing male privilege by abandoning their female bodies. This argument underscores the political nature of identity and that, within oppressed minority groups, consensus about identity—and the path towards equity—is not easily achieved.

Multiple forms of gender-based prejudice exist. Discrimination against trans people takes different forms and occurs for different reasons. As a trans woman and feminist, Serano (2007) explained the dynamics of traditional sexism (which regards maleness and masculinity as superior to femaleness and femininity) and oppositional sexism (which regards men and women as opposites and delegitimates traits that defy cultural gender and sexual norms). The existence of trans women is perceived as threatening male and heterosexual privilege. Consequently, trans women experience a different kind of disadvantage through *trans-misogyny*, the intersecting axes of systemic oppression experienced by trans women resulting from *transphobia* and *misogyny*. Transphobia is defined as the irrational fear or hatred of trans people which "occurs in a broader social context that systematically disadvantages trans people and promotes and

rewards anti-trans sentiment" (Bettcher, 2014, p. 249). Misogyny can be understood as "a system that operates within a patriarchal social order to police and enforce women's subordination and to uphold male dominance" (Manne, 2017, p. 33) Trans-misogyny is evidenced by the sensationalization, sexualization, and fetishization of trans women, within a cultural system that devalues femaleness and femininity. This trans-woman-specific discrimination occurs even in women-only or lesbian spaces, whereas trans men may be included in these spaces because they were born with female anatomy, and because their masculine gender expression affords them greater privilege. Serano (2007) argued that feminism has mostly been preoccupied with the concerns of cisgender women and called for a trans-inclusive feminism, allowing cisgender and trans women to join together in the fight against the devaluation of femaleness and femininity.

The socially interactive nature of identity which disrupts the normative binaries our society holds and illuminates the blurry intersections that exist with sex, gender, and sexual orientation is highlighted in Pfeffer's (2014) qualitative study of cisgender female partners of trans men. The 50 cisgender women in the study described the challenges of moving from a lesbian space prior to their partners' transition to being regarded as a heterosexual woman after their partners' transition. Now considered straight women, they had to cope with the loss of their lesbian identity, their disconnection from the lesbian community, and to confront the privilege of heterosexuality. Identity, thus, is not static. It can ensue social consequences and require negotiation which may create ambivalence and tension.

Language evolves rapidly and is influenced by a historical, social, cultural, and political context. While the definition of transgender allows for inclusivity of people who

depart from conventional gender norms in varying degrees, or who may not identify with the male/female binary classification, political tensions and a lack of consensus exist among researchers, scholars, law makers, and transgender individuals regarding the use of terminology and definition (Beemyn & Rankin, 2011; Lombardi, 2001). Just as the younger cohort of LGBT individuals have reclaimed the word *queer*—formerly a pejorative term but now used to describe individuals who are not cisgender or heterosexual—there is now a wider array of terminology describing the numerous identities within the transgender community (Simmons & White, 2014; Witten, 2016). The current cohort of transgender individuals have an expanded vocabulary which gives voice and meaning to their experiences. By controlling the language that represents them, the personal meaning reflected in word choice is an expression of their self-determination (Burdge, 2007). In the Report of the 2015 U.S. Transgender Survey (N = 27,715), the respondents wrote in more than 500 gender terms with which they self-identified in addition to the listed gender identifiers (James et al., 2016). Examples of current terminology include gender bender, third gender, gender variant, gender queer, bi-gender, multi-gender, gender fluid, crossdresser, etc. (James et al., 2016). Thus, the language used to describe transgender people is "dynamic, political, racially and culturally dependent, and very much cohort-dependent" (Witten, 2016, p. 63).

Although the variations in nomenclature may be affirming for transgender individuals, they add complexity and create inconsistency among scientists, scholars, and law makers. Who is considered transgender has become a nuanced and political conversation. For example, the definition of transgender is usually inclusive of transsexual people as a subgroup. A distinction often made between these two groups is

that transsexual individuals engage in a medical transition process while transgender people include those who may not wish to modify their bodies and for whom the line between male and female is less clear (Meier & Labuski, 2013). Yet, other scholars do not use the medical transition process as a differentiator and may refer to transsexual individuals more broadly as persons who identify as the opposite sex of that which they were assigned at birth—inclusive of those who make a social transition without necessarily a medical transition (Serano, 2007; Teich, 2012). Some researchers will include transgender individuals with gender non-conforming people under one umbrella (James et al., 2016) while others will distinguish between the two groups in their data analysis (Grant et al., 2011). The inclusion of cross-dressers and *drag queens or kings* (female or male impersonators respectively) under the transgender umbrella is also argued, as these individuals may not necessarily experience a dissonance between their gender identity and biological sex (Miner, Bockting, Romine, & Raman, 2012). Cross-dressing is considered a form of gender expression that is not indicative of gender identity (Teich, 2012). While there is lack of consensus on the nomenclature and definition, there is a recognition of diversity in the spectrum of identities within the transgender community (Grant et al., 2011; Institute of Medicine, 2011; James et al., 2016; Teich, 2012). Hence, a new term and abbreviation is now being used in recent literature which acknowledges this diversity and respects a non-binary model of gender identity: Transgender and Gender Non-Conforming (TGNC) (Ducheny et al., 2019; Simmons & White, 2014; Witten 2016). This is evidence of an ever-evolving lexicon—some of which has developed organically from within the transgender community—and

increasing sensitization in the attempt to understand people's lived experiences of their gender identity.

Today, the word transgender describes the multiplicity of gender variant and gender non-conforming identities which are subsumed within it (Drescher 2015, 2016). Although the word does not appear in any diagnostic manual, this self-identification serves as a declaration that there is an alternative way of being, and hints at the deeper reality that there exists a full spectrum of gender identity and expression.

> ''Transgender"…was meant to convey a nonpathological sense that one could live in a social gender not typically associated with one's biological sex or that a single individual should be able to combine elements of different gender styles and presentations. Thus, from the beginning, the category ''transgender'' represented a resistance to medicalization, to pathologization, and to the many mechanisms whereby the administrative state and its associated medico-legal-psychiatric institutions sought to contain and delimit the socially disruptive potentials of sex/gender atypicality, incongruence, and non-normativity. (Stryker & Currah, 2014, p. 5)

For many, the line between male and female is illusory and provides an opportunity to express their gender in creative and political ways. Both transgender and cisgender people have begun to challenge the restrictive categories of male and female, and to make an active investment in deconstructing this ancient binary. The use of the term *gender queer* is one example of this, in that what is being queered is the binary itself and not one's gender identity or sexual orientation (Meier & Labuski, 2013; Serano, 2007).

Prevalence. Understanding the size of a population assists in the advocacy efforts to shape public policy, improve health care, inform education, and seek funding for research and program development. Determining the size of the transgender population in the U.S. has been challenging. Given their history of discrimination and abuse, especially among the older cohort, many transgender people prefer not to reveal their natal sex (Witten 2009, 2016). After completing a medical transition, some individuals self-identify as men or women and do not regard themselves as transgender. There are different levels of disclosure ranging from disowning their trans history to not making it public, thereby maintaining the invisibility of these individuals. Because of the lack of consensus about recognized variables which legitimates the trans identity (such as the use of hormone treatments, gender-affirming surgeries, legal status, social transition status, etc.) the legitimacy of certain trans identities is debated. For example, those who do not live full time in a cross-gender social role or who have not initiated the medical or legal transition process may choose not to identify themselves as transgender. Yet, self-identification is distinct from external legitimization, with activists positing that it is not necessary for another party to affirm one's identity for it to be authentic (Meier & Labuski, 2013). Structural barriers exist (such as the omission of questions about gender identity in national surveys or intake assessments in health or human service organizations) which maintain transgender people's invisibility and social exclusion (Bauer et al., 2009; Cahill & Makadon, 2017). Studies that use gender clinics to calculate prevalence estimates are capturing a narrow sector of the transgender population by excluding those who do not wish to modify their bodies physically or who do not have the health insurance or financial means to cover their medical transition needs. Similarly,

using the number of people who have legally changed their gender in identification documents to calculate prevalence is equally problematic because states have varying regulations for name/gender change. Therefore, it is difficult to assess prevalence when the definition itself is ambiguous and the methods are flawed (Meier & Labuski, 2013).

Despite the challenges, attempts have been made to estimate the size of the transgender population. It is estimated that there are over 15 million trans people in the world (Winters & Conway, 2011 as cited in Meier & Labuski, 2013). Based on a review of prevalence studies globally, Meier and Labuski (2013) found that the incidence of transsexualism (per 100,000 ages 15 or above) ranged from 0.17 (Sweden) to 1,333 (in Malaysia). This startling difference in prevalence rates underscores the importance of considering the historical, social, cultural, and legal context of trans identities in other countries which can impact research methodology as well as the participants' willingness to self-identify as transgender. Some countries allow for greater fluidity in gender identity or have additional gender categories beyond the binary male/female classification system. It has also been posited that, in countries where homosexuality is criminalized and for which severe sanctions exist, individuals may choose to cross the gender divide to avoid persecution (Meier & Labuski, 2013). Thus, there is great complexity in estimating the prevalence of the transgender population and findings must be contextualized.

Interestingly, prevalence studies have revealed a compelling pattern that higher numbers of birth assigned males transition to another gender than birth assigned females (Meier & Labuski, 2013; Teich, 2012). According to the American Psychiatric Association, using the (now outdated) gender identity disorder as a diagnostic tool, "roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment

surgery" (American Psychiatric Association [APA], 2000, p. 579). It has been hypothesized that birth assigned females have greater social permission to exhibit a masculine expression than birth assigned males do to exhibit a feminine one. Consequently, more males feel the need to cross the gender divide to embrace their female identities (Meier & Labuski, 2013). An oft-cited reference, Gates (2011) estimated that 0.3% of the U.S. population identify as transgender, which equates to approximately 700,000 people. Using more recent data, Flores, Herman, Gates, and Brown (2016) estimated that 0.6% of adults in the U.S. (approximately 1.4 million people) identify as transgender. Lacking any available evidence about the size of the transgender population in Canada, Giblon and Bauer (2017) extrapolated Flores et al.'s (2016) prevalence estimate to the 2016 Canadian census and approximated that there are 200,000 transgender adults in Canada, of which an estimated 77,000 live in Ontario.

Representation in research. Research is frequently used as a platform to influence public opinion, shape clinical practice, and inform policy and, therefore, is an important component to advancing justice and equity for marginalized communities. Historically, research on transgender populations has focused on transition-related care and HIV/AIDS health disparities (Ducheny et al., 2019). The ability of researchers to access the transgender community as research participants has been a challenge—in part because the community itself is ill-defined. The language used to describe the range of gender experience is constantly evolving, with widely divergent subgroups contained within the transgender umbrella (Rachlin, 2007). Resulting from their history of stigmatization, transgender communities are hard-to-reach populations and are geographically dispersed. Many trans individuals live stealth and hence, are not available

for recruitment (Miner et al., 2012). Moreover, because they have often been pathologized by researchers in the past, many trans individuals are reluctant to participate in research and are often wary of researchers (Meezan & Martin, 2007; Meier & Labuski, 2013). Trans people's skepticism and distrust are further reinforced by researchers' lack of cultural competence or insider knowledge, as evidenced by the language used in the research questions being asked of participants or the study's lack of practical relevance for transgender communities. Those who are living their lives visibly as transgender people are frequently requested to participate in research which can lead to participant fatigue (Rachlin, 2007). Research studies with transgender participants commonly have small sample sizes which contributes to limitations in statistical analysis. Trans people will often refer each other to participate in studies which they deem as culturally sensitive and worthwhile (such as in studies employing snowball sampling or respondent driven sampling procedures), with transgender researchers often achieving greater success in obtaining larger sample sizes than cisgender researchers who are allies (Meier & Labuski, 2013). Given these challenges, much of the research which has been conducted about transgender people have used convenience sampling methods with recruitment taking place online and/or through clinical settings or human service organizations serving LGBT or transgender-specific populations. Findings from such research lack representativeness and are limited in their generalizability to the whole transgender population (Meier & Labuski, 2013; Miner et al., 2012; Rachlin, 2007).

Transgender communities have maintained a strong internet presence which has fostered collective identity development, enabled organizations to offer support and political education online, and provided a platform for activists to organize and mobilize

the trans movement. The internet allows users to maintain relative anonymity—a salient benefit for stigmatized individuals who feel they would be placing their safety at risk if they were out and visible (Shapiro, 2004). Researchers, in turn, have benefited from this internet presence for sample recruitment and data collection purposes, as online research methodologies enable transgender individuals who are living stealth to participate in studies without risking their anonymity or safety (Hash & Spencer, 2007; Meier & Labuski, 2013; Miner et al., 2012). The internet also facilitates researchers' ability to reach geographically dispersed populations (Miner et al., 2012), especially those who may be geographically isolated in rural areas (Hash & Spencer, 2007). Shapiro (2004) warned, however, that "access to the internet, like access to surgery and related medical technology, is mitigated by social class and race in the United States" (p. 175). Despite the numerous benefits of online technology, the internet may reinforce the age, race, and class divisions within trans communities. Differences in socio-demographic characteristics have been noted among participants in research studies conducted online: internet users are "generally younger, more educated, and less likely to be persons of color" (Miner et al., 2012, p. 207). Moreover, the availability of internet access in rural areas can be a challenge. Thus, research studies about trans populations which are conducted solely using an online platform may fail to reach individuals who do not have a computer, do not have internet access, or who may not be computer literate due to age, education, income, or geography (Hash & Spencer, 2007; Rachlin, 2007).

Sample recruitment through gender clinics, health, or social service organizations also provide a limited ability to infer representation of the broader population of interest. Such studies consist of participants who have requested medical or psychological

interventions. Yet, not all trans individuals seek these services or may have access to these services. Here again, race and class divisions may be reinforced, as access to gender clinics, health, and social services is often influenced by income, education, geographic proximity, and the social acceptability of these services. In these studies, the risk of response bias is high. The results offer limited information about the transgender people who were not sampled because they were not clients of these clinics or service organizations. Therefore, although the participants were accessible, their experiences were not necessarily normative of all people in transgender communities (Rachlin, 2007).

Recruitment through transgender community events or trans support organizations also offers a limited sampling frame in that only those who are willing to interact and participate in public spaces will attend. It is not unusual for trans individuals to attend these community events or seek support from these organizations when they are at a certain stage of exploration and subsequently move out of the community as they develop (Rachlin, 2007). Indeed, many trans people have been advised by gender clinics to live stealth post-transition and thus, have disowned their trans identity once their transition was completed (Shapiro, 2004). As members of hidden populations, the recruitment of these trans individuals for research remains difficult.

Researchers have noted the lack of diversity in samples within extant studies on transgender populations. Many of the samples consist predominantly of transgender women, with trans men and non-binary identities being underrepresented. This may be a result of participant recruitment through gender clinics and the higher prevalence of natal males seeking gender-affirming procedures than natal females (Levin, 2014). There is often very little racial or ethnic diversity, with many studies consisting mostly of white

participants. Yet, trans people of color are over-represented in studies examining HIV risk, drug abuse, or sex work (Rachlin, 2007). Research on transgender populations "has lacked representativeness because of the limitations on subject availability" (Miner et al., 2012, p. 206).

Challenging binary assumptions. Within Western culture, there exists a sexual and gender dimorphism as a conceptual system which has become central in social classification and scientific thought. Based on the ideology that sexuality is for reproduction, only two fixed and mutually exclusive categories exist, which are the products of biology: male or female. This dimorphism was considered natural or normative. Furthermore, an essentialist view is held that anatomy is destiny; sex determines gender and biology defines one's internal identity and external presentation. The construct of gender is culturally defined and is a learned element (Herdt, 1993). It is through dichotomous socialization and gendered expectations that individuals are defined as men or women and regarded as masculine or feminine. Assumptions are made instinctively about a person's gender, which falls in only one of these two categories. Gender, therefore, is regarded as a social construct which is a product of culture and defined by people (Acquaviva, 2017; Erickson-Schroth, Gilbert & Smith, 2014; Prieur, 1998).

Yet, categories can be flawed with imperfect boundaries. The binary model that is used to categorize biological sex is not an absolute, for nature can present a broader spectrum. For example, some babies are born with atypical or ambiguous anatomy, or have variations in their chromosomal makeup as a congenital condition. Historically, the parents of these infants have been informed by medical professionals that their babies'

sex organs failed to develop fully while in utero. These parents were pressured to decide their babies' sex and to subject them to medical intervention to align their body parts with their assigned sex (Fausto-Sterling, 2000). Classified as intersex (also known as Disorder of Sex Development), it has been estimated that these infants comprise up to 2% of all live births (Blackless et al., 2000). These individuals are often considered part of the transgender population, although their inclusion has been politically controversial (Erickson-Schroth et al., 2014; Meier & Labuski, 2013; Simmons & White, 2014).

Herdt (1993) argued that even the dichotomy between sexual nature and gendered culture is illusory; it is a cultural construction which should be critically reevaluated. There is historical and cross-cultural evidence of third sex and third gender systems using alternative theories about the human condition. "Variations in sex and gender, including the formation of third-sex and third-gender categories, roles and ontological identities are not universal; they vary across time and space" (p. 79). Alternative constructs of sex and gender have existed in pre-modern and non-Western societies, some of which have intersected with sexual object choice and the dualism of homosexuality and heterosexuality. In some societies, an intermediate sex has been discussed as a category which existed somewhere between the male and female polarity or alternatively, a third distinct category which did not use male or female as a reference point. Within these alternate sex/gender constructs, a power hierarchy often existed whereby the third sex or gender is either marginalized or revered within society (Herdt, 1993).

An ancient historical example of a distinctive third gender are *eunuchs* during the Byzantine Era. Commonly referred to as castrated men in modern day language, eunuchs in Byzantine society encompassed anyone who was physiologically incapable of

procreation or had chosen not to procreate. Until the ninth century, the term was inclusive of "men who were born sterile, men who became sterile through illness, accident, or birth defect, men who were lacking in sexual desire, and men and women who embraced the celibate life for religious reasons" (Ringrose, 1993, p.86). Over time, the definition of eunuch evolved and was influenced by the Church's views regarding sexuality and celibacy. Eunuchs in secular Byzantine society had a defined behavior, appearance, occupation, social role expectations, and an acculturation process to fulfill these expectations. Because the ability to procreate was considered the ideal as a point of reference, eunuchs were lower in status within the gender hierarchy (Ringrose, 1993).

Other historical examples of alternative sex and gender constructs can be found within Western European societies. Anatomical sex, sexual acts (i.e., passive receptor versus active penetrator), and sexual orientation were part of the 18th century Western European gender system rather than separate from it. The word *hermaphrodite* began to appear in the literature during the 17th century and its meaning has evolved over time. It has been used to describe effeminate men who desired sex with other men, to masculine women who were sexually attracted to other women, to women with enlarged clitorises or individuals with ambiguous anatomy. Regarded as both male and female and categorized as a third sex, hermaphrodites were considered to have imperfect, defective bodies. They were socially pressured to identify with one gender based on their sexual object choice (through imposed heterosexuality) and to adhere to it rather than transitioning back and forth between genders. During the early 18th century, the *molly* was considered a third gender. Mollies were cross-dressing adult males who were passive, effeminate, and desired men as their sexual object choice. Because they

challenged the cultural ideals of masculinity and procreation, mollies were regarded as the illegitimate gender. By the late 18th century, the paradigm evolved to include *sapphists*, a term describing women who desired and had sexual relations with other women and were ambiguous in their appearance. Thus, the paradigm in Western Europe beginning in the 17th century through the 18th century consisted of three sexes (i.e., male, female, hermaphrodite) and four genders (i.e., man, woman, molly, and sapphist) (Trumbach, 1993).

The Euro-Western dichotomized construct of sex and gender can limit the ability to understand alternative sex and gender systems that exist within other cultures. The characterizations of other systems are often viewed from an ethnocentric perspective that is unable or unwilling to recognize more than two sexes or genders (Schnarch, 1992). Cross cultural examples of alternative gender constructs reveal the constraints of the sex and gender dimorphism paradigm. Within each gender system, the individual occupies a position of power and/or oppression based on societal acceptance of diversity or ambiguity. In India, alternative sex and gender roles, transformations of sex and gender, and sexual ambiguity among humans and deities are common themes in Hindu mythology, ritual, and art. The *hijras* in India are "neither man nor woman," but the embodiment of "man plus woman" and regarded as "erotic and sacred female men" (Nanda, 1993, p. 373). Hijras are the vehicles of divine power and serve as ritual performers at the birth of a male child and at marriages. Ambiguous male genitalia and loss of masculinity (e.g., impotence, lack of sexual desire for women, sexual preference for men, and effeminate behavior) serve as the culturally defined signs of the hijra. They are considered incomplete men because of their defective male sexual organs. If they are

not born with defective organs, they undergo castration which is more common. Either as cross-dressing eunuchs or as intersex individuals, many hijras identify as women and have an exaggerated feminine presentation. They belong to a recognized social niche which is separate from the caste system. Women who cannot menstruate may also become hijras. Within Indian culture, full personhood is defined by the ability to produce progeny through sexual intercourse in marriage. Hijras are not men because their male organs do not function, and they are not women because they are unable to bear children. Hence, for individuals who are unable to procreate, the role of the hijra enables them to transform incomplete personhood to a transcendent one (Nanda, 1993). The *berdache* within Native American societies offers another cross-cultural example. A berdache is a person who holds a title which is distinct from man or woman. Berdaches have a recognized social status which affords them unique spiritual powers, enabling them to serve as mediators between the spiritual and physical worlds, and between men and women (Schnarch, 1992). Today, the preferred terminology used to describe gender variant individuals in Native American societies is *two-spirit*.

The eunuch, molly, sapphist, hijra, and two-spirit provide evidence that the dichotomous sex and gender classification system is a cultural construct. Recognition of third and fourth genders through these historical and cross-cultural examples does not simply serve as a proliferation of gender but rather, eschewing the dimorphic sex and gender system realizes the importance of gender diversity. Knowledge of other sex and gender paradigms throughout history or within other societies can inform and support goals for social change (Schnarch, 1992).

The pathologizing of trans identities. The underlying assumption of the conventional male/female gender binary frames the debate about its oppressive nature in that anyone who does not adhere to the cultural norms of this dualistic paradigm is marginalized and censured. There are moral underpinnings associated with binary beliefs about gender. This cultural bias has influenced how homosexual and transgender identities have been pathologized in the Western medical model, how the transgender population has been represented in research, and how intersex or gender variant individuals have been treated in society. In the 19th century, the beliefs about gender intersected with the binary of homosexuality/heterosexuality which rendered gay men and lesbian women deviant (Drescher, 2010). Transgenderism was commonly conflated with homosexuality (Drescher, 2015). Discussions about third sex systems, which involve homosexuality, challenge the procreation ideology. The requirement of species survival through procreation necessitates a male and female and thus places heterosexuality as the ideal and normal state. Through the lens of 19th century Darwinian theory, any non-procreative sexual behaviors were regarded as forms of pathology and perversion. Hence, heterosexual and cisgender identities became the frames of reference and were considered the biological norms (Drescher, 2010, 2015). People who do not conform to sex or gender conventions must hide or pass as either male or female under the threat of punishment (Herdt, 1993). Through imposed heterosexuality, gender variant and intersex individuals were pressured to identify with a specific gender based on their sexual object choice (Trumbach, 1993). Trans individuals who identified with a heterosexual orientation were given greater legitimacy, as evidenced in the realm of research (Levin, 2014).

Classification systems allow researchers and clinicians to (a) categorize clusters of symptoms and conditions; (b) establish a consistent nomenclature for illness; (c) facilitate understanding about the onset, duration, pathogenesis, functional disability, and treatability; (d) guide further research into the development of effective treatments; and (e) facilitate access to care. Clinical nomenclature and diagnostic nosology are culture and time dependent. Treatment and standards of care are influenced by cultural shifts and advances in clinical knowledge (Coleman et al., 2012). Within the U.S., health care providers use two main classification systems: the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems (ICD). An exploration of gender diagnoses within these two classification systems reveals the changing cultural attitudes towards gender variance and the evolving clinical understanding of the transgender identity.

The DSM is used as the authoritative guide in the diagnosis of mental disorders by health care professionals. For clients suffering from mental illness, the DSM offers a means to access care in that insurance companies require the use of a medical diagnosis for payment to be rendered to the health care provider. Yet, the inclusion of certain diagnoses has major social and political implications, and often shifts over time depending on societal tolerance of difference. For example, Drescher (2010, 2015) chronicled the history of homosexuality as a psychiatric diagnosis from its first appearance in DSM-I (APA, 1952) when it was considered a "sociopathic personality disturbance," to DSM-II (APA, 1968) when homosexuality was reclassified as a "sexual deviation." Gay and lesbian people were ostracized and faced socio-economic and legal

discrimination (Franklin, 2014). Then, the civil rights movements in the U.S. occurred during the 1960's and 1970's. Gay activism, spurred by the Stonewall riots on June 28, 1969, was burgeoning in communities. There was also a change in leadership within the APA. In response to the internal and external political climate, homosexuality's place was re-conceptualized in the DSM. By 1973, homosexuality was removed from the DSM, resulting from a vote by the APA's Board of Trustees and a subsequent referendum by the APA's voting members (Drescher, 2015, 2016). The APA recognized that the classification of homosexuality as a mental disorder was based on social stigma rather than empirical research (Scasta & Bialer, 2013). As cultural attitudes shift, beliefs about what constitutes a mental disorder can also change.

These cultural shifts are hard won and are eventually reflected in the country's laws. For example, same sex intimacy was considered a crime in the U.S. until June 26, 2003, when Lawrence v. Texas (2003) invalidated sodomy laws which were used to criminalize homosexuality. Subsequently, gay and lesbian couples began to fight for legalization of same sex marriage. In a landmark decision on June 26, 2015, a divided U.S. Supreme Court (with a 5 to 4 vote) ruled to legalize same-sex marriage in the U.S. in Obergefell v. Hodges (2015). Though the quest for equity is still ongoing, the current law pertaining to same sex marriage in the U.S. reflects greater social acceptance of homosexuality today (Drescher, 2016, 2016).

Parallels can also be drawn with how gender variance and gender non-conformity are classified in the DSM. Although the word transgender has never been used in the DSM, the concept first appeared within DSM-III (APA, 1980) as Gender Identity Disorder of Childhood (GIDC) and Transsexualism under the parent category of

"psychosexual disorders." In DSM-III-R (APA, 1987), a third diagnosis of Gender Identity Disorder of Adolescence and Adulthood, Nontranssexual Type was added. The three diagnoses were moved to a new parent category of "disorders usually first evident in infancy, childhood or adolescence." By DSM-IV (APA, 1994; APA, 2000), the third diagnosis was eliminated and the first two diagnoses of GIDC and Transsexualism were combined into one overarching diagnosis of Gender Identity Disorder (GID) with different criteria sets for children versus adolescents and adults. These diagnostic labels created much debate, as activists argued that labelling gender variance or non-conformity as a disorder only served to pathologize this population and contribute to their discrimination. Rather than changing the social forces that oppress gender variance and non-conformity, the inclusion of a trans diagnosis focuses on individual difference. Yet, the structure of the health care system within the U.S. necessitated the need for a medical diagnosis in order to maintain access to care. If GID was removed from the DSM entirely, it would deprive transgender individuals from being able to access gender-affirming treatments through their health insurance. Hence, in the revision process for DSM-V, the APA's Workgroup on Sexual and Gender Identity Disorders was challenged with improving access to care while attempting to reduce the stigma associated with a psychiatric diagnosis (Drescher, 2015, 2016).

As a result of increasing visibility and social consciousness about this population, the diagnosis of Gender Identity Disorder was re-conceptualized as Gender Dysphoria (GD) in DSM-V (APA, 2013a). The significance of this step was compared to the APA's decision to remove homosexuality from the DSM in 1973. The use of the word dysphoria emphasized the clinically significant distress that individuals experience because there is

a mismatch between their expressed/experienced gender and their assigned gender. Moreover, the APA specifically noted,

> Gender nonconformity is not in itself a mental disorder…Persons experiencing gender dysphoria need a diagnostic term that protects their access to care and won't be used against them in social, occupational, or legal areas. When it comes to access to care, many of the treatment options for this condition include counseling, cross-sex hormones, gender reassignment surgery, and social and legal transition to the desired gender. To get insurance coverage for the medical treatments, individuals need a diagnosis. (APA, 2013b, p. 1-2)

In the effort to destigmatize the transgender population, GD was moved to its own section in the DSM and was separated from Sexual Dysfunctions and Paraphilic Disorders (APA, 2013a; Drescher 2015, 2016). Additionally, to advocate for the transgender population, the APA published two position statements: (a) in support of access to care (APA, 2012a) and (b) in opposition to any form of discrimination against transgender and gender variant individuals (APA, 2012b).

Despite these positive intentions, arguments persist regarding the effectiveness of this new psychiatric nomenclature. Many transgender individuals feel that having to be labelled with a mental disorder to gain access to care remains oppressive. Furthermore, some perceive that their condition is a medical one rather than a psychiatric one. For members of the trans community who do not wish to seek medical or surgical intervention to affirm their gender identities, the GD diagnosis simply maintains their stigmatization (Drescher, 2015). Moreover, an assumption is made that the dysphoria may be eliminated if the individual experienced a gender transition by living full time in

the desired gender role. Critics have argued that surgery and hormone therapy may be palliative measures and not necessarily a cure. By emphasizing assigned gender (rather than biological sex), the word dysphoria does not reflect the sense of wrong embodiment that many transgender people experience. Consequently, the GD diagnosis does a disservice to some members of the trans population; it was created in response to political and social pressure rather than based on scientific or clinical evidence (Lawrence, 2014).

The WHO's ICD is also used to access medical care in the U.S. Like the DSM, the gender diagnoses in the ICD have undergone a gradual evolution. It first appeared in ICD-8 as the diagnosis of Transvestitism under the category of Sexual Deviations (WHO, 1965). Over time, a second diagnosis was added which appeared in ICD-9: Transsexualism (WHO, 1975). In ICD-10, the WHO reorganized the gender diagnoses to a new parent category called Gender Identity Disorders and expanded the diagnosis names to: (a) Transsexualism; (b) Dual-role Transvestism; (c) Gender Identity Disorder of Childhood; (d) Other Gender Identity Disorders; and (e) Gender Identity Disorder (Unspecified) (WHO, 1990). Although considered to be an independent group of disorders, these diagnoses represented the continued pathologization of trans identities.

A historic landmark occurred at the World Health Assembly in May 2019 when the WHO redefined gender identity-related health by approving a diagnosis name change in ICD-11 to Gender Incongruence. The parent category of Gender Incongruence now consists of two diagnoses: (a) Gender Incongruence of Adolescence and Adulthood; and (b) Gender Incongruence of Childhood. Moreover, this diagnostic category has been moved from the Mental and Behavioral Disorders section to a new section called Conditions Related to Sexual Health. Hailed as a sign of progress, this change was aimed

at improving access to care and reducing stigma (WHO, 2019). The declassification of Gender Incongruence as a mental disorder is an attempt at acknowledging diversity and normalizing gender variance. Yet, critics have noted that this is merely an intermediate step in depathologizing trans identities. The inclusion of Gender Incongruence in the ICD-11—itself a manual encompassing all diseases—demonstrates the challenge of balancing access to services with reflecting shifts in social attitudes and upholding human rights standards (Reed et al., 2016; Rodriguez, Grande, & Gonzalez, 2018). Moreover, it remains to be seen how the ICD-11 may impact the psychiatric nomenclature in future versions of the DSM (Drescher, 2015).

An architecture of exclusion. Transgender people experience profound discrimination which permeates multiple facets of their lives and produces deleterious effects on their health and wellbeing (Albuquerque et al., 2016; Brandes, 2014; Grant et al., 2011; James et al., 2016; Kcomt, 2018; McCann & Brown, 2017; Winter et al., 2016). For example, transgender individuals often encounter employment inequities which lead to income disparities and can impact their access to health insurance. They experience high rates of poverty and homelessness (Grant et al., 2011; Institute of Medicine, 2011; James et al., 2016, Winter, et al., 2016). Consequently, they may engage in the underground economy for survival, which places them at greater risk for health and legal problems (Grant et al., 2011; James et al., 2016; Moolchaem et al., 2015). Many of the crimes committed against them are spurred by transphobia. Unfortunately, many of these crimes remain unreported because transgender people are fearful of experiencing further discrimination in the criminal justice system (Grant et al., 2011; James et al., 2016; Moolchaem et al., 2015; Winter et al., 2016). This interlocking web of inequities produce

and reproduce the social exclusion which maintains their oppression (Fish, 2010; Grant et al., 2011; James et al., 2016).

Transgender people's experience of *stigma* can be used as a starting point to understand how this systemic oppression occurs. In his seminal text, *Stigma: Notes on the Management of Spoiled Identity*, Goffman (1963) defined stigma as an "attribute that is deeply discrediting," reducing an individual from being "a whole and usual person to a tainted, discounted one" (p. 3). Expanding this concept further, Link and Phelan (2001) explained that stigma consists of four components converging together to create and reproduce social inequalities:

1. Labeling—where human differences are identified, and labels are affixed, yet the validity of these designations are questionable
2. Stereotyping—in which the human differences are associated with negative attributes and are thus devalued
3. Exclusion—where labelled individuals are set apart and dehumanized
4. Status loss and discrimination—whereby individuals are relegated to a lower rung in a status hierarchy, lending itself to individual and structural discrimination

The status loss can itself be a source of discrimination and may have a cascading negative effect on a person's life opportunities (e.g., exclusion from social networks, labor market, neighborhoods, etc.). Furthermore, because the negative stereotypes are so pervasive within a specific culture, it can become part of the socialization process within that culture. Expectations are formed about whether the labelled individuals will be rejected or devalued, and individuals who find themselves with the possibility of having the label applied to them will begin to fear and expect such rejection and devaluation.

This can have serious consequences on their psychology (such as decreased self-esteem, depressive symptoms, etc.) as well as their social relationships (such as strained interactions with potential stigmatizers and a constricted social network), which can impact the individual's quality of life (Link & Phelan, 2001). Lastly, the social production of stigma occurs through the exercise of power which allows this process to unfold. Beyond the micro-level interactions, stigma can have broader social effects at the macro level (Link & Phelan, 2001, 2014). Termed *structural stigma*, this process is aimed at controlling and marginalizing stigmatized groups. Structural stigma is defined as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (Hatzenbuehler & Link, 2014, p. 2).

Drawing upon these concepts of stigma, White Hughto, Reisner, and Pachankis (2015) explained how structural, interpersonal, and individual stigma can impact transgender people's lives. Stigma is a fundamental cause of adverse health outcomes among transgender populations. It can function directly (by inducing stress and making transgender individuals more vulnerable to physical and mental health problems) and indirectly (by restricting access to resources). Examples of structural stigma experienced by trans people include: the medical profession's historical pathologization of trans identities which labeled trans people as disordered; employment inequities leading to the high prevalence of trans individuals being uninsured, thereby restricting their access to trans-related or preventive care; the use of hormones and silicone injections from non-medical sources among those who are socio-economically disadvantaged, thereby increasing their risk of exposure to blood borne pathogens; and the knowledge deficit

about trans health issues among health care providers (White Hughto, Reisner, & Pachankis, 2015).

Interpersonal stigma refers to "direct or enacted forms of stigma such as verbal harassment, physical violence, and sexual assault due to one's gender identity or expression" (White Hughto et al., 2015, p. 223). Those who have low visual conformity may be at greater risk of experiencing interpersonal stigma (Bradford et al., 2013; Meier & Labuski, 2013; Miller & Grollman, 2015, Reisner et al., 2015). The level of visual conformity can also be related to socio-economic status: Those with less resources are often less able to access gender-affirming treatments, and therefore, more likely to experience interpersonal stigma (Serano, 2007; White Hughto et al., 2015) Individuals who disclose their trans identity to others also risk exposing themselves to rejection and abuse. Family rejection can have profound consequences such as homelessness, social isolation, low self-esteem, depression, etc. Transgender individuals can experience interpersonal stigma from health care providers in the form of mistreatment, physical or verbal abuse, or refusal of care (White Hughto et al., 2015).

The interpersonal stigma can produce psychological effects within the individual, which impact behavioral, cognitive, and affective processes. *Individual stigma* refers to "the feelings people hold about themselves or the beliefs they perceive others to hold about them that may shape future behavior such as the anticipation or avoidance of discrimination" (White Hughto et al., 2015, p. 223). Individual stigma induces feelings of shame and a desire to conceal one's transgender identity. This can lead to a constant state of hypervigilance about not wanting to be outed as a transgender person (Ducheny, et al., 2019; Reisner et al., 2015). Over time, internalized stigma can erode one's ability to cope

with external stressors or one's sense of self-efficacy to engage in health-promoting or help-seeking behaviors (White Hughto et al., 2015). This concept of stigma as a social process, a convergence of different components and comprised of different levels, lays the foundation for understanding how it can serve as both the cause and effect of inequities.

Other scholars have also advanced understanding about how systemic social exclusion occurs at the structural or institutional level and is entrenched within cultural and political contexts. Bauer et al. (2009) discussed the concept of *erasure* to explain trans people's invisibility within informational systems and institutional policies and practices. *Informational erasure* refers to the lack of knowledge production and information dissemination about trans people and the issues which concern them. This lacuna is manifest in the research, curricula, and textbooks used by health care providers and policy makers. When researchers make the flawed assumption that all research participants are cisgender, the questions that are important to trans populations are never brought into focus. This contributes to the lack of content about trans-related health issues in educational curricula and textbooks. Even when information about trans people is included, it is often subsumed under the LGBT umbrella and gender identity is conflated with sexual orientation, thereby obscuring the needs of trans populations. Thus, this lack of knowledge production and information dissemination renders health care providers poorly equipped to manage the needs of their trans patients (Bauer et al., 2009; White Hughto et al., 2015).

Institutional erasure refers to policies or organizational infrastructures that exclude the possibility or existence of trans identities and trans bodies. Examples include

intake forms that utilize binary categories for sex/gender, segregation of patients based on biological sex (such as in hospital wards), and billing systems that require concordance between the patient's gender marker in the electronic health record and the sex-specific procedure (such as a Pap smear or prostate exam). As Bauer et al. (2009) explained:

> … trans people are often forced to choose between accessing services according to their birth sex or foregoing services entirely… Broadly, trans people seeking health care are often faced with the acute realization that many providers are not familiar with or willing to accept the possibility of trans identities, which impacts both the availability and quality of care. Embedded in this particular configuration of institutional erasure is a politics of recognition regarding being in the appropriate place or possessing the correct anatomy to be provided service. (Bauer et al., 2009, p. 355)

Trans patients who have disclosed their gender identity have experienced active, direct discrimination from health care providers such as the denial of care, abuse, or harassment (Fredriksen-Goldsen et al., 2011; Grant et al., 2011; James et al., 2016; Lambda Legal, 2010; Reisner, White et al., 2014). To avoid discrimination, many trans patients opt not to disclose their trans identity by passing as cisgender or engage in selective disclosure based on their perception of the health care provider's attitude, the setting, or the medical need. This complex disclosure process shapes the access to care and impact health outcomes (Bauer et al., 2009; Cruz, 2014). "Disclosure involves the risk of denial of care or mistreatment; lack of disclosure involves the risk of inappropriate health care and possible unintentional disclosure through medical examinations or testing" (Bauer et al., 2009, p. 357).

Informational and institutional erasure are inextricably linked and mutually reinforcing. Erasure underpins *cisnormativity*, the systemic marginalization of trans people in a sociocultural context which identifies or represents cisgender identities as normal and expects that all people are cisgender (Bauer et al., 2009; Hudson, 2019; Logie, James, Tharao, & Loutfy, 2012; Pyne, 2011). Cisnormative assumptions are so pervasive that health care providers and institutions do not question the experience of gender, do not anticipate the possibility of a trans existence and so, are unprepared when such a person seeks their services. Paradoxically, the sustained invisibility of trans identities creates a hyper-visibility when a trans patient enters the health care system such that these situations are regarded as anomalies which result in a social emergency (Bauer et al., 2009; Pyne, 2011). Cisnormativity in health care systems contributes to poor quality of care for trans patients (Hudson, 2019). It captures the nuances of discrimination and the system that empowers it (Bauer et al., 2009; Pyne, 2011).

Cisgenderism is defined as the "ideology that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned gender at birth as well as resulting behavior, expression, and community" (Lennon & Mistler, 2014, p. 63). This ideology privileges cisgender identities and reinforces prejudice against transgender people. By relegating trans individuals as the Other and deeming them as unnatural, the cis-trans distinction breeds a culture of discrimination and oppression against transgender and gender non-conforming people (Ansara, 2015). Many health care providers reflect society's cisgenderist attitudes because of their lack of training on the needs of the trans population and trans health issues. Even if they do not align with cigenderist ideology on an individual basis, health care providers often work in broader social contexts which

produce and perpetuate cisgenderism at systemic and structural levels (Ansara, 2015). Cisgenderism can result in subtle microaggressions which occur through both unintentional and well-intentioned practices. Examples of cisgenderism may include (a) pathologizing (i.e., characterizing a person's gender identity as disordered); (b) misgendering (i.e., classifying individuals in a way that is inconsistent with their gender identity); (c) marginalizing (i.e., regarding a person's gender identity as weird or strange); (d) coercive queering (i.e., imposing a queer or LGBT label on trans people who identify as heterosexual and assuming that they have the same needs as those in sex gender relationships); and (e) objectifying biological language (i.e., using language which describes a person's assumed physical characteristics such as female-to-male or FTM) (Ansara, 2015). This systemic discrimination becomes a barrier to transgender people's ability to communicate with health care providers and access appropriate care.

Significance of the Study

The paucity of research about the transgender population perpetuates their invisibility, and has left social workers, health care systems, and service organizations ill-equipped to meet their needs. Social workers need to increase their understanding about the complexities and multiplicities of gender, and to develop competency in serving transgender populations. In this study, secondary data analysis was conducted on the 2015 U.S. Transgender Survey—the largest database of transgender people in the United States (U.S.) to date—with the goal of understanding the risk and protective factors influencing health care access in the U.S. The study unveiled the diversity which exists in the transgender population and examined the complex interactional effects that demographic and socio-economic characteristics have on health care access. These results

can be used to inform gender-affirming care and to raise awareness among social workers and other health care providers about the inequities experienced by disadvantaged transgender subgroups compared to their relatively privileged counterparts. Although the trans community may have gained increased visibility in public media, much effort is still needed to combat their erasure and to create an inclusive environment which supports their needs.

This study has relevance for all health providers, but is especially salient for social workers, as they have an ethical responsibility to address the health care needs of vulnerable, marginalized, and disadvantaged populations. Transgender people are among the most marginalized members of society. Within health care settings, social workers are an integral part of interdisciplinary teams, playing a leadership role in providing the psychosocial aspects of care and working collaboratively in the care delivery process (NASW, 2016). Trained to use the biopsychosocial-spiritual perspective, social workers listen to their patients' narratives and bear witness to the impact of inequity on their patients' lives. As advocates for social justice, social workers may participate in quality improvement efforts within their health organizations. They are poised to be change agents in reducing barriers to health care access and enhancing the quality of services. Thus, the findings of this study can be used to impact clinical care at the micro level and to inform change efforts at the mezzo and macro levels of social work practice.

Organization of the Dissertation

Chapter 1 provided the background and historical context to understand the transgender identity and the history of transgender people's pathologization within the U.S. health care system. A review of the empirical literature is provided in Chapter 2,

which includes an overview of the theoretical frameworks and models used to guide this study. Chapter 3 begins with an overview of the methodology used for 2015 U.S. Transgender Survey implemented by the National Center for Transgender Equality and a detailed description of the methodology for the secondary data analyses is offered. The results of this study are explicated in Chapter 4. Finally, Chapter 5 provides a summary of the findings as they relate to the hypotheses and a discussion of the implications for practice, policy, and social work education. The strengths and limitations of this study and the implications for future research are also examined.

Chapter 2: Literature Review

The Health Care Needs of Transgender People

The medical transition process. The medical transition process encompasses a range of technologies including counseling, gender-affirming hormone therapy, and gender-affirming surgeries. For transgender individuals wishing to pursue a medical transition, access to such services can be complex and is often dependent on their health insurance. Insurance policies also differ in their coverage of gender-affirming treatments.

In the U.S., access to health insurance is linked to socio-economic status (which, itself, can be impacted by race, gender, and education) (Hoffman & Paradise, 2008; Institute of Medicine, 2009). The health insurance system in the U.S. consists of a private sector (largely employer-sponsored) and a public sector (with Medicare for the elderly and disabled; Medicaid for those living below the poverty line). Those who are employed are more likely to have health insurance, but those who are underemployed, unemployed, or self-employed may have inadequate insurance or no insurance. Not all individuals have health insurance coverage and transgender people are more likely to be uninsured compared to the general population due to employment inequities (dickey, Budge, Katz-Wise, & Garza, 2016; Grant et al., 2011; James et al., 2016). Therefore, transgender individuals who can access medical transition services are generally more privileged (Meier & Labuski, 2013; Serano, 2007).

Treatment models of care. Historically, health care providers have been perceived as the gatekeepers of the gender transition process. Past clinical models required transgender individuals seeking hormone therapy or gender-affirming surgeries to meet certain prerequisites before these options could be explored. These prerequisites included

receiving a formal diagnosis of gender dysphoria as described in the DSM V, undergoing extensive psychotherapy, and living full-time in their affirmed gender for a period of six to 24 months (Houlberg, 2019).

Treatment models of care for gender transition services continue to evolve. Standards of care and clinical guidelines published by the World Professional Association for Transgender Health (WPATH) (Coleman et al., 2011), The Center of Excellence for Transgender Health at the University of California San Francisco (UCSF) (Deutsch, 2016), and the Endocrine Society (Hembree et al., 2017) provide the framework to determine a patient's candidacy for gender-affirming hormone therapy and surgeries, treatment protocols, and considerations for long-term care. These standards of care and clinical guidelines inform health care practitioners about medical transition procedures and sensitize them to the primary health needs of transgender people. Deutsch (2016a) specifically noted that the UCSF's guidelines were intentionally designed to be implemented in primary care settings, including settings with limited resources. Thus, these tools serve to increase access to trans-related health care as well as to promote culturally competent primary health care.

The WPATH *Standards of Care* are used as a touchstone by most providers for developing their own systems and determining patient criteria for treatment. They are flexible guidelines intended to promote optimal health care for patients experiencing gender dysphoria. Individual practitioners or programs may modify them based on "a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction

strategies" (Coleman et al., 2012, p. 166). The Standards of Care clarify that psychotherapy is no longer an explicit criterion in the pathway to access transition services. However, they acknowledge the important role mental health professionals play in helping patients cope with the negative effects of discrimination or facilitating the gender role and psychosocial adjustment process. In recommending the services of mental health professionals, the Standards of Care extend beyond the Informed Consent Model (which focuses on the patient's ability to understand the options related to medical transition services and their associated risks and benefits) used by many practitioners (Coleman et al., 2012). These Standards of Care recognize gender diversity and offer a platform to advance legal reform and public policy which promotes equity for gender minorities (Wylie et al., 2016). Complementing the WPATH's Standards of Care, the Endocrine Society's *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (Hembree et al., 2017) and the UCSF's *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* (Deutsch, 2016a) explicates the treatment protocols for gender-affirming hormone treatment, the clinical considerations for gender-affirming surgeries, as well as mental health considerations. Interprofessional collaboration among providers is strongly recommended before, throughout, and after a patient's medical transition procedures to facilitate safe and positive outcomes (Coleman et al., 2011; Hembree et al., 2017).

Assessment of candidacy. Assessment of a patient's candidacy for hormone therapy and top surgery can be completed by mental health professionals or medical providers with appropriate training and demonstrated competency in the assessment of

gender dysphoria and capacity to provide informed consent (Deutsch, 2016a; Wylie et al., 2016). Adult patients must present with persistent, well-documented gender dysphoria, must demonstrate the capacity to make a fully informed decision and to consent for treatment, and has reached the age of majority in the country where treatment is sought (Coleman et al., 2011; Hembree et al., 2017). Before beginning treatment, clinicians should evaluate their patients for medical conditions which may be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender (Hembree et al., 2017). Any other physical or mental health concerns must be reasonably well controlled (Coleman et al., 2011; Hembree et al., 2017). One letter of recommendation by a qualified health professional is required before gender-affirming hormone therapy and top surgery can be initiated. Patients who wish to undergo gonadectomy (hysterectomy and oophorectomy for natal females; orchiectomy for natal males) should receive 12 continuous months of hormone therapy prior to their surgery (unless hormone therapy is medically contraindicated). Additionally, patients who wish to have genital surgery (metoidioplasty or phalloplasty in natal females; vaginoplasty in natal males) must live full time in their affirmed gender identity for 12 continuous months prior to their surgery. Two letters of recommendation from two independent, qualified health professionals are required for genital surgery to be completed (Coleman et al., 2011; Houlberg, 2019; Wylie et al., 2016).

Though these assessments are intended to establish the patients' surgery readiness, patients may perceive them as gatekeeping mechanisms to the medical transition process. This perception can challenge the development of therapeutic rapport between health providers and their trans patients. Collazo, Austin, and Craig (2013) advised health

providers (including social workers) who conduct surgery readiness assessments to be mindful about this perception, and to facilitate the transition process by serving as advocates rather than as gatekeepers.

The availability of qualified professionals to perform these assessments may be limited in certain geographic areas, creating long waiting periods or the burden of extended travel distance before access can be obtained. Additionally, patients may have to pay privately for these assessments depending on their health insurance policies. The direct and indirect costs of transition care can become additional barriers with which economically disadvantaged patients must grapple.

Counseling. In addition to assessing for gender dysphoria and a patient's candidacy for medical transition procedures, mental health professionals can provide individual, couple, family, or group psychotherapy services for the purposes of: assisting individuals in their exploration of gender identity, role, or expression; facilitating the coming out process; alleviating internalized transphobia; enhancing peer and social support systems; and promoting resilience. Counseling is an important resource to help people cope with the psychological effects of stigma and discrimination, which contribute to minority stress. Both the WPATH and the Endocrine Society acknowledge mental health professionals or behavioral health specialists as integral members of a team in facilitating an individual's gender transition process (Coleman et al., 2011; Hembree et al., 2017). Psychosocial counseling is included in the spectrum of medical transition services because it reinforces a holistic care model, and in the U.S., such mental health services may be covered by the individual's health insurance policy.

Gender-affirming hormone therapy. The regimen for hormone therapy is dependent on several factors, including the patient's age and treatment goals. Generally, it involves reducing the individual's endogenous sex hormone levels (to reduce the secondary sex characteristics of the individual's assigned gender) and to administer exogenous sex hormone levels consistent with the individual's affirmed gender identity (to induce feminizing or masculinizing changes). Transgender men are often prescribed testosterone while transgender women are prescribed androgen blockers and estrogen (Coleman et al., 2011; Hembree et al., 2017). The hormone therapy regimen is altered if the testes in transgender women or the ovaries in transgender men are removed (Unger, 2014). Those who receive hormone treatments must do so for the rest of their lives to maintain the masculinizing and feminizing effects of testosterone and estrogen respectively (Peate, 2008). Some people wish to achieve the maximum masculinizing/feminizing effects of hormone treatment, while others may prefer a more androgynous presentation from hormonal minimization of existing secondary sex characteristics (Coleman et al., 2011). Thus, there is space allowed for people with non-binary identities to pursue treatment goals which may not be at either end of the traditional gender spectrum (Houlberg; 2019).

Prescribing gender-affirming hormones is within the scope of a range of medical providers, including nurse practitioners, physician assistants, primary care physicians, and providers who have been trained in family medicine, internal medicine, geriatrics, obstetrics and gynecology, and endocrinology (Coleman et al., 2011; Deutsch, 2016a). Patients should be made aware of the risks associated with gender-affirming hormone therapy. For transgender women receiving estrogen, there is a very high risk of

thromboembolic disease and a moderate risk of experiencing macroprolactinoma, breast cancer, coronary artery disease, cerebrovascular disease, cholelithiasis, and hypertriglyceridemia. For transgender men receiving testosterone, there is a very high risk of erythrocytosis and a moderate risk of severe liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast or uterine cancer. Thus, it is critical for transgender individuals receiving hormone therapy to be monitored by their practitioner on an ongoing basis (Hembree et al., 2017).

Gender-affirming surgeries. For many transgender individuals, undergoing gender-affirming surgery is a step towards achieving their goal of living in their desired gender, as these procedures bring their physical bodies into alignment with their gender identity. Individuals who have had hormone therapy for at least 12 months can be referred for genital surgery if they are 1) satisfied with their social transition process, 2) satisfied with the effects of hormone therapy, and 3) definitively desire surgical changes (Coleman et al., 2011; Hembree et al., 2017). For transgender men, the surgeries can include mastectomy, hysterectomy, bilateral salpingo-oophorectomy, vaginectomy, metoidioplasty, phalloplasty, and scrotoplasty. For transgender women, the surgical interventions can include penectomy, bilateral orchiectomy, vaginoplasty, breast augmentation, tracheal surgery, facial feminization surgery, silicon injections, and voice surgery (Carabez et al., 2015; Hardacker, Chyten-Brennan et al., 2019; Houlberg, 2019; Peate, 2008; Zucker 2015). Depending on the nature of the surgery, the post-operative healing process can be lengthy and complex, and often involves specialists from multiple disciplines (e.g., wound care specialists, physical therapists, etc.) (Hardacker, Chyten-Brennan et al., 2019).

As with any surgical procedure, complications can develop such as wound infections, wound breakdown, and injury to surrounding structures (Hardacker, Chyten-Brennan et al., 2019). For transgender women, the risks also include necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, urethral stenosis, and having a vagina that is too short or too small for coitus (Coleman et al., 2011; Meltzer, 2016). For transgender men, the adverse outcomes of phalloplasty include urethral stenosis, fistulas, necrosis of the neophallus, pelvic or groin hematomas, rectal injury, and donor site scarring. Those who undergo metoidioplasty may have a micro-penis without the capacity to stand during urination (Coleman et al., 2011; Crane, 2016). Depending on the complexity of the complications, repeat surgeries may be required (Hardacker, Chyten-Brennan et al., 2019). Using an Informed Consent Model, transgender patients seldom expressed regret for undergoing surgery despite the complications they may have experienced (Coleman et al., 2011).

Other gender-affirming treatments. Transgender people may seek hair reduction or removal based on their personal and transition goals. Hair removal is often used by transgender women on their face, neck, or genital area (in preparation for vaginoplasty) while transgender men use hair reduction on their forearm or thigh future graft sites (in preparation for phalloplasty). Waxing and depilatory creams offer temporary measures. Many prefer a more permanent solution using laser hair removal and/or electrolysis—both of which require multiple sessions and can be somewhat painful. The combined use of laser hair removal and electrolysis offer the best results (Reeves, Deutsch, & Wilson Stark, 2016).

For transgender individuals, the incongruence between their gender and their voice and communication style can increase dysphoria and undermine their ability to pass as their affirmed gender identity. Aspects of voice and communication include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate, language and non-verbal communication. Voice and communication therapy can aid in the development of gender congruent voice characteristics and non-verbal communication skills. Voice therapy has proven to be effective in contributing to the perception of gender (Schneider & Courey, 2016).

Primary health care. Like everyone else, transgender people require routine medical care for disease prevention and health optimization (e.g., obtaining flu shots, etc.). Routine medical visits are also critical for risk assessments and detection of early stage disease. Yet, accessing culturally and medically competent primary care can be a challenge for transgender people due to structural barriers (such as their compromised access to health insurance and informational erasure leading to providers' knowledge deficit about trans health issues) (Bauer et al., 2009; Lerner & Robles, 2017; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). Consequently, many trans people do not have a primary care provider and often delay seeking care. The underutilization of health care can lead to poor health outcomes (Bradford et al., 2013; Cruz, 2014; Grant et al., 2011; James et al., 2016; Reisner, White et al., 2014; Stotzer et al., 2014). The following are highlights of the unique primary care needs which trans people may have.

Transgender individuals may have an increased risk of developing metabolic diseases secondary to hormone use. Therefore, individuals who are undergoing hormone therapy need routine lipid, glucose, and blood pressure screening, as well as testing for

liver function abnormalities. Bone mineral density measurements should be obtained if risk factors for osteoporosis exist, especially among individuals who have stopped hormone therapy (Unger 2014). The extant research on the risk of developing hormone-related tumors (i.e., breast, ovarian, and prostate cancer) are limited and results are inconclusive (Agénor, 2015). However, there is a concern that transgender people may be at higher risk of developing such cancers because of the extended exposure to estrogen therapy among trans women, remaining breast tissue among trans men who have had top surgery, and prolonged testosterone therapy converting to endogenous estrogen levels among trans men. Without appropriate care, malignancies may remain undetected (Levitt, 2015).

Transgender individuals may require different screening procedures and frequency depending on their hormonal and surgical status (Unger, 2014). Patients who have not undergone gender-affirming hormone treatment or surgery should receive cancer screening using the same criteria or risk parameters as for people of their natal sex (Deutsch, 2016b). However, clinical considerations are needed for those who are receiving hormone therapy or have undergone gender-affirming surgery. For example, long-term testosterone therapy can lead to vaginal and cervical atrophy which can alter Pap test results and make the examination process more uncomfortable. Researchers have found that transgender men were more likely than cisgender women to have an inadequate Pap test (i.e., the lack of sufficient cells or other obscuring factors rendering the test unreadable), which may be related to testosterone use and provider/patient discomfort with the exam (Peitzmeier, Reisner, Harigopal, & Potter, 2014). Because a painful Pap smear experience can hinder the collection of an optimal sample and reduce

the patients' adherence to future screenings, several strategies can be employed to reduce the patients' discomfort without compromising the Pap smear sample, including the use of a pediatric speculum or water-based lubricant (Hsaio, 2016). Trans men who have had a hysterectomy and have a prior history of cervical dysplasia or cervical cancer should undergo a Pap smear of the vaginal cuff (Levitt, 2015; Unger, 2015). For transgender women, the prostate-specific antigen levels (the screen for prostate cancer) may be falsely low if they have had prolonged exposure to estrogen therapy. While the digital rectal examination is recommended to evaluate the prostate in all trans women, a transvaginal examination of the prostate may be more effective for post-operative trans women who have undergone vaginoplasty (Levitt, 2015; Unger, 2014; Wesp, 2016). Certainly, the provider's knowledge about these clinical considerations, their use of effective screening methods for trans bodies, and the cultural sensitivity demonstrated by health care providers in their discussions with trans patients impact the patients' experience and the likelihood of their continued engagement with the health care system—or not.

Transgender people may make assumptions or have misconceptions about their susceptibility to acquiring certain diseases which can influence their decision making or how they respond to diagnosis or treatment. For example, a trans man who has had top surgery may perceive that his trans identity protected him against the risk of breast cancer. This misconception may result in his choosing not to undergo breast exams, thereby delaying diagnosis and early intervention. Medically competent health providers who have developed a strong relationship with their patients—and who are aware of their patients' anatomy—can conduct the proper screening necessary to detect disease.

Moreover, providers who are sensitive to the relationship between trans people's identities and their bodies can address the sociocultural beliefs which may impact their patients' treatment decisions (such as whether to undergo surgery which may affect their gendered appearance) (Lombardi & Banik, 2015).

Transgender people bear a heavy burden of HIV disease, particularly among transgender women and men who have sex with men. The high rate of HIV infection in transgender communities is related to multiple co-occurring public health problems, including high rates of violence, substance abuse, sexual abuse and assault, discrimination, and mental health problems. The HIV epidemic can be contextualized as a syndemic associated with structural and social inequities which synergistically reinforce and predict HIV risk (Glynn & van den Berg, 2017; WHO 2015). Transgender subpopulations who face heightened vulnerability for contracting HIV disease (e.g., sex workers, etc.) benefit from voluntary HIV testing on a routine basis.

For some individuals, being able to align their physical bodies with their gender identity takes precedence over seeking HIV prevention or care services. Transgender individuals who have difficulty accessing gender-affirming medical care for transition may inject hormones or soft tissue fillers (silicone) obtained outside of the formal health system. Without access to sterile injecting equipment, these individuals may share needles which increase their risk of infection with HIV and other bloodborne pathogens such as Hepatitis B and Hepatitis C (WHO, 2015). Consequently, difficulties in accessing medical transition services and the concerns about obtaining hormones or silicone from non-medical sources are particularly salient for trans individuals who have inadequate or lack of insurance due to their socio-economic status.

The risk of cervical cancer is a concern for transgender men. Nearly all cervical cancer is caused by contracting the human papilloma virus (HPV) through unprotected sexual activity (Hsiao, 2016). HPV is also a causal risk factor for anal cancer (Quinn et al., 2015). Routine medical visits with a culturally and medically competent health provider are essential for prevention, screening, and early intervention of disease.

Discussion about sexual preferences or identity may be uncomfortable for patients. However, such discussions are important to assess the patients' participation in behaviors which may place them at greater risk for certain diseases and to offer preventive treatments or solutions to mitigate this risk (Poteat, 2016c; Unger 2014). For example, given that transgender patients are at higher risk of contracting HIV and other sexually transmitted infections (STI), health care providers may counsel patients about safer sex practices. Other preventive measures include offering the pre-exposure prophylaxis or non-occupational post-exposure prophylaxis to minimize risk for HIV infection (Poteat, 2016b) and offering HPV vaccinations which hold great promise in the prevention of cervical and anal cancer (Quinn et al., 2015). The clinician's assessment of STI risk is based on the trans patient's sexual behaviors and current anatomy, without making any assumptions regarding sexual orientation or practices, or the presence/absence of specific anatomy. A sensitive and informed provider who understands the physiology of trans bodies can use appropriate screening measures to test for the presence of STIs (Poteat, 2016b). They are also mindful about potential drug interactions between hormone therapy and the medications to treat HIV or other pathogens (Poteat, 2016a, 2016b).

Transgender people also need counseling about reproductive health and the impact of transition on their fertility. The assumption that infertility is an absolute or universal outcome of hormone therapy is a false one. Pregnancy can result from any transgender person with gonads engaging in sexual activity (Amato, 2016). If the trans person wishes to have biological children in the future, then the options for fertility preservation and reproduction should be explored (e.g., sperm banking or egg freezing) (Amato, 2016; Hoffkling, Obedin-Maliver, & Sevelius, 2017). Discussion about family planning options should take place prior to the initiation of gender-affirming hormone therapy or surgery (Amato, 2016).

Transgender people face certain health vulnerabilities because of the discrimination they experience. The concept of stigma described earlier underpins the minority stress model, which explains how the experience of stigma can impact physical and mental health outcomes. Minority stress is defined as "the psychological stress derived from minority status" in relation to "the juxtaposition of minority and dominant values and the resultant conflict with the social environment experienced by minority group members" (Meyer, 1995, p. 38-39). Because of their experiences of discrimination committed against them at the structural and interpersonal levels, and the subsequent anticipation of these events, transgender individuals may begin to internalize the negative attitudes and prejudices to which they have been subjected (Hendricks & Testa, 2012, Meyer, 1995). At its extreme, individual stigma can manifest as internalized transphobia, which involves negative self-appraisal based upon societal expectations of gender norms and a rejection of this aspect of one's identity (Budge, Adelson, & Howard, 2013). To cope with their minority stress, transgender individuals may engage in behaviors such as

alcohol and substance abuse and dependence (James et al., 2016), which can lead to physical health problems. Research has shown that alcohol, tobacco, and drug use were more prevalent among transgender people compared to the LGB subgroups in the same study (Fredriksen-Goldsen et al., 2011), and compared to the general population in the U.S. (James et al., 2016). There is also a high prevalence of depression, anxiety, and suicidality among transgender populations (Hendricks & Testa, 2012). For example, 41% of transgender respondents in the National Transgender Discrimination Survey in the U.S. reported a lifetime prevalence of suicide attempt (James et al., 2016). Minority stress can precipitate health care need.

Transgender individuals who have been victimized by violence may seek medical interventions to treat their physical and psychological injuries. It is not uncommon for transgender people to experience physical or sexual violence related to their gender identity (i.e., the victims' perception of their perpetrators' motivation for this violence was transphobia or anti-transgender bias) (Cook-Daniels & munson, 2010; Grant et al., 2011, Stotzer, 2009). Stotzer's (2009) review of studies in the U.S. found that transgender people have experienced multiple types and incidences of violence and that, in many cases, the perpetrators were known to the victims. Among the study samples, the lifetime prevalence of physical and sexual violence due to their gender identity ranged from 33% to 53% and 10% to 69%, respectively. Research has also shown that visually non-conforming individuals were more likely to be victims of violence (Reisner et al., 2015). Here, transgender identity can intersect with socio-economic status, placing those who are economically disadvantaged—and thus, cannot afford gender-affirming treatments to become more visually conforming—at greater risk of experiencing violence.

The effect of transgender people's underutilization of health care services resulting in poor health outcomes is a real concern, especially given the evidence of a disproportionately high disease burden which exists among transgender populations. In their review of Medicare billing data in 2013, Proctor, Haffer, Ewald, Hodge, and James (2016) used ICD-9 codes relating to transsexualism and gender identity disorder to identify the transgender Medicare beneficiaries. Results revealed that three-quarters of the transgender Medicare beneficiaries in 2013 were under age 65 (76.7%), which implied that many of them enrolled in the program because of a disability. This contrasts sharply with the majority of the general Medicare population (75.6%) who qualified for Medicare through Old Age and Survivors Insurance, indicating that they were 65 or older. Many of the transgender beneficiaries (58.5%) suffered from either hyperlipidemia or hypertension, even though these diseases are typically associated with advancing age. Furthermore, over one-quarter of the transgender Medicare beneficiaries suffered from other conditions such as tobacco and drug use disorders, fibromyalgia, obesity, anemia, rheumatoid arthritis/osteoarthritis, asthma, diabetes, and heart disease. The researchers acknowledged that these results may underrepresent the true disease burden among transgender populations, as this dataset captured only those who had sought medical transition services or had been diagnosed with GID (Proctor, Haffer et al., 2016). Given known disease burdens, transgender people's underutilization of health care services can magnify these health disparities.

Health insurance coverage. Health insurance coverage for medically necessary services such as transition-related and preventive care for transgender people can be complex, and health care reform continues to be a hotly debated topic in the U.S.

Historically, insurance plans contained broadly written exclusions which denied coverage for care related to transsexualism, sex change treatments, gender identity disorders, or transgender care which meant that transgender individuals had to pay privately for such care (Wilson & Green, 2016). Enacted in 2010, the Patient Protection and Affordable Care Act (ACA) was designed to improve people's access to health insurance and eliminate the actions which health insurance companies employed to deny coverage, especially for people with pre-existing conditions. Additionally, the ACA expanded coverage for essential health benefits, including prevention services that can improve health outcomes for many chronic diseases. Section 1557, also known as the Health Care Rights Law, is the nondiscrimination provision of the ACA which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs and activities which receive federal funding (such as insurance carriers and hospitals), are administered by a federal agency (such as Medicaid, Medicare, TRICARE, Veterans' Health Administration programs, the Children's Health Insurance Program, and the Indian Health Service) or are governed by any entity established under Title 1 of the ACA (such as the federal and state-run Health Insurance Marketplaces and all insurance carriers that sell plans through the Marketplaces) (Lombardi & Banik, 2015; National Center for Transgender Equality, n.d.). However, this did not explicitly guard transgender people against discrimination in the health care system. For example, in some automated health insurance systems, transgender individuals were denied coverage for sex-specific procedures because of a sex-gender mismatch between the procedure code and the patient's electronic medical record. Thus, a transgender man noted as a male in his medical record would be denied coverage for a pap smear because this procedure was

strictly designated for female bodies. For many, navigating through the maze of health insurance policies and communicating with insurance carrier representatives who were not knowledgeable about gender transition procedures or how to respectfully support transgender individuals proved to be a frustrating experience. These adversities and systemic barriers contributed to transgender people's avoidance of or delayed entry into the health care system (Hardacker, Chyten-Brennan et al., 2019; Wilson & Green, 2016).

Most notably, an advancement for transgender people's rights was made by the Department of Health and Human Services' Office of Civil Rights in 2016, when they issued a final ruling to clarify existing nondiscrimination requirements and to set forth new standards in implementing Health Care Rights Law of the ACA (Department of Health and Human Services, 2016). The Department of Health and Human Services' regulation prohibited discrimination on the basis of sex which "includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity" (p. 337). Furthermore, it defined gender identity as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth" (p. 335). The ruling also offered protection for people who are intersex: "the prohibition on sex discrimination extends to discrimination on the basis of intersex traits or atypical sex characteristics" (p. 50). The Department of Health and Human Services' regulations apply to:

1. all health programs and activities, any part of which receives federal financial assistance administered by the Department of Health and Human Services

2. health programs and activities administered by the Department, including the federally-facilitated Marketplaces
3. health programs and activities administered by entities established under Title I of the ACA, including the state-based Marketplaces (p. 11).

For transgender people, the Department of Health and Human Services' regulation meant that insurance companies can no longer have automatic exclusions for transition-related care, to limit coverage, or to deny coverage for other care because of the individual's trans status. Insurance companies are prohibited from refusing coverage for gender-specific treatment if the individual identifies as a different gender than what is listed in their medical record. Furthermore, it is illegal for insurance companies to refuse enrollment, to cancel coverage, or to impose a higher premium rate because of a person's transgender status (National Center for Transgender Equality, n.d.). While the Department of Health and Human Services' regulation offered increased protection from discrimination for trans people, it did not eliminate all the systemic barriers related to payment for transition-related health care. There were some limitations which should be noted. Principally, the regulation does not require insurance carriers to provide universal coverage for all transition-related procedures. Insurance carriers are still allowed to make determinations on a case by case basis depending on whether the treatment is deemed medically necessary for the individual—though the standard of medical necessity cannot be higher for transgender people (National Center for Transgender Equality, n.d.). Furthermore, the regulation only applied directly to programs which are funded or administered by the Department of Health and Human Services (Department of Health and Human Services, 2016). The vast majority of health providers and insurance

companies fall into this category. However, the Department of Health and Human Services' regulation does not apply directly to other federal agencies such as the Office of Personnel Management and the Departments of Defense, Labor, and Veterans Affairs. Although these agencies must also adhere to the Health Care Rights Law of the ACA, they can have their own regulations related to coverage for transition-related care (National Center for Transgender Equality, n.d.). Currently, the Department of Defense TRICARE program provides coverage for hormone therapy and psychological counseling for gender dysphoria but excludes coverage for gender-affirming surgeries (see https://tricare.mil/CoveredServices/IsItCovered/GenderDysphoriaServices). The Veterans Health Administration will provide coverage for gender transition counseling, evaluations for hormone therapy, and medically necessary post-op care but will not pay for gender-affirming surgeries (see https://www.va.gov/health/newsfeatures/2017/january/transgender-vets-the-va-and-respect.asp). These inconsistencies in policy result in inequitable access to medical transition services.

Health insurance coverage for medical transition services is a vital component of health care access for transgender people. The demand for gender-affirming surgeries appears to be on the rise, as evidenced by Canner et al.'s (2018) study of temporal trends in the uptake of such surgeries among transgender patients in the U.S. In their analysis of the National Inpatient Sample from 2000 to 2014, there was a four-fold increase in the incidence of patients who had ICD-9 diagnosis codes of transsexualism or GID. Their sub-analysis of patients who sought gender-affirming surgery during 2000 to 2011 found an increase of patients who received genital surgery alone, from 72% during the period of

2000 to 2005, to 83.9% during 2006 to 2011. Moreover, the latter cohort of patients were more likely to pay out of pocket for these procedures, as 65.8% of these patients had no health insurance coverage, compared to 50.8% who had no insurance coverage during the period between 2000 to 2005. From 2012 to 2014, the evidence points to an increase in the number of genital surgeries covered by Medicare. The authors posit that this increase may have been influenced by the full enactment of the ACA in 2014. Thus, adequate health insurance coverage enables transgender people to access previously unaffordable, yet medically necessary, gender-affirming care (Canner et al., 2018).

Yet, for transgender individuals who are insured, barriers to access may persist. Given the limited availability of culturally competent health providers and the limited coverage of many gender-affirming surgeries (which may be deemed cosmetic or medically unnecessary by the insurance company), transgender patients may be forced to pay privately for a provider who is outside of their plan, which leads to higher expenditures. Furthermore, the cost of copayments, deductibles, and out-of-pocket expenses can make health care unaffordable, even for those with insurance (White Hughto, Murchison, Clark, Pachankis, & Reisner, 2016; White Hughto et al., 2015).

Theoretical Framework

Intersectionality theory. Crenshaw (1989) is credited with introducing the term intersectionality in her seminal essay entitled, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics* which illuminated the erasure of Black women in feminist theory and anti-racism politics. In it, she explains the limitations of a single-axis framework of power in understanding the dynamics of racism and sexism, which does not accurately

reflect the interaction of race and gender, and that there exists a multidimensionality of oppression. Rooted in Black feminism and Critical Race Theory, the framework of intersectionality has been instrumental in advancing knowledge about the ways in which multiple social identities intersect at the individual level to reflect interlocking processes or systems of privilege and oppression at the structural level (Bowleg, 2012, Hulko, 2009; Mullaly, 2010). It examines similarities and differences, and their relation to power; it is a method of thinking about and conducting analyses (Cho, Crenshaw, & McCall, 2013). Intersectionality theory has been used across other disciplines and has travelled internationally as academics and policy makers have engaged in discourse to address the global dimensions of power, privilege, and oppression (Carbado, Crenshaw, Mays, & Tomlinson, 2013). This lens has enabled researchers to conceptualize and examine disparities in health care access and health outcomes, particularly for populations which have been historically oppressed and marginalized (Bowleg, 2012).

Critics of intersectionality theory assume a preoccupation with categories or identities which emphasizes difference between groups. However, intersectionality theory is primarily concerned with an interrogation of the power and structural inequities which produce and reproduce oppression (Cho et al., 2013). As one of its basic tenets, this framework does not assume that all interlocking identities are equally disadvantaged. Hence, there are varying degrees of oppression and privilege based on one's social location as it relates to sex, gender, sexual orientation, race, age, ability, religion, class, education, language, and all the dimensions of social inequality which can manifest. It acknowledges the multiplicity of oppression that can be experienced by people who belong to more than one marginalized community. Intersectionality theorists are

committed to advocacy and social justice for marginalized groups. By acknowledging differences and promoting commonalities, intersectionality theory potentiates the ability to build coalitions. It reveals how the structures of oppression experienced by separate identity groups are linked, thus creating a shared experience of privilege and marginalization which can be used to forge alliances and facilitate social change (Carbado et al., 2013). Moreover, the complex dynamics of privilege and oppression are temporally and context dependent (Hulko, 2009). Therefore, the framework can be useful in understanding paradoxical or unanticipated findings (Bowleg, 2012). Given the heterogeneity which exists in transgender communities, the aim to advance understanding of the risk and protective factors which influence their health care access, and how these factors may moderate their experience of accessing care, the theoretical framework of intersectionality will be used to guide this study—an approach also supported by the Institute of Medicine's Committee on LGBT Health (2011).

Health care access models. Access to health care is defined as the "timely use of personal health services to achieve the best possible outcomes" (Institute of Medicine, 1993, p. 4). Yet, interpersonal and structural discrimination can impact health care accessibility in manifold ways. Access is often characterized as the ability and ease of the consumer to seek and obtain needed services from providers or institutions as well as the cost of health care. Access is also influenced by the characteristics of health care providers and potential consumers; these characteristics can impact service delivery and service consumption (Levesque, Harris, & Russell, 2013; Pechansky & Thomas, 1981). In their systematic review of access to health care, Levesque et al. (2013) conceptualized accessibility as consisting of the following dimensions: (a) approachability (e.g.,

information regarding available treatments and services, outreach activities, transparency, etc.); (b) acceptability (e.g., professional values and norms, sociocultural factors which impact the consumer's level of acceptance to aspects of the service, judged appropriateness of the consumer seeking care, etc.); (c) availability and accommodation (e.g., geographic location of the service, hours of operation, building accessibility, presence and qualification of the health professional, modes of provision of services, etc.); (d) affordability (e.g., capacity of consumers to spend resources and time to utilize services, direct costs of services, related costs such as travel time, opportunity costs related to loss of income, etc.); and (e) appropriateness (e.g., the fit between the services and the consumers' needs, the technical and interpersonal quality of the services provided) (p. 5-6). For the trans community, each of these dimensions of accessibility is compromised, as evidenced by their challenges with health care assess at the interpersonal and structural levels. Moreover, trans individuals with certain sociodemographic characteristics may be at greater disadvantage in accessing health care. For example, health insurance and income are significant predictors for postponement of care. Transgender people without health insurance were nearly five times more likely to postpone care due to affordability concerns compared to trans individuals with private health insurance (Cruz, 2014). Race/ethnicity is another risk factor as it may challenge acceptability (related to providers' attitudes about the preferred attributes of their clients) (Pechansky & Thomas, 1981). Indeed, evidence has shown that transgender people of color experience higher levels of discrimination when accessing health care and social services than their white counterparts (Kattari, Walls, Whitfield, & Langenderfer-Magruder, 2015, 2017).

The Health Care Access Barriers Model complements and overlaps with Levesque et al.'s model. It provides a pragmatic framework to identify, classify, and target access barriers associated with adverse health disparities experienced by vulnerable populations. Carrillo et al. (2011) described three main types of modifiable and interlinking access barriers: (a) financial, (b) structural, and (c) cognitive. Financial barriers emphasize the affordability of care which include being uninsured or underinsured. Structural barriers consist of institutional and organizational barriers including the availability and proximity of the health care providers or facilities, transportation, the availability of child care resources, waiting time, etc. Cognitive barriers are knowledge and communication barriers which include the patients' beliefs about the disease, prevention and treatment, the patients' health literacy, the quality of the provider-patient communication, availability of cross-cultural communication services, racial/ethnic concordance between patient and provider, etc. The financial, structural, and cognitive barriers can occur independently, simultaneously, or sequentially, and can have a compounding effect on each other. These access barriers are associated with three intermediary measures: (a) decreased screening, (b) late presentation to care, and (c) lack of treatment, which can lead to poor health outcomes and health disparities. By targeting the measurable and modifiable barriers, the Health Care Access Barriers model can be used as a framework to facilitate root-cause analysis, intervention design, and research using factor analysis or regression analysis (Carrillo et al., 2011).

Interface with the Health Care System

The architecture of exclusion created by stigma, cisnormativity, erasure, and cisgenderism is evidenced in the barriers and the poor quality of care that transgender

people encounter when they interface with the health care system. These barriers occur at multiple levels and can have cascading effects. Erasure and cisnormativity marginalize trans people and make their experiences unintelligible to health providers, as in the case of pregnant trans men seeking routine perinatal care (Hoffkling et al., 2017). Multiple studies have illuminated transgender people's experiences of their health providers' knowledge deficit, which creates tension in the provider-patient relationship and results in trans people feeling as though their bodies were anomalies (Chisolm-Straker et al., 2017; Lindroth, 2016; Poteat, German, & Kerrican, 2013; von Vogelsang, Milton, Ericsson, & Stromberg, 2016). Health care providers themselves have identified multiple barriers which prevent them from providing respectful and inclusive care, such as: their trans-specific medical knowledge deficit; a health care system which adheres to a restrictive binary model of gender (effectively negating individuals who do not conform to a two-gender paradigm); lack of knowledge about or the availability of gender inclusive forms; the medical profession's historical bias towards pathologizing trans status; the limited availability of referral networks for trans medical care; lack of familiarity with terminology, distinctions between various trans communities, and their cultural norms; the conflation of gender identity with sexual orientation; and time constraints which impede their ability to build trusting therapeutic relationships (Carabez et al., 2015; Lurie, 2005; Snelgrove et al., 2012).

Researchers have examined other interpersonal and structural barriers that transgender people encounter in their access to health care (Bauer et al., 2014; Bradford et al., 2013; Fredriksen-Goldsen et al., 2011; Grant et al., 2011; Gonzales & Henning-Smith, 2017; James et al., 2016; Kosenko, Rintamaki, Raney, & Maness, 2013; Lambda

Legal, 2010; Lerner & Robles; One Colorado, 2014; Reisner, White et al., 2014; Stotzer et al., 2014). Examples of such barriers include: being denied care (i.e., trans-related or other health care); receiving substandard care; receiving forced care (e.g., unnecessary examinations, psychiatric care); lacking health insurance; health providers' knowledge deficit about trans health issues; providers' gender insensitivity; providers' displays of discomfort; health care professionals using harsh or abusive language; health care professionals being physically rough or abusive; receiving verbal harassment in a health care setting; being physically attacked in a health care setting; and lack of a primary care physician. These experiences can result in transgender patients postponing or not receiving needed medical care.

In a rapid systematic review of surveys which estimated the prevalence of interpersonal and structural barriers to health care access experienced by transgender people, Kcomt (2018) found that over one quarter of the transgender population in the U.S. have been denied care by a health provider at least once in their lifetimes. Furthermore, transgender individuals were more than twice as likely as LGB people to be denied care. Between group comparisons within the same primary study revealed an even greater disadvantage: Lambda Legal (2010) and Fredriksen-Goldsen et al. (2011) showed that transgender patients in the U.S. were three times more likely to have been denied health care and almost two times more likely to have been abused verbally or physically by their health care providers than members of the LGB population. Considering their negative experiences with health care providers, it is not surprising, then, that almost one-quarter of transgender people have delayed receiving necessary medical care and preventive medical care in the past 12 months (Kcomt, 2018).

Using the Behavioral Risk Factor Surveillance Survey (BRFSS), a probability-based sample, researchers have made comparisons between transgender and cisgender populations in their access to health care. Results revealed that transgender people were more likely than cisgender women to be uninsured and to have unmet health care needs, and less likely to receive routine care. Interestingly, cisgender men were observed to experience barriers similar to those of transgender people in the sample, suggesting that health care access may be influenced by gender (Gonzales & Henning-Smith, 2017). In a study which compared access to health care between trans men and cisgender men, results showed that trans men had less access to health care. However, the results were not statistically significant after controlling for sociodemographic factors, suggesting the greater socio-economic vulnerability of trans men. These findings support the use of intersectional strategies to mitigate racial and economic inequalities when serving trans men (Seelman, Miller, Fawcett, & Cline, 2018).

Researchers have begun to examine the unique experiences of subgroups within the transgender population in the U.S. Transgender people of color had less education, lower incomes, and poorer health insurance compared to their white counterparts (Erich, Tittsworth et al., 2010). Individuals who were recognizable as a trans person faced increased risk of discrimination by health care providers. Those who delayed care because of fear of discrimination tended to be in the lower income strata and to be in poorer physical and mental health (Seelman et al., 2017). Transgender people who were visually non-conforming were more likely to report perceived discrimination by health care providers (Kattari & Hasche, 2016; Miller & Grollman, 2015).

The experiences of trans men in the U.S. have also been explored. Rachlin, Green, and Lombardi (2008) examined trans men's utilization of transition-related health care and found that many received hormone therapy and had undergone or planned to have top surgery, but most were foregoing bottom surgery. Studies have found that trans men were more likely than trans women to experience discrimination from health care providers or to postpone care due to fear of discrimination and that factors such as socio-economic status, ethnicity, health insurance, relationship status, and sexual orientation influenced their outcomes (Cruz, 2014; Jaffee, Shires, & Stroumsa, 2016; James et al., 2016; Shires & Jaffee, 2015). Trans men with low incomes, no health insurance, and who were not single were much more likely to postpone care (Cruz, 2014). Trans men who were Native Americans or multiracial, queer, or unemployed had increased risks of experiencing discrimination or of delaying care because they feared such discrimination (Jaffee et al., 2016; Shires & Jaffee, 2015).

Although the above findings about trans men are consistent with the intersectionality framework, several limitations were noted in these studies. For example, Jaffee et al. (2016) identified that multiple factors (minority racialized group membership or sexual orientation, and lower levels of education) contributed to increased odds of delaying needed health care among trans men. However, wide confidence intervals (CI) were not definitive in establishing that those were indeed risk factors and not chance associations. Additionally, the studies cited above (Cruz, 2014; Jaffee et al., 2016; Shires & Jaffee, 2015) contained smaller, inadequately powerful, samples of trans men who responded to the 2008 National Transgender Discrimination Survey in the U.S. Previous studies on health care discrimination experienced by transgender people examined the

prevalence of being denied care without distinguishing specifically the type of health care to which access was being denied (i.e., primary care versus trans-related care). The present study uses a more recent national database of transgender people in the U.S. with a much larger sample to confidently establish risks and protections, to estimate their strength of association with discrimination experienced especially by trans men, and to explore the interactions of gender identity with other potential risk and protective factors.

Research Questions and Hypotheses

In bringing trans men from the margins of transgender health research to the center, this study extends the current body of knowledge by addressing the following research questions and their respective hypotheses:

1. Is there a significant association between gender identity and access to health care? Hypothesis: Trans men are less likely than trans women to have access to health care. This hypothesis will be tested across nine measures of health care access:

    a) Delaying health care during the past year due to cost
    b) Delaying health care during the past year due to possible mistreatment
    c) Being denied trans-related health care during the past year
    d) Being denied other health care during the past year
    e) Experiencing at least one insurance denial during the past year
    f) Being respected by a health care provider during the past year after disclosing trans identity
    g) Trans-related provider being rated by participants as knowing some or almost nothing about trans-related health care
    h) Having seen a doctor or health care provider during the past year

i) Receiving gender-affirming hormone treatments or surgery

2. Is there a significant association between racialized group status and access to health care?

Hypothesis: Racialized minority group members are less likely than non-Hispanic white people to have access to health care.

3. Is there a significant association between poverty and access to health care?

Hypothesis: Individuals who live in poverty are less likely than those who are not living in poverty to have access to health care.

4. Is there a significant association between having health insurance and access to health care?

Hypothesis: People with health insurance are more likely to have access to health care than those who do not have health insurance.

5. Is there a significant association between disclosure of trans identity and access to health care?

Hypothesis: Individuals who have disclosed their trans identity are more likely to have access to health care than those who have not disclosed their trans identity.

6. Is there an interaction of gender identity with race in access to health care?

Hypothesis: The gender identity divide (i.e., disadvantage of trans men) is larger among racialized minority group members than among non-Hispanic white people.

7. Is there an interaction of gender identity with poverty in access to health care?

Hypothesis: The gender identity divide (i.e., disadvantage of trans men) is larger among those who live in poverty than among those who do not.

8. Is there an interaction of gender identity with health insurance in access to health care?

Hypothesis: The gender identity divide (i.e., disadvantage of trans men) is smaller among those with health insurance than among those without.

9. Is there an interaction of gender identity with disclosure of trans identity in access to health care?

Hypothesis: The gender identity divide (disadvantage of trans men) is smaller among those who have disclosed their trans identity than among those who have not.

Note: Hypotheses 2 through 9 will be systematically replicated across the same nine health care access measures listed under Hypothesis 1.

Chapter 3: Methodology

The 2015 U.S. Transgender Survey

Design and sample recruitment. This study secondarily analyzed the 2015 U.S. Transgender Survey (USTS) database. Implemented by the National Center for Transgender Equality (NCTE)—a social justice organization committed to advancing the rights of transgender people—the 2015 USTS received an unprecedented response resulting in the largest database of transgender people in the world to date (N = 27,715) (James et al., 2016). It examined the experiences of transgender adults living in the U.S. or on any American military base. Eligibility criteria for the survey were: (1) 18 years of age or older; (2) currently residing in a U.S. state or territory, or an American military base; (3) at any stage in the gender transition process; and (4) self-identified as transgender, trans, gender queer, non-binary, or another identity on the transgender spectrum. Institutional Review Board approval was obtained from the University of California Los Angeles for the original survey, and this analysis of the 2015 USTS data was reviewed and cleared by the Research Ethics Board at the University of Windsor.

The primary researchers used non-probability sample methods, which consisted of direct outreach, modified venue sampling, and snowball sampling. The robust sample size is likely a result of the extensive outreach efforts which began approximately six months prior to the data collection period. The outreach strategy was a multi-pronged approach designed to reach as many transgender people as possible through various points of access, including transgender or lesbian, gay, bisexual, transgender, queer (LGBTQ)-specific organizations, support groups, health centers, and online communities. The NTCE established a network of supporting organizations to facilitate the recruitment

of a diverse transgender sample. Over 800 organizations were contacted through email, phone, and social media. Approximately half of these organizations responded to the request for support by performing outreach to assist with the sample recruitment efforts. The NCTE also convened an advisory committee to promote community engagement in the survey project and to facilitate the collection of data which best reflected the range of narratives and experiences of transgender people in the U.S. Multiple communication methods were used to promote awareness about the survey including email, print media, social media, and additional creative campaigns. The survey and its promotional materials were available in both English and Spanish to increase accessibility. This diverse, coordinated approach was intended to expand the survey's reach to a wide range of transgender people, and likely contributed to the unparalleled response.

Instrumentation. The survey instrument was developed over the course of a year by a team of researchers and advocates in collaboration with individuals who had lived experience. Careful attention was paid to language, balancing the need for accessibility while maintaining comparability with existing national surveys (e.g., American Community Survey [ACS], BRFSS, etc.). Great efforts were made to avoid potentially stigmatizing or value-laden language and to use inclusive terminologies that would be accessible to the widest range of transgender people, given the diversity which exists within the spectrum of transgender identities.

The primary study researchers decided to disseminate the survey online, given the length and complexity of the skip logic used through the questionnaire. The survey contained a total of 324 possible questions in 32 sections addressing a variety of subjects such as experiences related to health and health care access, education, employment,

housing, law enforcement, military service, etc. (Appendix A). The self-administered survey consisted mainly of closed-coded questions with fixed choice responses. In addition, participants were offered the opportunity to provide narrative responses to 53 questions. The online survey platform with the use of skip logic allowed the participants to receive questions that were appropriate based on their previous responses. As a result of this customization, the length of the survey varied between participants.

The National Transgender Discrimination Survey (N = 6,450), conducted by the NTCE in 2008, was the USTS's precursor. Multiple health services researchers have analyzed its database and published their results in peer reviewed journals (see Cruz, 2014; Jaffee et al., 2016; Kattari et al., 2015, 2017; Miller & Grollman, 2015; Rodriguez et al., 2017; Shires & Jaffee, 2015). Additionally, the Institute of Medicine (2011) highlighted the results of this survey in its report on *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. When the NTCE created the 2015 USTS's instrument, many of its questions were adapted from the National Transgender Discrimination Survey. In addition, many of the 2015 USTS's questions were drawn from other national surveys. Furthermore, the variables related to health care access had been used in previous studies of transgender people (see Grant et al., 2011; Fredriksen-Goldsen et al., 2011; Lambda Legal, 2010; One Colorado, 2014; Reisner, White et al., 2014; Stotzer et al., 2014), observing associations between variables in predictable ways and offering evidence of construct validity of key outcome measures. Lastly, the questionnaire was reviewed by stakeholders (researchers, advocates and members of the transgender community) for face validity during its development.

Data collection. The primary researchers used a unimodal data collection method through an online self-administered survey. The survey was launched on August 19, 2015 and data collection continued for 34 days. Access to the survey was exclusively through the USTS website and participants could complete the survey using a computer, phone, or tablet. Some community organizations held Survey Taking Events, offering space and resources (computers or other web-enabled devices) to facilitate access. This was intended to increase accessibility for transgender individuals without internet access, who needed assistance with completing the survey, or who needed a safe place to complete the survey. To maintain the integrity of the data collection process, the NCTE established a protocol with best practice guidelines for these Survey Taking Events. The protocol included rules for hosting a Survey Taking Event, ways to conduct community outreach about the event, and guidelines to prevent the introduction of bias. Host organizations were required to inform the NCTE of their survey event. Seventy-one organizations hosted Survey Taking Events.

The USTS questionnaire began with a Study Information Sheet describing the study and the rights of participants. To be included in the study, participants were required to indicate their consent. This established that the participants were fully informed about the potential risks and benefits of their voluntary participation. Consenters were then advanced to the Survey Instructions screen. See Appendix A for copies of the Study Information Sheet, Consent Form, and Survey Instructions. As an incentive to complete the survey, participants were offered the opportunity to enter a drawing for three cash prizes (one $500 and two $250 prizes).

Certain sections of the survey asked participants about experiences which may be

emotionally difficult (e.g., Section 16 [suicidal thoughts and behaviors] and Section 18 [unwanted sexual contact]). At the beginning of these sections, participants were notified about the subject area of the questions and were thus encouraged to seek help from someone they trusted or to contact the anonymous helplines which were provided at the end of these sections. These resources were listed again at the end of the survey.

Study Sample

The original sample from the 2015 USTS was heavily skewed towards the youngest age cohort, where 42.7% of the sample was between the ages of 18 and 24 and its cohort of older adults aged 65 and over was quite limited (2.9%). Such was likely influenced by the methods used for sample recruitment and online data collection (Hash & Spencer, 2007; Miner et al., 2012; Rachlin, 2007; Shapiro, 2004). To address this concern the sample for the present analysis was restricted to transgender respondents aged 25 to 64. This decision was motivated by practical analytic concerns. It would enable a more accurate analysis of the respondents' socio-economic status (SES), minimizing the chances that theirs would be confounded by their parents' SES. The second motive to so restrict the analytic sample was related to one of the central aims of this study, that is, to assess barriers to health care access among transgender people. A well-known such barrier in the U.S. is health insurance inadequacy, and there are greatest needs for and variability in health insurance statuses among people between the ages of 25 and 64 (DeNavas-Walt & Proctor, 2015). Those 25 or older are unlikely to be covered by their parents' health insurance plans and those 65 or older are eligible for Medicare, the federal health insurance program for older adults and disabled people. Finally, respondents who identified as crossdressers (2.7%) were excluded from the study sample.

Crossdressing is regarded as a form of gender expression and does not necessarily reflect gender identity. The sample for the present analysis was 14,540 transgender respondents.

Study Measures

Outcomes. Levesque et al.'s (2013) five categories of health care access and Carrillo et al.'s (2011) three categories of health care access barriers were used as the lens through which the outcome variables were selected based on their face and criterion validity. Reflecting dimensions of health care access, nine outcomes were analyzed:

1. Delaying health care during the past year due to cost ("Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?")
2. Delaying health care during the past year due to possible mistreatment ("Was there a time in the past 12 months when you needed to see a doctor but did not because you thought you would be disrespected or mistreated as a trans person?")
3. Being denied trans-related health care during the past year ("A doctor or other health care provider refused to give me trans-related care.")
4. Being denied other health care during the past year ("A doctor or other health care provider refused to give me other health care [such as a physical exam, flu shot, or diabetes care].")
5. Experiencing at least one insurance denial during the past year
6. Being respected by a health care provider during the past year after disclosing trans-identity ("My doctor knew I was trans and treated me with respect.")
7. Trans-related provider knowing some or almost nothing about trans-related health care ("Thinking about the doctor or provider you go to for your trans-related

health care [such as hormone treatment], how much do they know about providing health care for trans people?")

8. Having seen a doctor or health care provider during the past year ("In the past year, have you seen a doctor or health care provider?")
9. Receiving gender-affirming hormone treatments or surgery

Delaying care, being denied care, and being denied by an insurance company are indicative of barriers to health care access. Two of these variables (i.e., being respected by a health care provider after disclosing trans identity and trans-related provider knowing some or almost nothing about trans-related health care) may be more subjective in nature. However, they relate to the respondents' perception of their providers' acceptance and cognitive barriers which may impact the quality of their care. Utilization of services (i.e., having seen a doctor or health care provider in the past year and receiving gender-affirming hormone treatments or surgery) are reflective of the availability and accommodation of health care services.

These variables all have dichotomous response sets. In most instances, a yes/no response was required. Variables which had multiple ordinal response categories (e.g., provider's knowledge about trans-related health care) were subsequently dichotomously recoded. Two of the outcomes were composite variables created by the primary researchers (insurance denial and received hormone treatments or surgery). For insurance denial, seven items were provided and respondents were asked to select all that applied to them. Respondents who selected at least one instance of denial were categorized as "yes." Multiple questions were also asked to assess respondents' receipt of gender-affirming hormone treatments or surgeries based on their assigned sex at birth.

Those who received hormone treatments or any such surgery were categorized as "yes."

Main predictors.

Gender identity. Gender Identity was chosen as the centrally hypothesized predictor because previous research has shown that trans men experienced greater challenges with health care access than trans women (Cruz, 2014; Jaffee et al., 2016; James et al., 2016; Shires & Jaffee, 2015). Respondents were asked to choose one of six terms that best described their gender identity (cross dresser, woman, man, trans woman [MTF], trans man [FTM], and non-binary/gender queer). As the centrally hypothesized predictor, the gender identity variable was recoded into three categories (transgender women, non-binary/gender queer, and transgender men), with cross-dressers being excluded from the study sample. The referent for gender identity comparisons was transgender women.

Race. Race was selected as a predictor variable based on previous research which showed racial/ethnic differences in the experience of discrimination in health care access among transgender populations (Kattari et al., 2015) as well as in the U.S. general population (Hausmann, Jeong, Bost, & Ibrahim, 2008). The survey instrument provided 10 response categories for racial/ethnic identity. Balancing desires to maintain both racial heterogeneity and statistical power, race was recoded into five categories: non-Hispanic white, Hispanic, African American, biracial/multiracial, and others. Because the sample was predominantly non-Hispanic white (83.4%) with relatively small subsamples of Asian Americans (2.0%), Alaska Native/American Indian (1.4%), Native Hawaiian/ Pacific Islander (0.3%), and racial/ethnic identity not listed (0.2%), these were combined into "others." The referent for racial/ethnic identity comparisons was non-Hispanic white.

Lives in poverty. Health, health care, and poverty are interconnected; there are income-related disparities to health care access in the U.S. Many low-income people do not qualify for Medicaid and private insurance is often unaffordable for them even when it is available. Those who live in poverty are more likely to have no health coverage, as much of their household budgets are used to cover basic needs such as food and housing (Hoffman & Paradise, 2008; Institute of Medicine, 2009). Transgender individuals experience higher levels of unemployment and poverty than non-transgender people (Crissman, Berger, Graham, & Dalton, 2017), making their access to health insurance more challenging (Institute of Medicine, 2011). Even for those with health insurance, many private and public health plans have denied or limited their coverage of gender-affirming medical treatments (Institute of Medicine, 2011). Thus, the affordability of general health care or transition-related care is problematic for many transgender individuals. The USTS included items (i.e., age of householders, and household size and income) which enabled the assessment of poverty based on the U.S. Census Bureau's official poverty measure. Using these items, the primary researchers created a poverty measure identifying respondents who lived below the federally established poverty line.

Has health insurance. The U.S. has a multi-tiered health insurance system consisting of both private and public sectors. It is largely based on employer sponsored private insurance, with public insurance for the elderly and disabled (i.e., Medicare) and for those living below the poverty line (i.e., Medicaid). Research has shown that having health insurance coverage enables timely access to health services, and that being uninsured leads to adverse health outcomes, health disparities, and poorer quality of life (Blackwell, Martinez, Gentleman, Sanmartin, & Berthelot, 2009; Hoffman & Paradise,

2008; Institute of Medicine, 2009). Moreover, transgender individuals were more likely to be uninsured than cisgender individuals (dickey et al., 2016). Health insurance status was assessed by the following item, “Are you currently covered by any health insurance or health coverage plan (yes/no)?” Having health insurance was used as the referent category.

Disclosure of transgender identity. For transgender individuals, the disclosure of their trans identity or *coming out* is a complex issue and is often dependent on the availability of resources and support as well as their sense of safety and control (Ducheny et al., 2019). There can be varying degrees of disclosure based on the setting, social context, and the individual’s transition status (Budge et al., 2013; Hoffkling et al., 2017). Being out exposes transgender individuals to the risk of transphobic violence, discrimination, and potential loss (Budge et al., 2013). However, disclosure also potentiates the ability to access social support and to experience internal and external affirmation of their gender identity (Hoffkling et al., 2017). The shared social connectedness and sense of belonging with transgender community members is an important aspect of developing resilience and enhancing coping skills. Those who avoid disclosure may have a constant worry of being discovered or outed by others, creating a sense of hypervigilance and self-consciousness in public interactions (Ducheny et al., 2019). Through their disclosure, transgender individuals can experience increased levels of social support, increased self-esteem, and decreased levels of psychological distress (McCann & Brown, 2017; Strain & Shuff, 2010).

Disclosure of trans identity was used as a proxy for social support in this study. Participants were asked, “How many people in each group below currently know you are

trans?" The response set consisted of five categories (all know that I am trans; most know that I am trans; some know that I am trans; and none know that I am trans; I currently have no people like this in my life) for eight categories of people (immediate family you grew up with [mother, father, sisters, brothers, etc.]; extended family [aunts, uncles, cousins, etc.]; lesbian, gay, bisexual, or trans [LGBT] friends; straight, non-trans [non-LGBT] friends; current boss/manager/supervisor; current coworkers; current classmates; current health care providers). The primary researchers computed a summary measure, the Disclosure of Transgender Identity Scale, which was recoded to reflect categorical degrees of outness that ranged from having disclosed to no one (referent) to everyone. Chronbach's α for the Disclosure of Transgender Identity Scale was 0.83 among this study's sample with two interrelated factors that accounted for 63.0% of the inter-item variability, one of which accounted for 75.6% of that variability.

Covariates. Potential confounds were used to control for health care need when examining service use or quality. Multiple theoretically informed confounds were examined including age, general health status, disability status, visual conformity, HIV status, and immigration status. If a variable was significantly associated with the centrally hypothesized predictor (gender identity) and the outcome variable in bivariate analyses, then it met the minimum definition of an analytic confound and was included in the subsequent multivariable analysis. HIV status and immigration status were tested and found to be not significantly confounding or predictive. Thus, the four principle confounding variables routinely accounted for when testing the hypotheses were age, general health status, disability status, and visual conformity.

Age. Participants were asked to indicate their age using a drop-down list of all ages from "18 through 99," and "100 and above". Age was recoded into four categories: 25 to 34; 35 to 44; 45 to 54; and 55 to 64. The referent for age comparisons was 25 to 34.

General health status. Single items measuring subjective health have been found to have validity in predicting help seeking behavior and health care utilization (Bowling, 2005; Shields & Shooshtari, 2001) and self-reported health status has been observed to be inversely associated with the number of physician visits per year (Miilunpalo, Vuori, Oja, Pasanen, & Urponen, 1997). Self-reported general health rating is used in the BRFSS, a U.S. national health survey conducted by the Centers for Disease Control and Prevention. To facilitate comparison with the U.S. general population, self-reported health status was included in the 2015 USTS. Respondents were asked to assess their general health status with the item, "Would you say that in general your health is…" The response set consisted of five categories: excellent, very good, good, fair, and poor. The sample size of those who answered "poor" was very small (4.5%) relative to the other response categories and thus, the "fair" and "poor" categories were combined in this analysis, resulting in a recoded variable with four response categories. The referent for health status comparisons was "excellent" health.

Any disability. Respondents were asked a series of questions drawn from the ACS to assess if they had any disabilities ("Are you deaf or have serious difficulty hearing? Are you blind or have serious difficulty seeing even when wearing glasses? Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Do you have serious difficulty walking or climbing stairs? Do you have difficulty dressing or bathing? Because of a physical, mental, or

emotional condition, do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?" The primary researchers computed a summary measure which identified respondents who reported having any one or more of the individual disabilities.

Visual conformity. Visual conformity was included as a potentially confounding variable because there is evidence to suggest that one's recognizability as transgender is positively associated with experiencing discrimination in a health care setting (Rodriguez et al., 2017) and that gender non-conformity may heighten transgender people's exposure to transphobic discrimination (Grant et al., 2011; Miller & Grollman, 2015; Reisner et al., 2015). Respondents were asked, "People can tell I am trans even if I don't tell them." The response set had five categories: always, most of the time, sometimes, rarely, and never. This variable was recoded into three response categories: visual conformers (where other people could not tell that the individual was trans), somewhat visually conforming, and visually non-conforming (where others can tell that the individual is trans). The referent was visual conformers.

Interaction terms. To observe whether the predictive associations of gender identity with outcome measures of health care access or quality were moderated by the other main predictors, four interaction terms were computed (variable 1 x variable 2). They consisted of two-way interactions between gender identity and race, lives in poverty, has health insurance, and disclosure of trans identity, respectively.

Analytic Plan

Descriptive statistics. Univariate frequency distributions were used to describe the study sample. Because all of the outcome or criterion variables were discrete and

binary, and all of the predictor variables (centrally hypothesized as well as covariates) were also categorical, examinations of parametric assumptions with diagnostic descriptive statistics (means, medians, standard deviations and measures of skewness, kurtosis and their standard errors) were moot.

Bivariate analyses. Nonparametric chi-square tests were used to test the associations between the following:

- gender identity with all the other predictors and covariates.
- gender identity with all the outcomes
- all the predictors and covariates with all the outcomes.

The criterion for statistical significance was a two-tailed α of 0.05 ($p < .05$).

Multivariable analyses. Logistic regression models tested the nine hypotheses across nine different outcomes. Logistic regressions were preferred because the outcome variables were all dichotomous (Harrell, 2015; Hosmer, Lemeshow, & Sturdivant, 2013; Kleinbaum & Klein, 2010; Vittinghoff, Glidden, Shiboski, & McCulloch, 2012). Multivariable analyses began by testing the associations between the covariates and gender identity and the outcomes. Only covariates which were significantly associated with gender identity and an outcome were deemed potentially confounding and thus, included in that model. Then, each logistic regression model series was built in the following manner:

1. Gender identity was entered as the lone predictor in Model 1. This model explored the unadjusted association between gender identity and the outcome.

2. Potentially confounding covariates were entered in Model 2. This model aimed to provide some measure of control for health status and likely variabilities on the need for health care.
3. Other main predictors and potential moderators of the experience of health care access (i.e., race, poverty, health insurance, and disclosure) were entered in Model 3. This model allowed for estimation of the independent association of gender identity with the outcome or criterion variable (health care access or quality) controlling for other well-known risk (or protective) factors.
4. 2-way interactions were tested in Model 4. If an interaction was significant it remained in the model. Otherwise, it was removed. If there were no significant interactions, then model 4 was not presented.

Logistic regression modeling principles and interpretations. Further principles of logistic regression modeling that were followed in this study and their consequent interpretations follow.

First, the statistical and practical significance or strength and precision of the predictor-outcome relationships were estimated with odds ratios (OR) and their 95% CIs that were derived from regression statistics ($OR = e^{\beta}$ and $CI = e^{\beta +/- 1.96(SE)}$). A 95% CI that did not include the null value of 1.00 indicated that the observed association was statistically significant ($p < .05$). It should also be noted that variable categories were coded so that ORs > 1.00 were indicative of relative risks while ORs < 1.00 indicated relative protections from undesirable outcomes. For desirable outcomes, ORs were keyed in the opposite direction and thus, estimated relative risks (RR). For example, an OR of 1.50 corresponding to the hypothesis of trans men versus trans women being more likely

to be denied trans-related care could be interpreted as follows: The odds, likelihood, or risk of trans men being denied trans-related health care was 50% greater than that of trans women. Strictly speaking, ORs are better estimators of RRs when "diseases" or outcomes and "exposures" or predictors are rare. In this study (large database allowing for precise estimations with relatively rare "exposures:" trans men [29%], racialized minority group member [17%], lived in poverty [23%], without health insurance [14%], and being out to everyone [10%] and similarly rare outcomes [eight of nine ranged from 5% to 20%]) that ORs approximated RRs relatively closely. Yet, even when that was not strictly true, the relative size of ORs still corresponded to the relative strength of associations. A larger OR denotes a stronger association or larger effect. For example, an OR of 10.00, even if not five-times larger, is indicative of a much stronger association than an OR of 2.00.

Second, significant interactions were depicted in the text. That is, ORs were reported within strata. For example, suppose a significant 2 x 2, gender identity by disclosure interaction, was detected on the denial of trans care. ORs indicative of the gender identity-trans care denial association (the gender divide) would be reported within each disclosure strata. Imagine if the analysis produced the following results: trans men versus others among those who had disclosed to no one or a few people (OR = 1.75) and trans men versus others among those who had disclosed to many or all in their social networks (OR = 1.25). It would demonstrate that the gender divide on the denial of trans care was significantly larger among those who were not out to many about their trans identity. Additionally, it would suggest a substantial protective effect of such disclosures.

Third, although parametric assumptions are not relevant with logistic regressions, multicollinearity should still be ruled out. Because there were no continuous variables in

any model, multicollinearity seemed highly unlikely. Still, all of the categorical predictors' (gender identity, other centrally hypothesized predictors and covariates) associations with each other were calculated (χ^2) and then converted to another measure of association, Pearson's correlation coefficient ($r = [\chi^2 / N]^{½}$, Cooper, 2017). The strongest association observed was quite modest ($r = .38$). The corresponding coefficient of determination (r^2) was .14, meaning that only 14% of the variance of those two predictors was overlapping. Most of the others were much smaller. Clearly, multicollinearity appeared to be a nonissue; the predictors under study represented largely independent, non-overlapping constructs. Finally, all analyses used SPSS, Version 25.0 including its model fitting statistics: Hosmer and Lemeshow goodness-of-fit test and Negelkerke's pseudo-R^2 test (Hosmer et al., 2013; IBM Corporation 2018).

Power Analysis

Given that this study conducted secondary analyses of an available sample to answer several research questions, statistical power calculations were completed *post hoc* using G*Power software (Cohen, 1988; Faul, Erdfelder, Buchner, & Lang, 2009; 2013; Faul, Erdfelder, Lang, & Buchner, 2007). A study by Jaffee et al. (2016) showed that trans men were more likely than trans women to delay needed care (41% versus 22% respectively, with a difference of 19%). With the large analytic sample of 14,540 transgender participants, there was ample confidence and power to ensure that neither type I nor type II sampling errors were made while detecting much smaller between-group differences. Prevalent outcome differences between two groups as small as 3% (e.g., delays of 40% among trans men and 37% among trans women), with a 2-tailed α criterion of 0.05, yielded power estimates that ranged from 99.9% to 96.0% for this

study's typical analytic models that, respectively, included eight to ten variables (main predictors and interactions). Essentially, this meant there was very little threat of sampling error and that, from a statistical standpoint, there was much confidence in this study's statistically significant and null findings. Additionally, the oft-emphasized conclusion of $p < .05$ meant little in this context. More important were issues of practical significance indicated by the relative size of reported ORs and the relative precision of those estimates as evidenced by the widths of their CIs.

Missing Data

Missing data was almost nonexistent among six of the nine central predictors, including covariates (all $\leq$ 0.3%). Even among the other three computed variables, it was very modest: disability (1.9%), poverty (3.1%) and disclosure (3.5%) statuses. As for the nine outcome variables, seven of the nine had less than one percent missing data, and again, the two computed outcomes (health insurance denial and receipt of trans care) had slightly more: 2.9% and 4.8%, respectively. Missing data likely did not confound any of the nine central analytic runs, as all the missing completely at random (MCAR) χ^2 tests were null (Little, 1988). Because such modest amounts of missing data were not confounding and there was ample analytic power despite this, missing data were deleted list wise, rather than imputed. Such analyses of participants with complete data avoid confounding real people with statistical constructs. In other words, each unique logistic regression was a complete case analysis that included only study participants with valid data on all the variables: main predictors, covariates, interactions, and outcomes.

Chapter 4: Results

Sample Characteristics

Age. After implementing the age restriction to participants aged 25 to 64 years of age, the study sample for this secondary analysis was 14,540. Over half of the sample (54.2%) was 25 to 34 years of age, with decreasing prevalent representation of each increasing decanal age cohort (Table 1). For example, approximately one in ten participants (11.4%) were categorical older adults aged 55 to 64 years, which were 1,658 such participants. There were ample subsamples across the age spectrum of young, middle-aged and older adults to effectively account for their probable correlates and needs for health and trans care in adjusted, multivariable analyses.

Gender identity and sexual orientation. The study sample was more prevalently represented by trans women (45.4%), with trans men (28.7%) and nonbinary/gender queer people (25.9%) constituting approximately one-quarter each of the sample (Table 1). About half of the sample self-identified as visually conforming (51.9%), meaning that others could not tell they were transgender. Visual non-conformers were rarer (13.7%) and the remainder of the sample claimed to be "somewhat conforming" (34.5%). Again, such ample representation across categories of this potential confound bodes well for its control in adjusted, multivariable analyses. About half each of the participants were assigned female or male sex at birth. Heterogeneity was also present in the respondents' sexual orientation, with almost one-quarter of the study sample identifying as queer (22.4%) and one-fifth identifying as gay, lesbian, or same gender loving (19.9%). Among the seven sexual orientation categories, transgender people who identified as heterosexual or straight were also well represented (14.8%).

Table 1 Demographic Characteristics of Transgender Participants (N = 14,540)

Variable Categories	Sample Size	Valid Percent
Age		
25 to 34	7,879	54.2
35 to 44	2,912	20.0
45 to 54	2,091	14.4
55 to 64	1,658	11.4
Gender Identity		
Trans men	4,176	28.7
Trans women	6,601	45.4
Nonbinary/gender queer	3,763	25.9
Sex Assigned at Birth		
Male	7,629	52.5
Female	6,911	47.5
Visual Conformity		
Visual conformers	7,523	51.9
Somewhat visual conforming	4,998	34.5
Visual non-conformers	1,981	13.7
Missing	38	0.3
Sexual Orientation		
Queer	3,253	22.4
Gay, lesbian, same gender loving	2,893	19.9
Pansexual	2,279	15.6
Bisexual	2,222	15.3
Heterosexual/straight	2,157	14.8
Asexual	918	6.3
Sexual orientation not listed	827	5.7

Race/ethnicity. The study sample was predominantly White/Middle Eastern/North African (83.4%, Table 2). Certain historically oppressed racialized/ethnic minority groups appeared adequately represented for subsample analyses (e.g., 4.7% each African American and Hispanic) and others, not so well (e.g., American Indians [1.4%]).

Table 2 Race/Ethnicity of Transgender Participants

Categories	Sample Size	Valid Percent
White/Middle Eastern/North African	12,122	83.4
Biracial/Multiracial	690	4.7
Hispanic/Latino/a	685	4.7
Black/African American	477	3.3
Asian/Asian American	293	2.0
Alaska Native/American Indian	205	1.4
Native Hawaiian/Pacific Islander	39	0.3
Racial/ethnic identity not listed	29	0.2

Table 3 Educational Achievement of Transgender Participants

Categories	Sample Size	Valid Percent
Less than high school	220	1.5
High school diploma	1,071	7.4
Some college	3,787	26.0
Associate's degree	1,637	11.3
Bachelor's degree	4,742	32.6
Graduate or professional degree	3,083	21.2

Education. This sample was highly educated—much more so than the general population (Table 3). Nearly all received some post-secondary education (91.1%) and more than half had achieved bachelors or graduate degrees (53.8%).

Employment status and income. A quarter of the sample was unemployed or had withdrawn from the labor market altogether (Table 4). Their household incomes were diversely representative, but again, almost a quarter of the transgender participants lived below the poverty line (22.8%). Such prevalent poverty seemed inconsistent with their high educational achievement.

Table 4 Employment and Income Status of Transgender Participants

Variable Categories	Sample Size	Valid Percent
Employment Status		
Employed	10,852	75.1
Unemployed	1,180	8.2
Out of the labor force	2,425	16.8
Household Income		
No income	276	2.0
$1 to $9,999	1,089	7.9
$10,000 to $24,999	2,680	19.5
$25,000 to $49,999	3,379	24.6
$50,000 to $100,000	3,810	27.8
$100,000 or more	2,482	18.1
Household Income Below Poverty	3,209	22.8

Note. Missing data: Employment (0.6%), household income (5.7%), and poverty (3.1%).

Marital status and social support network. Approximately one-quarter of the sample were married or in a legally recognized civil union (26.3%), while most of the respondents claimed to be single or never married (54.4%, Table 5). A quarter of the respondents lived alone and most of them did not reside with any children or youths less than 18 years of age (84.9%, Table 6). The most typical household composition was the transgender participant living with one other adult.

Table 5 Marital Status of Transgender Participants

Categories	Sample Size	Valid Percent
Married/legally recognized civil union	3,812	26.3
Registered domestic partnership	188	1.3
Widowed	124	0.9
Divorced	2,161	14.9
Separated	396	2.7
Single, never married	7,829	54.4

Note. Missing data (0.2%).

Table 6 Household Compositions of Transgender Participants

Variable Categories	Sample Size	Valid Percent
Household size		
Lives alone	3,575	24.6
Lives with 1 other person	5,493	37.8
Lives with 2 or 3 others	4,333	29.9
Lives with 4 or more others	1,117	7.6
Number of adults in household, including self		
Lives alone	3,855	26.5
Lives with 1 other adult	6,514	44.8
Lives with 2 others	2,433	16.7
Lives with 3 others	1,144	7.9
Lives with 4 or more others	582	4.0
Number of children in household under age 18		
None	12,337	84.9
1 child	1,207	8.3
2 or 3 children	881	6.1
4 or more children	104	0.6

Note. Missing data for all variables (< 0.5%).

Table 7 Participants' Disclosure of Trans Identity to Social Support Network

Variable Categories	Sample Size	Valid Percent
Individual Measures of Disclosure		
Immediate family		
All know I am trans	8,849	61.0
Most know I am trans	1,058	7.3
Some know I am trans	1,783	12.3
None know I am trans	2,216	15.3
No people like this in my life	610	4.2
Extended family		
All know I am trans	4,342	30.0
Most know I am trans	2,392	16.5
Some know I am trans	2,952	20.4
None know I am trans	4,005	27.7
No people like this in my life	791	5.5
LGBT friends		
All know I am trans	9,010	62.2
Most know I am trans	2,604	18.0
Some know I am trans	1,998	13.8
None know I am trans	470	3.2
No people like this in my life	396	2.7
Non-LGBT friends		
All know I am trans	4,948	34.2
Most know I am trans	3,232	22.4
Some know I am trans	4,610	31.9
None know I am trans	1,306	9.0
No people like this in my life	359	2.5
Current boss		
All know I am trans	4,697	32.6
Most know I am trans	715	5.0
Some know I am trans	1,135	7.9
None know I am trans	4,548	31.5
No people like this in my life	3,334	23.1

Current co-workers		
All know I am trans	3,148	21.8
Most know I am trans	1,374	9.5
Some know I am trans	2,863	19.8
None know I am trans	3,820	26.5
No people like this in my life	3,221	22.3
Current classmates		
All know I am trans	1,197	8.4
Most know I am trans	532	3.7
Some know I am trans	1,247	8.7
None know I am trans	2,738	19.1
No people like this in my life	8,615	60.1
Current health care providers		
All know I am trans	6,959	48.0
Most know I am trans	1,929	13.3
Some know I am trans	2,125	14.7
None know I am trans	2,355	16.2
No people like this in my life	1,126	7.8
Disclosure of Transgender Identity Scale		
Out to everyone	1,473	10.5
Many	7,803	55.6
Some	4,606	32.8
Out to no one	146	1.0

Note. Missing data for all individual measures (≤ 1.5%) and for the summary measure (3.5%).

The respondents' disclosure about their trans identities to the people in their lives varied. Two-thirds (68.3%) reported that all or most of their immediate family members knew about their trans status (Table 7). The prevalence of disclosure to health care providers was similarly high. Two-thirds of the participants reported that all or most of their health care providers knew about their trans identity (61.3%). Disclosure to people at work was less prevalent: one-third reported that all or most of their bosses (37.6%) and current coworkers (31.1%) were aware of their trans identity. Within all except one of the social network categories (LGBT friends) and in aggregate, 20% to 40% or more were out to some or no one. This may be a vulnerable group of transgender adults. Family members

and others who were aware of the participant's trans identity generally demonstrated support. The majority rated their family members and others as very supportive or supportive (Table 8). Still, about one of every five of the participants may be socially vulnerable as they reported that their family members were unsupportive or very unsupportive. When immediate family members were supportive, it was evidenced through social behaviors—predominantly, through expression of verbal respect (65.0%), using the participant's preferred name (63.6%) and preferred pronoun (59.3%, Table 9). Very few received financial support from their families (15.6%).

Table 8 Rating of Social Support Among Those with Whom Participants Have Disclosed Their Trans Identity

Variables Categories	Sample Size	Valid Percent
Family Support (*n* = 11,690)		
Very supportive	3,039	26.0
Supportive	4,167	35.7
Neither supportive nor unsupportive	2,390	20.5
Unsupportive	1,225	10.5
Very unsupportive	856	7.3
Co-Worker Support (*n* = 7,385)		
Very supportive	2,450	33.2
Supportive	2,729	37.0
Neither supportive nor unsupportive	1,946	26.4
Unsupportive	175	2.4
Very unsupportive	71	1.0
Classmate Support (*n* = 2,976)		
Very supportive	698	23.7
Supportive	1,032	35.1
Neither supportive nor unsupportive	1,099	37.4
Unsupportive	75	2.6
Very unsupportive	35	1.2

Note. Missing data for all variables (< 1.0%).

Table 9 Trans-Related Support from Immediate Family Members with Whom Participants Have Disclosed Their Trans Identity

Variables	Sample Size	Valid Percent
Verbally expressed respect and support	7,583	65.0
Used preferred name	7,419	63.6
Use correct pronoun	6,912	59.3
Stood up for me with family, friends or others	4,428	38.0
Researched how to support trans identity	3,839	32.9
Gave money to assist with gender transition	1,819	15.6
Helped with name/gender change on documents	825	7.1
Provided support in another way	1,274	10.9
Provided no such support	1,946	16.7

Note. Missing data for all variables (< 1.0%).

Table 10 General Health Status of Transgender Participants

Categories	Sample Size	Valid Percent
Excellent	2,067	14.2
Very good	5,095	35.1
Good	4,693	32.3
Fair	2,023	13.9
Poor	652	4.5

Note. Missing data (0.1%)

Table 11 Disability Status of Transgender Participants

Variable	Sample Size	Valid Percent
Individual Disability Measures		
Deaf or serious difficulty hearing	583	4.0
Blind or serious vision impairment	302	2.1
Concentration/memory/decision making impairment	3,241	22.4
Serious difficulty walking or climbing stairs	1,013	7.0
Difficulty dressing or bathing	433	3.0
Difficulty doing errands alone	2,128	14.8
Summary Disability Measure		
Person with a disability	4,469	31.3

Note. Missing data for all individual measures ($\leq$ 1.0%) and for the summary measure (1.9%).

Health status, health insurance, and health care experiences. Overall, the participants' general health status was quite good. In fact, the vast majority (81.6%) rated their health as "good" to "excellent" (Table 10). This seemed consistent with other non-elder general population estimates and will be important to account for in multivariable analyses of health and trans care access. The prevalence of HIV positive status among this study sample was 1.6% (data not shown). Approximately one in three participants identified themselves as a person with a disability (31.3%), and approximately one in ten reported difficulties with common or instrumental activities of daily living (Table 11). Generally, though, this sample of transgender adults seemed quite healthy and able.

Table 12 Heath Insurance Status of Transgender Participants

Variable Categories	Sample Size	Valid Percent
Has Health Insurance	12,550	86.3
Types of Health Insurance		
Through employer[a]	6,099	41.9
Through another's employer[a]	1,534	10.6
Through Health Insurance Marketplace[a]	1,576	10.8
Directly from insurance company[a]	508	3.5
Medicaid	2,207	15.2
Medicare	706	4.9
VA	472	3.2
TRICARE or other military health care	267	1.8
Indian Health Service	35	0.2
Other	520	3.6

Note. Missing data: Has health insurance (0.1%). [a] Private/commercial health insurance.

The vast majority of the sample (86.3%) had health insurance coverage, which meant that almost 14% of the sample were uninsured (Table 12). Two-thirds of the participants (66.8%) had private or commercial insurance. Medicaid recipients comprised 15.2% of the study sample, while 4.9% were Medicare beneficiaries. There appeared to be overrepresentation of uninsured and Medicaid-covered participants in this sample of non-elder transgender adults in post-ACA America.

The participants' utilization of health care services and their experiences with health care providers are displayed in Table 13. The vast majority of the participants (89.6%) saw a doctor or health care provider at least once during the year prior to the survey. Affordability was a barrier for many participants who needed health care; one in three individuals (32.2%) delayed seeing a doctor due to cost. Almost one-quarter (23.4%) of the participants did not see a doctor when needed because they feared they

Table 13 Transgender Participants' Health Care Utilization and Experience with Providers in the Past Year

Variables Categories	Sample Size	Valid Percent
Total Transgender Sample (*N* = 14,540)		
Saw a doctor at least once	13,004	89.6
Delayed care due to cost	4,663	32.2
Delayed care due to possible mistreatment	3390	23.4
Those Who Saw Doctor or Health Care Provider (*n* = 13,004)		
Disclosed identity and was treated with respect	9616	74.5
Had to teach provider about trans care	3,649	28.3
Denied trans-related care	1,210	9.4
Denied other health care	465	3.6
Received invasive questions about trans status	2,152	16.7
Verbally harassed in health care setting	870	6.8
Received harsh or abusive language	699	5.4
Received physically rough or abusive treatment	272	2.1
Unwanted sexual contact in health care setting	175	1.4
Physically attacked in health care setting	75	0.6
Those with a Trans-Related Provider (*n* = 9,849)		
Trans-related provider's knowledge about trans health care		
Know almost everything	3,845	39.0
Know most things	2,655	27.0
Know some things	1,913	19.4
Know almost nothing	752	7.6
I am not sure	684	6.9
Travel distance to trans-related provider		
Less than 10 miles	4,496	46.1
10-25 miles	2,589	26.6
25-50 miles	1,252	12.8
50-75 miles	560	5.7
75-100 miles	283	2.9
Over 100 miles	565	5.8

Those with a Routine Health Care Provider (*n* = 5,837)		
Routine health care provider's knowledge about trans health care		
Know almost everything	133	2.3
Know most things	352	6.0
Know some things	1,304	22.3
Know almost nothing	1,582	27.1
I am not sure	2,466	42.2
Travel distance to routine health care provider		
Less than 10 miles	3,896	66.9
10-25 miles	1,458	25.0
25-50 miles	310	5.3
50-75 miles	86	1.5
75-100 miles	28	0.5
Over 100 miles	49	0.8

Note. Missing data for all variables (< 1.0%).

would be disrespected or mistreated as a trans person. Of the respondents who saw a doctor or health care provider during the past year, the majority (74.5%) reported that their doctor knew about their trans status and had treated them with respect. However, the providers' knowledge deficit about trans health issues and their willingness to provide care were apparent barriers to access. Over one-quarter of the sample (28.3%) reported that they had to teach their provider about trans people to receive appropriate care. One in ten individuals (9.4%) were denied trans-related health care by their provider in the past year, and 3.6% of the participants were denied other health care. Of the participants who were assigned female at birth, only one-third (37.5%) reported receiving a pap smear during the past year (data not shown).

Having access to a doctor or health provider for transition-related care was a problem for many individuals (Table 13). One-third of the respondents (32.3%) reported that they did not have a doctor or provider for transition-related health care. Indicative of the relative low quality of such care experienced by many, among those who had a trans-related health provider, 27.0% rated their provider as knowing only some to almost

nothing about trans-related health care. Proximity versus remoteness of service is also an important element of health care access. Of the individuals who had a trans-related provider, almost half (46.1%) reported driving less than 10 miles, but one in twenty such individuals (5.8%) must drive over 100 miles to receive trans-related health care. Most of the respondents who had a trans-related provider also saw the same provider for their routine health care (57.7%, data not shown). One in nine (11.7%) reported that they did not receive routine care (data not shown). Only 40.1% of the participants reported having a provider specifically for routine health care. When asked to rate their routine health care provider's knowledge about health care for trans people, half of the sample (49.4%) stated that their provider knew only some to almost nothing about trans-related care. These are indicative of some of the criterion health care access and quality vulnerabilities that this study aims to explain.

Among the participants who had health insurance and made requests of their insurance carriers for trans-related or routine health services, many were denied access (Table 14). One in three participants had at least one experience of being denied by their insurance carrier during the past year (35.6%, data not shown). Over half of the participants requesting gender-affirming surgery (56.4%) and one-quarter of those who requested hormone therapy (22.7%) were denied coverage. Even the most fundamental care was frequently denied. Respondents were commonly denied gender-specific health screenings (e.g., pap smears, mammograms, and prostate exams, 14.3%), as well as routine health care (7.0%). It seems that in America's policy context, trans care or health care for transgender people do not meet the definitions of "medically necessary care" among many insurers.

Table 14 Health Insurance Denial Experienced by Transgender Participants

Variable	Sample Size	Valid Percent
Denied surgery for transition	2,030	56.4
Not requested	10,940	75.2
Covers only some surgeries for transition	1,822	42.2
Not requested	10,227	70.3
Denied hormones for transition	1,586	22.7
Not requested	7,567	52.0
Covers surgery, but no in-network providers	832	20.9
Not requested	10,555	72.6
Denied name/gender change in records	570	14.2
Not requested	10,531	72.4
Denied gender-specific health care	707	14.3
Not requested	9,588	65.9
Denied routine health care	509	7.0
Not requested	7,288	50.1

Note. Missing data for all variables (< 1.0%).

The great diversity of transition care options is displayed in Table 15. Many (69.2%) have received gender-affirming surgery or hormone therapy, and the clear majority (80.3%) have received some form of medical transition services, either physical or psychosocial. Notwithstanding the fact that some did not desire any such care, it was clear that there were numerous unmet transition care needs. For example, though many have availed themselves of counselling (70.6 %), perhaps many more could benefit from this form of support. Significant proportions of participants were “not sure if they wanted” various surgeries or procedures. Psychosocial interventions might help these transgender individuals to make these difficult decisions.

Table 15 Gender Transition Care Among Transgender Participants

Variable Categories	Sample Size	Valid Percent
Total Transgender Sample (*N* = 14,540)		
Received counseling/therapy	10,182	70.6
Received hormone treatment	9,274	64.3
Received puberty blocking hormones	187	1.3
Received any surgical transition	4,495	32.2
Received hormones or surgery	9,576	69.2
Received counseling, hormones, or surgery	11,106	80.3
Assigned Female at Birth (*n* = 6,911)		
Surgical breast reduction or reconstruction		
Have had it	2,446	35.5
Want it someday	2,947	42.7
Not sure if I want this	897	13.0
Do not want this	608	8.8
Hysterectomy		
Have had it	1,064	15.5
Want it someday	2,883	41.9
Not sure if I want this	1,734	25.2
Do not want this	1,202	17.5
Clitoral release/metoidioplasty/centurion procedure		
Have had it	141	2.1
Want it someday	1,348	19.8
Not sure if I want this	2,571	37.7
Do not want this	2,764	40.5
Phalloplasty		
Have had it	166	2.4
Want it someday	725	10.6
Not sure if I want this	2,121	31.0
Do not want this	3,822	55.9
Assigned Male at Birth (*n* = 7,629)		
Hair removal/electrolysis		
Have had it	3,976	52.3
Want it someday	3,155	41.5
Not sure if I want this	233	3.1
Do not want this	241	3.2
Breast augmentation surgery		
Have had it	739	9.8
Want it someday	2,821	37.2

Not sure if I want this	2,349	31.0
Do not want this	1,670	22.0
Silicone injections		
Have had it	119	1.6
Want it someday	622	8.3
Not sure if I want this	1,900	25.5
Do not want this	4,811	64.6
Orchidectomy		
Have had it	896	12.0
Want it someday	3,161	42.2
Not sure if I want this	1,697	22.6
Do not want this	1,740	23.2
Vaginoplasty/labiaplasty		
Have had it	993	13.2
Want it someday	3,734	49.5
Not sure if I want this	1,629	21.6
Do not want this	1,189	15.8
Trachea shave		
Have had it	431	5.7
Want it someday	2,127	28.3
Not sure if I want this	2,091	27.8
Do not want this	2,862	38.1
Facial feminization surgery		
Have had it	587	7.8
Want it someday	2,983	39.5
Not sure if I want this	2,230	29.5
Do not want this	1,760	23.3
Voice therapy (non-surgical)		
Have had it	1,165	15.5
Want it someday	3,402	45.2
Not sure if I want this	1,280	17.0
Do n want this	1,682	22.3
Voice surgery		
Have had it	70	0.9
Want it someday	1,238	16.6
Not sure if I want this	2,335	31.3
Do not want this	3,829	51.2

Note. Missing data for all variables was < 1.0% except for the following: any surgical transition (4.0%); hormones and surgery (4.8%); counseling, hormones, and surgery (4.8%); assigned female at birth subsample (< 1.5%); and assigned male at birth subsample (< 2.5%).

Bivariate Analyses

Gender identity with potential confounds and predictors. All between-gender identity group differences were statistically significant, meaning that some statistically significant difference was observed between at least two of the three groups. As each covariate was significantly associated with gender identity, any that were also significantly associated with an outcome was treated as a confound in that analytic run. Some of these comparisons also further informed our understandings of the diversity of transgender people and further described key study subsamples. The transgender men, for example, were much younger than the transgender women; they were almost twice as likely to be represented among the youngest cohort (62.2% versus 39.9%) and four times less likely to be among the oldest cohort (4.8% versus 19.5%, Table 16). The transgender men were also significantly more likely to have reported that they were visually conforming (65.1%) than did their counterparts who were either non-binary (51.8%) or transgender women (43.5%). The transgender male subsample was more highly represented by racialized/ethnic minority group members, particularly by Hispanic people and African Americans. Yet, of the three gender identity subgroups, they were the least likely to live in poverty (21.7%) or to be uninsured (11.6%). The study groups also differed on how much they had disclosed their transgender identities. Compared to the transgender women, the transgender men were less likely to have disclosed to very few people or to no one (20.4% versus 26.2%), while they were more likely to be out to almost everyone or everyone in their social network (79.7% versus 73.9%). Perhaps not surprisingly, the majority of non-binary people had not disclosed their gender identity to anyone.

Table 16 Comparisons of Gender Identity Groups: Bivariate Analysis of Covariates and Predictors

	Valid Percentage Distributions		
	Transgender Women *n* = 6,601	Nonbinary *n* = 3,763	Transgender Men *n* = 4,176
Age			
25 to 34	39.9	70.4	62.2
35 to 44	21.2	17.4	20.6
45 to 54	19.4	7.7	12.5
55 to 64	19.5	4.5	4.8
Health Status			
Excellent	17.4	11.0	12.1
Very good	34.8	32.3	38.0
Good	31.2	33.4	33.0
Fair or poor	16.6	23.4	16.9
Any Disability	27.3	40.7	29.3
Visual Conformity			
Conformers	43.5	51.8	65.1
Somewhat conforming	37.0	39.1	26.3
Non-conformers	19.5	9.0	8.6
Racialized Group			
Non-Hispanic white	85.7	83.0	80.1
Hispanic	4.3	4.0	5.9
African American	2.7	2.8	4.6
Biracial/multiracial	3.5	6.6	5.6
Others	3.7	3.6	3.8
Lives in Poverty	22.2	25.0	21.7
Has Health Insurance	85.2	86.4	88.4
Disclosure of Transgender Identity Scale			
Disclosed to no one or a few	26.2	62.4	20.4
Disclosed to many	57.7	34.5	71.4
Disclosed to everyone	16.2	3.1	8.3

Note. All gender identity group differences were statistically significant (Pearson's χ^2 test, $p < .05$).

Table 17 Comparisons of Gender Identity Groups: Bivariate Analysis of Outcomes

	Valid Percentage Distributions		
	Transgender Women *n* = 6,601	Nonbinary *n* = 3,763	Transgender Men *n* = 4,176
Past Year[a]			
Saw a Health Care Provider[*]	90.2	83.9	93.6
Did Not See a Health Care Provider due to Cost[*]	28.6	37.7	33.0
Delayed Health Care due to Possible Mistreatment[*]	20.5	20.2	30.8
	n = 5,948	*n* = 3,151	*n* = 3,905
Among Those Who Saw a Doctor or Health Care Provider in the Past Year[b]			
Denied Trans-Related Care[*]	10.7	5.2	10.8
Denied Other Health Care	3.5	3.3	4.0
Disclosed Trans Identity and Was Treated with Respect[*]	84.1	40.1	87.2
	n = 4,861	*n* = 991	*n* = 3,313
Among Those Who Have a Trans-Related Health Care Provider[c]			
Providers Know Some to Almost Nothing about Trans Care[*]	27.1	35.0	30.2
	n = 5,616	*n* = 3,246	*n* = 3,688
Among Those Who Have Health Insurance[d]			
Health Insurance Denial[*]	40.6	13.3	47.8
	n = 6,601	*n* = 3,763	*n* = 4,176
Received Hormones/Surgery[e*]	83.4	27.8	84.9

[a] Data for all variables among the total transgender sample was less than 0.5% missing.
[b] Among the subsample of those who saw a health care provider in the past year data was $\leq$ 1.0% missing.
[c] Among those who had a trans health care provider there was no missing data.
[d] Among those who had health insurance there was 2.9% missing data.
[e] Among the total transgender sample there was 4.8% missing data.
[*] Gender identity group differences were statistically significant (Pearson's χ^2 test, $p < .05$).

Gender identity with outcomes. A comparison of the gender identity groups with the outcome variables revealed several salient, statistically significant findings (Table 17). First, gender identity was observed to be significantly associated with all but one of the nine outcome indicators of health care access or quality. Second, and consistent with life space intuition, transgender men saw health care providers more often than did others during the past year. Third, on six of the eight remaining study outcomes, transgender men were significantly more likely to report barriers to health care or trans care access or to report lower quality of care than did transgender women and or non-binary people. These were essentially uncontrolled hypothesis tests, not yet accounting for the influence of other well-known or suspected predictors of health and trans care access and quality. Multivariable analyses will provide these better controlled hypothesis tests.

Potential confounds and predictors with outcomes. Results of the bivariate analyses of potential confounds and predictors with the nine outcome variables can be found in Table 18. Age was significantly associated in predictable ways with eight of the outcomes. Health status was similarly associated with eight of the nine outcomes—the apparent pattern being that those who self-reported fair or poor health were more likely to have experienced care barriers and poorer quality of care. Having a disability was predictably associated with less access/lower quality for six of the outcomes. Finally, visual conformity was significantly associated with eight of the nine outcomes. With some equivocation, non-conformity was associated with less access/lower quality in the majority of these instances. The potential confounding influence of these four covariates was clear. Therefore, they will be accounted for in subsequent multivariable analyses.

Table 18 Bivariate Analysis of Covariates and Predictors with Outcomes in the Past Year

	Prevalence Estimates		
	Saw Health Care Provider	Delayed Health Care—Cost	Delayed Health Care Fear Mistreatment
Age			
25 to 34	87.1	39.0	27.8
35 to 44	91.3	38.8	23.1
45 to 54	93.2	22.7	16.5
55 to 64	93.5	17.9	11.3
Health Status			
Excellent	90.9	17.2	13.7
Very good	91.7	24.8	18.9
Good	88.3	36.4	25.9
Fair or poor	86.7	50.6	34.6
Any Disability (No)	89.7*	26.7	19.7
Yes	89.2*	44.0	31.3
Visual Conformity			
Conformers	89.8*	30.9	20.6
Somewhat conforming	88.8*	33.0	25.4
Non-conformers	90.5*	35.5	28.9
Racialized Group			
Non-Hispanic white	88.8	31.0	22.5
Hispanic	88.0	37.0	25.4
African American	87.0	37.0	25.8
Biracial/multiracial	87.2	43.3	29.8
Others	90.5	33.9	29.7
Lives in Poverty (No)	91.2	28.1	21.4
Yes	84.7	46.4	30.3
Has Health Insurance (No)	70.4	66.3	27.7
Yes	92.6	26.8	22.6
Disclosure of Transgender Identity Scale			
Disclosed to no one or a few	83.0	34.4	19.5
Disclosed to many	92.8	31.2	26.0
Disclosed to everyone	93.7	31.4	22.4

	Prevalence Estimates		
	Denied Trans Care	Denied Other Health Care	Disclosed Identity Treated with Respect
Age			
25 to 34	9.6	3.9*	69.8
35 to 44	9.9	3.5*	77.6
45 to 54	9.8	3.2*	79.8
55 to 64	7.1	2.9*	83.4
Health Status			
Excellent	6.0	2.1	81.7
Very good	6.7	2.0	78.5
Good	10.2	3.4	72.9
Fair or poor	16.1	8.5	63.4
Any Disability (No)	7.4	2.4	77.5
Yes	13.6	6.2	67.8
Visual Conformity			
Conformers	8.0	3.3	72.1
Somewhat conforming	10.6	3.6	75.4
Non-conformers	11.6	4.9	81.1
Racialized Group			
Non-Hispanic white	9.2*	3.4	74.5*
Hispanic	9.4*	4.0	76.9*
African American	7.5*	4.1	76.6*
Biracial/multiracial	11.5*	5.2	70.3*
Others	12.0*	5.4	75.9*
Lives in Poverty (No)	7.8	2.9	75.7
Yes	15.0	6.0	71.6
Has Health Insurance (No)	12.3	5.5	70.0
Yes	9.0	3.4	75.0
Disclosure of Transgender Identity Scale			
Disclosed to no one or a few	5.6	2.6	42.1
Disclosed to many	10.7	4.0	88.1
Disclosed to everyone	13.4	4.9	93.8

	Prevalence Estimates		
	Providers Know Some/ Almost Nothing	Insurance Denial	Received Hormones or Surgery
Age			
25 to 34	27.6	34.1	61.3
35 to 44	29.6	38.0	74.8
45 to 54	31.9	37.6	80.2
55 to 64	30.2	35.8	84.9
Health Status			
Excellent	22.6	36.4*	77.9
Very good	25.1	36.0*	73.4
Good	32.3	35.8*	66.9
Fair or poor	40.4	33.8*	58.4
Any Disability (No)	27.0	36.1*	73.0
Yes	34.3	34.4*	60.8
Visual Conformity			
Conformers	30.3	34.3	68.5
Somewhat conforming	28.0	35.2	68.0
Non-conformers	27.2	42.3	75.5
Racialized Group			
Non-Hispanic white	28.9	35.4*	69.4*
Hispanic	30.6	38.8*	69.6*
African American	23.1	38.0*	71.4*
Biracial/multiracial	33.3	35.0*	64.9*
Others	32.1	35.4*	68.9*
Lives in Poverty (No)	28.3	35.7*	71.4
Yes	32.4	36.4*	63.4
Has Health Insurance (No)	32.3	na	60.6
Yes	28.7	na	70.6
Disclosure of Transgender Identity Scale			
Disclosed to no one or a few	34.0	16.1	37.7
Disclosed to many	27.9	44.9	84.2
Disclosed to everyone	27.7	49.4	92.2

Notes. na = not applicable. * All bivariate associations were significant except these (χ^2 test, $p < .05$).

As for the hypothesized predictors, first, statistically significant differences were observed between the racial groups on five outcomes (Table 18). Differences were as expected; members of racialized/ethnic minority groups, including those who identified as multiracial, were more vulnerable than non-Hispanic white people. Next, consistent with well-known relationships among other non-transgender populations, both poverty and health insurance were significantly associated with eight of the study's outcomes—poverty as a robust risk factor and health insurance as a protective factor. Finally, the extensiveness of disclosing one's transgender identity or "outness" was significantly associated with all nine outcomes. With equivocation, having disclosed to many or all of the people in one's social network was associated with access/quality in some instances, but with a lack of access/quality in others. Other factors were likely to moderate these relationships. These were also uncontrolled hypothesis tests, not yet accounting for the influence of gender identity and other well-known or suspected correlates of health and trans care access and quality. Multivariable analyses will provide these better controlled hypothesis tests. The potent influence of these four established risk or protective factors was clear. It appeared that any study of the health care (including trans-related care) of transgender people would need to account for them. Hence, they will be accounted for in the subsequent multivariable analyses.

Multivariate Analyses

Predictors of delaying health care during the past year due to cost. The results of the nine hypothesis tests on the first of nine outcomes—delaying health care during the past year due to cost—are displayed in Table 19. As for the first hypothesis test, it can be

Table 19 Predictors of Delaying Health Care during the Past Year due to Cost: Logistic Regression Models (*N* = 13,269)

Predictors	Model 1		Model 2		Model 3	
Categories	OR	95% CI	OR	95%	OR	95% CI
Gender Identity (GI)						
Transgender women	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	1.51	1.39, 1.65	1.09	0.99, 1.20	1.16	1.04, 1.29
Transgender men	1.23	1.13, 1.34	1.04	0.95, 1.14	1.16	1.05, 1.28
Age						
25 to 34			1.00	…	1.00	…
35 to 44			0.67	0.61, 0.74	0.70	0.63, 0.78
45 to 54			0.48	0.43, 0.55	0.52	0.46, 0.60
55 to 64			0.37	0.32, 0.43	0.43	0.37, 0.50
Health Status						
Excellent			1.00	…	1.00	…
Very good			1.46	1.27, 1.66	1.47	1.27, 1.70
Good			2.38	2.08, 2.72	2.29	1.98, 2.64
Fair/poor			3.84	3.32, 4.45	3.54	3.02, 4.15
Any Disability			1.46	1.34, 1.58	1.43	1.31, 1.57
Visual Conformity						
Conformers			1.00	…	1.00	…
Somewhat conforming			1.10	1.01, 1.19	1.10	1.01, 1.21
Non-conformers			1.24	1.11, 1.39	1.26	1.11, 1.42

Racialized group		
Non-Hispanic white	1.00	…
Hispanic	1.19	0.99, 1.44
African American	0.98	0.78, 1.22
Biracial/multiracial	1.37	1.15, 1.64
Others	1.02	0.83, 1.25
Lives in Poverty	1.38	1.26, 1.52
Has Health Insurance (HI)	0.21	0.18, 0.23
Disclosure of Transgender Identity Scale		
Disclosed to no one or a few	1.00	…
Disclosed to many	0.91	0.83, 1.00
Disclosed to everyone	1.00	0.86, 1.17

Notes. CI, confidence interval; GI, gender identity; HI, health insurance; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (91.3%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.10, p = .75. Final model fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 4.03, p = .86 and Negelkerke R^2 in Model 1 = 0.9%; in Model 2 = 12.0%; and in Model 3 = 21.0%.

seen across the top of the table that transgender men, as hypothesized, were more likely than transgender women to delay care, and support for this hypothesis was observed in both unadjusted (OR = 1.23) and fully adjusted models (OR = 1.16). Incidentally, non-binary/gender queer people similarly delayed care. Findings relevant to hypotheses two through five can be seen in the table's lower right column (Model 3). As hypothesized, biracial/multiracial transgender people (OR = 1.37) and those living in poverty (OR = 1.38) were at significantly increased risk of delaying care due to cost. Health insurance, again as hypothesized, was significantly and substantially protective (OR = 0.21). However, no support was found for hypothesis five (disclosure as a protective factor potentiating health care access), nor were any of the hypothesized interactions significant (hypotheses six through nine). Lastly, the final, main predictive associations in Model 3 seemed to fit the data well judging by Hosmer and Lemeshow's test (χ^2 (8) = 4.03, p = .86) and the fact that it could account for a fifth of the variability in health care delays due to cost (Negelkerke R^2 in Model 3 = 21.0%).

Further interpretation of these findings may provide more clarity. The three covariates (age, health, and disability statuses) were mundane in their well-known associations with health and health care. However, less is known about visual conformity and it seemed important beyond its potentially confounding influence in this study. After accounting for all the other predictors, it was significantly associated with delaying health care due to cost. Visual non-conformers were at significantly increased risk (OR = 1.26). As for the interpretation of ORs, the estimated risks associated with being a multiracial transgender person or a transgender person living in poverty may be considered modestly large. Strictly speaking, the ORs estimated that the odds or chances of delaying health

care due to cost among the noted risk groups were elevated 37% to 38% compared to otherwise similar non-Hispanic white or non-poor transgender people. In addition, the protective association of having health insurance and delaying care (OR = 0.21) may be characterized as large. That is, the odds of delaying care among the insured were observed to be approximately 80% lower than among the uninsured. As for the transgender male-female divide, the unadjusted (OR = 1.23) versus adjusted (OR = 1.16) analyses suggested that much (approximately two-thirds), but not all of the transgender divide on this outcome may be accounted for by differences between transgender men and women on the other significant predictors—that is, all the other predictors except disclosure. Finally, though the OR of 1.16 is relatively small, if it were to hold as a true relative risk estimate and if it were applied to the entire national population of transgender people, it would be deemed extraordinarily large in a population attributable risk sense (Northridge, 1995).

Predictors of delaying health care during the past year due to possible mistreatment. The first hypothesis was again supported—this time with evidence of a much stronger association (Table 20). The unadjusted association in Model 1 suggested that transgender men were much more likely than transgender women to postpone care due to concerns about possible mistreatment (OR = 1.73). This association was maintained in the full Model 4 (OR = 2.21). Two of the other four predictor hypotheses were also supported: “other” racialized minority group members (OR = 1.31) and lives in poverty (OR = 1.23). The disclosure-delay association was also significant, but it was in

Table 20 Predictors of Delaying Health Care during the Past Year due to Possible Mistreatment: Logistic Regression Models (*N* = 13,539)

Predictors Categories	Model 1 OR	 95% CI	Model 2 OR	 95%	Model 3 OR	 95% CI	Model 4 OR	 95% CI
Gender Identity								
Transgender women	1.00	…	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.98	0.89, 1.09	0.76	0.69, 0.85	0.80	0.71, 0.90	0.84	0.75, 0.94
Transgender men	1.73	1.58, 1.88	1.59	1.44, 1.75	1.55	1.40, 1.71	2.21	1.83, 2.67
Age								
25 to 34			1.00	…	1.00	…	1.00	…
35 to 44			0.78	0.70, 0.86	0.79	0.71, 0.88	0.79	0.71, 0.88
45 to 54			0.52	0.45, 0.59	0.55	0.48, 0.63	0.55	0.48, 0.63
55 to 64			0.34	0.29, 0.40	0.34	0.29, 0.41	0.34	0.28, 0.41
Health Status								
Excellent			1.00	…	1.00	…	1.00	…
Very good			1.36	1.17, 1.57	1.38	1.18, 1.60	1.38	1.18, 1.60
Good			2.06	1.78, 2.37	2.07	1.78, 2.40	2.07	1.78, 2.40
Fair/poor			3.20	2.57, 3.73	3.14	2.68, 3.69	3.16	2.70, 3.71
Visual Conformity								
Conformers			1.00	…	1.00	…	1.00	…
Somewhat conforming			1.43	1.31, 1.56	1.36	1.24, 1.49	1.35	1.23, 1.48
Non-conformers			1.71	1.52, 1.93	1.64	1.45, 1.86	1.61	1.42, 1.83

Racialized group				
Non-Hispanic white	1.00	…	1.00	…
Hispanic	1.05	0.87, 1.28	1.05	0.86, 1.27
African American	1.02	0.81, 1.27	1.00	0.80, 1.25
Biracial/multiracial	1.20	1.00, 1.43	1.19	0.99, 1.42
Others	1.31	1.07, 1.61	1.31	1.07, 1.60
Lives in Poverty	1.24	1.13, 1.37	1.23	1.12, 1.36
Has Health Insurance	0.90	0.80, 1.01	0.90	0.80, 1.01
Disclosure of Transgender Identity Scale				
Disclosed to no one or a few	1.00	…	1.00	…
Disclosed to many	1.24	1.13, 1.37	1.43	1.27, 1.61
Disclosed to everyone	1.13	0.97, 1.33	1.29	1.09, 1.53
Gender Identity by Disclosure (2 x 2)				$p < .001$

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (93.1%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.12, p = .73. Final model fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 9.11, p = .33 and Negelkerke R^2 in Model 1 = 1.8%; in Model 2 = 9.2%; in Model 3 = 10.0%; and in Model 4 = 10.2%.

the counter-hypothetical direction. The gender identity by disclosure interaction was also significant. The interaction was such that the gender identity divide—that is, the relative disadvantage of transgender men compared to others—was much larger among those who had disclosed their identity to no one or to a few people (OR = 2.45, 95% CI 2.05, 2.93) than among those who had disclosed their identity to many people or to everyone in their social network (OR = 1.44, 95% CI 1.30, 1.61). As a final adjunct finding, visual non-conformers were again at increased risk (OR = 1.61).

Predictors of being denied trans-related health care during the past year.

The first hypothesis was not supported in the unadjusted model (Table 21), but it was in the much better controlled Model 4 (OR = 1.67). Transgender men were significantly and substantially more likely to have been denied trans-related care than were transgender women. One of the other four main predictor hypotheses was also supported: lives in poverty (OR = 1.46). The disclosure-delay association was also significant, but again, it was in the counter-hypothetical direction. The gender identity by disclosure interaction was also significant again. The interaction was such that the gender identity divide—that is, the relative disadvantage of transgender men compared to others—was quite large among those who had disclosed their identity to no one or to a few people (OR = 2.63, 95% CI 1.93, 3.60). However, among those who had disclosed their identity to many people or to everyone in their social network, it was null (OR = 0.99, 95% CI 0.84, 1.15). In other words, there was no gender identity divide among transgender people who were prevalently out and probably well supported. Visual non-conformers were again at increased risk, but this time it was those who were somewhat non-conforming relative to conforming people who seemed at increased risk (OR = 1.20).

Table 21 Predictors of Being Denied Trans-Related Health Care during the Past Year: Logistic Regression Models (*N* = 11,830)

Predictors	Model 1		Model 2		Model 3		Model 4	
Categories	OR	95% CI	OR	95%	OR	95% CI	OR	95% CI
Gender Identity								
Transgender women	1.00	…	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.46	0.38, 0.55	0.36	0.30, 0.44	0.44	0.35, 0.53	0.46	0.38, 0.57
Transgender men	1.02	0.89, 1.16	1.01	0.88, 1.16	0.96	0.83, 1.11	1.67	1.21, 2.31
Age								
25 to 34			1.00	…	1.00	…	1.00	…
35 to 44			1.04	0.89, 1.22	0.98	0.83, 1.16	0.99	0.83, 1.16
45 to 54			0.94	0.79, 1.13	0.96	0.80, 1.16	0.96	0.80, 1.16
55 to 64			0.65	0.52, 0.81	0.65	0.51, 0.83	0.65	0.51, 0.83
Health Status								
Excellent			1.00	…	1.00	…	1.00	…
Very good			1.08	0.86, 1.35	1.09	0.86, 1.37	1.08	0.86, 1.38
Good			1.60	1.28, 1.99	1.63	1.29, 2.05	1.63	1.29, 2.05
Fair/poor			2.46	1.94, 3.12	2.51	1.96, 3.22	2.53	1.97, 3.25
Any Disability			1.63	1.43, 1.87	1.49	1.29, 1.72	1.49	1.29, 1.72
Visual Conformity								
Conformers			1.00	…	1.00	…	1.00	…
Somewhat conforming			1.35	1.18, 1.55	1.22	1.06, 1.41	1.20	1.04, 1.39
Non-conformers			1.32	1.10, 1.57,	1.15	0.95, 1.39	1.13	0.93, 1.36

Racialized group				
Non-Hispanic white	1.00	…	1.00	…
Hispanic	0.99	0.73, 1.35	0.99	0.73, 1.34
African American	0.71	0.47, 1.06	0.69	0.46, 1.04
Biracial/multiracial	1.09	0.83, 1.45	1.09	0.82, 1.45
Others	1.25	0.93, 1.69	1.25	0.93, 1.69
Lives in Poverty	1.47	1.28, 1.70	1.46	1.26, 1.69
Has Health Insurance	0.90	0.75, 1.09	0.90	0.75, 1.09
Disclosure of Transgender Identity Scale				
Disclosed to no one or a few	1.00	…	1.00	…
Disclosed to many	1.67	1.40, 1.98	2.06	1.67, 2.55
Disclosed to everyone	1.98	1.58, 2.49	2.43	1.88, 3.15
Gender Identity by Disclosure (2 x 2)				$p < .001$

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (91.0%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.03, p = .87. Final model fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 9.73, p = .28 and Negelkerke R^2 in Model 1 = 1.6%; in Model 2 = 6.6%; in Model 3 = 8.3%; and in Model 4 = 8.5%.

Table 22 Predictors of Being Denied Other Health Care during the Past Year: Logistic Regression Models (*N* = 11,836)

Predictors	Model 1		Model 2		Model 3	
Categories	OR	95% CI	OR	95%	OR	95% CI
Gender Identity						
Transgender women	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.92	0.73, 1.18	0.81	0.63, 1.04	0.95	0.72, 1.25
Transgender men	1.16	0.94, 1.43	1.23	0.98, 1.53	1.18	0.93, 1.48
Health Status						
Excellent			1.00	…	1.00	…
Very good			0.86	0.59, 1.26	0.82	0.55, 1.21
Good			1.37	0.95, 1.98	1.32	0.91, 1.92
Fair/poor			3.04	2.09, 4.41	2.80	1.91, 4.11
Any Disability			1.88	1.52, 2.32	1.82	1.46, 2.27
Visual Conformity						
Conformers			1.00	…	1.00	…
Somewhat conforming			1.10	0.88, 1.36	0.96	0.77, 1.21
Non-conformers			1.40	1.07, 1.83	1.24	0.94, 1.64
Racialized group						
Non-Hispanic white					1.00	…
Hispanic					1.20	0.77, 1.87
African American					1.17	0.69, 1.97
Biracial/multiracial					1.06	0.70, 1.62
Others					1.56	1.02, 2.37

Lives in Poverty	1.35	1.09, 1.68
Has Health Insurance	0.73	0.56, 0.96
Disclosure of Transgender Identity Scale		
Disclosed to no one or a few	1.00	…
Disclosed to many	1.58	1.21, 2.05
Disclosed to everyone	1.91	1.34, 2.72

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (91.0%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.00, p = .99. Final model fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 5.91, p = .66 and Negelkerke R^2 in Model 1 = 0.1%; in Model 2 = 6.4%; and in Model 3 = 7.8%.

Predictors of being denied other health care during the past year. On the criterion outcome of having been denied other health care, there was no support for the gender identity hypothesis (Table 22). The three gender identity groups did not differ significantly from each other in any of the models. However, three of the other main predictor hypotheses were supported. Specifically, those who were of "other" race/ethnicity (OR = 1.56) or lived in poverty (OR = 1.35) were more likely to be denied other health care, whereas those who were insured (OR = 0.73) were less likely to do so. Disclosure was observed to be counter-hypothetically predictive (OR = 1.91). Finally, none of the hypothesized interactions were significant.

Predictors of health insurance denial at least once during the past year. On the criterion outcome of having been denied any health care coverage at least once during the past year, there was ample support for the gender identity hypothesis from both the unadjusted (OR = 1.34) and fully adjusted models (OR = 1.76, Table 23). Transgender men were at significant and substantially increased risk relative to transgender women. Though not a central hypothesis, the non-binary participants reported significantly less risk than either transgender women or men. Only one of the other main predictor hypotheses was supported. The type of health insurance one had was significantly predictive, with the Medicare-insured being at particular risk (OR = 1.31). The main predictive effect of disclosure was again significant, but counter-hypothetical. The gender identity by disclosure was again the only significant interaction. However, this was a 3 x 3 interaction so the association of gender identity was depicted across all three strata of disclosure. The interaction was such that the gender identity divide—that is, the relative disadvantage of transgender men compared to transgender women—was only

Table 23 Predictors of Health Insurance Denial At Least Once during the Past Year: Logistic Regression Models (*N* = 11,407)

Predictors	Model 1		Model 2		Model 3		Model 4	
Categories	OR	95% CI	OR	95%	OR	95% CI	OR	95% CI
Gender Identity								
Transgender women	1.00	…	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.23	0.20, 0.25	0.22	0.20, 0.25	0.32	0.28, 0.36	0.37	0.32, 0.43
Transgender men	1.34	1.23, 1.46	1.37	1.25, 1.50	1.27	1.16, 1.40	1.76	1.47, 2.11
Age								
25 to 34			1.00	…	1.00	…	1.00	…
35 to 44			1.05	0.95, 1.16	0.99	0.89, 1.10	0.99	0.89, 1.11
45 to 54			0.94	0.84, 1.05	0.91	0.80, 1.02	0.91	0.81, 1.03
55 to 64			0.86	0.76, 0.97	0.80	0.69, 0.91	0.79	0.69, 0.91
Visual Conformity								
Conformers			1.00	…	1.00	…	1.00	…
Somewhat conforming			1.16	1.07, 1.27	1.02	0.93, 1.12	1.02	0.93, 1.12
Non-conformers			1.39	1.24, 1.56	1.12	0.98, 1.26	1.10	0.97, 1.25
Racialized group								
Non-Hispanic white					1.00	…	1.00	…
Hispanic					1.20	0.99, 1.47	1.20	0.98, 1.46
African American					0.98	0.77, 1.24	0.96	0.75, 1.22
Biracial/multiracial					0.96	0.79, 1.17	0.96	0.79, 1.16
Others					0.96	0.77, 1.19	0.96	0.77, 1.19
Lives in Poverty					1.00	0.89, 1.13	1.00	0.89, 1.12

Has Private Health Insurance	1.07	0.88, 1.29	1.08	0.89, 1.30
Has Medicare/Other Public Insurance	1.31	1.11, 1.55	1.31	1.11, 1.55
Has Medicaid Health Insurance	1.01	0.83, 1.22	1.01	0.84, 1.22
Has Other Health Insurance	0.84	0.67, 1.07	0.85	0.67, 1.08
Disclosure of Transgender Identity Scale				
Disclosed to no one or a few	1.00	…	1.00	…
Disclosed to many	3.04	2.76, 3.41	3.56	3.13, 4.04
Disclosed to everyone	3.49	3.00, 4.06	4.43	3.66, 5.37
Gender Identity by Disclosure (3 x 3)				$p < .001$

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (90.9%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.63, p = .43. Final model did not fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 76.81, $p < .001$ and Negelkerke R^2 in Model 1 = 11.7%; in Model 2 = 12.1%; in Model 3 = 17.8%; and in Model 4 = 18.0%.

significant (and quite large) among those who had disclosed their identity to no one or to a few people (OR = 2.20, 95% CI 1.77, 2.73), but it was null among those who had disclosed their identity to many people (OR = 1.11. 95% CI 0.99, 1.25) or to everyone in their social network (OR = 1.06, 95% CI 0.79, 1.42). Finally, one may note that this model may not be the best fit with these data. Yet, it can account for approximately a fifth of the explanation for such health insurance denials (Negelkerke R^2 in Model 4 = 18.0%). It will be retained here, as is, for consistency with the other eight analytic runs.

Predictors of being respected by a health care provider during the past year after disclosing trans identity. Table 24 displays hypothesis tests related to the criterion outcome of being respected by a health care provider after disclosure of one's transgender identity. Transgender men were more likely than transgender women to report receiving respect after such disclosure in both unadjusted (OR = 1.29) and fully adjusted models (OR = 1.55). Three of the four other main predictor hypotheses were also supported: poverty (OR = 0.84 [risk]), health insurance (OR = 1.59 [protective]) and disclosure (ORs = 8.93 and 17.05 [respective protective associations among those who had disclosed to many or everyone]). The 3 x 3, gender identity by disclosure interaction, was again significant. The interaction was such that the gender identity divide—in this instance, the relative advantage of transgender men compared to transgender women—was only significant among those who had disclosed their identity to no one or to a few people (OR = 1.70, 95% CI 1.39, 2.09), but it was null among those who had disclosed their identity to many people (OR = 0.99, 95% CI 0.81, 1.21) or to everyone in their social network (OR = 1.17, 95% CI 0.66, 2.09). Finally, the full model could account for nearly half of the criterion outcome's variability (Negelkerke R^2 in Model 4 = 43.2%).

Table 24 Predictors of Being Respected by Health Care Provider During the Past Year After Disclosing Trans Identity: Logistic Regression Models (*N* = 11,854)

Predictors	Model 1		Model 2		Model 3		Model 4	
Categories	OR	95% CI	OR	95%	OR	95% CI	OR	95% CI
Gender Identity								
Transgender women	1.00	…	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.13	0.11, 0.14	0.14	0.13, 0.16	0.21	0.19, 0.24	0.23	0.20, 0.26
Transgender men	1.29	1.14, 1.45	1.55	1.37, 1.76	1.32	1.15, 1.52	1.55	1.28, 1.87
Age								
25 to 34			1.00	…	1.00	…	1.00	…
35 to 44			1.22	1.08, 1.37	1.20	1.05, 1.38	1.21	1.05, 1.38
45 to 54			1.14	0.99, 1.31	1.23	1.05, 1.45	1.24	1.06, 1.46
55 to 64			1.38	1.18, 1.63	1.44	1.20, 1.74	1.45	1.20, 1.75
Health Status								
Excellent			1.00	…	1.00	…	1.00	…
Very good			0.89	0.77, 1.04	0.97	0.82, 1.15	0.97	0.82, 1.15
Good			0.66	0.56, 0.77	0.75	0.63, 0.89	0.75	0.63, 0.89
Fair/poor			0.46	0.39, 0.55	0.50	0.41, 0.61	0.50	0.41, 0.61
Any Disability			0.93	0.84, 1.03	0.90	0.80, 1.01	0.90	0.80, 1.01
Visual Conformity								
Conformers			1.00	…	1.00	…	1.00	…
Somewhat conforming			1.49	1.35, 1.65	1.09	0.97, 1.22	1.09	0.97, 1.22
Non-conformers			1.66	1.44, 1.93	0.88	0.74, 1.03	0.87	0.74, 1.02

Racialized group				
Non-Hispanic white	1.00	…	1.00	…
Hispanic	1.25	0.97, 1.61	1.25	0.97, 1.60
African American	1.26	0.92, 1.71	1.24	0.91, 1.69
Biracial/multiracial	0.90	0.71, 1.14	0.90	0.71, 1.14
Others	1.11	0.85, 1.45	1.11	0.85, 1.45
Lives in Poverty	0.84	0.74, 0.96	0.84	0.74, 0.95
Has Health Insurance	1.58	1.35, 1.86	1.59	1.35, 1.87
Disclosure of Transgender Identity Scale				
Disclosed to no one or a few	1.00	…	1.00	…
Disclosed to many	7.93	7.10, 8.85	8.93	7.71, 10.34
Disclosed to everyone	14.08	10.99, 18.03	17.05	12.68, 22.92
Gender Identity by Disclosure (3 x 3)				p = .02

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (91.2%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.63, p = .43. Final model fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 10.33, p = .24 and Negelkerke R^2 in Model 1 = 24.4%; in Model 2 = 27.0%; in Model 3 = 43.1%; and in Model 4 = 43.2%.

Table 25 Predictors of Participants Rating Their Trans-Related Provider as Knowing Some or Almost Nothing About Trans Health Care: Logistic Regression Models (*N* = 8,454)

Predictors	Model 1		Model 2		Model 3	
Categories	OR	95% CI	OR	95%	OR	95% CI
Gender Identity						
Transgender women	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	1.45	1.25, 1.68	1.47	1.26, 1.72	1.48	1.26, 1.74
Transgender men	1.16	1.05, 1.28	1.15	1.04, 1.28	1.18	1.05, 1.32
Age						
25 to 34			1.00	…	1.00	…
35 to 44			1.17	1.04, 1.32	1.18	1.04, 1.34
45 to 54			1.30	1.14, 1.48	1.33	1.15, 1.52
55 to 64			1.28	1.10, 1.48	1.31	1.18, 1.53
Health Status						
Excellent			1.00	…	1.00	…
Very good			1.14	0.99, 1.32	1.14	0.98, 1.33
Good			1.57	1.35, 1.82	1.54	1.32, 1.80
Fair/poor			2.18	1.83, 2.60	2.12	1.77, 2.55
Any Disability			1.17	1.05, 1.30	1.16	1.03, 1.30
Visual Conformity						
Conformers			1.00	…	1.00	…
Somewhat conforming			0.86	0.77, 0.96	0.85	0.76, 0.95
Non-conformers			0.82	0.71, 0.94	0.83	0.72, 0.96

Racialized group		
Non-Hispanic white	1.00	…
Hispanic	1.05	0.84, 1.31
African American	0.69	0.51, 0.92
Biracial/multiracial	1.15	0.92, 1.44
Others	1.09	0.85, 1.39
Lives in Poverty	1.11	0.98, 1.25
Has Health Insurance	0.86	0.73, 1.01
Disclosure of Transgender Identity Scale		
Disclosed to no one or a few	1.00	…
Disclosed to many	0.76	0.67, 0.87
Disclosed to everyone	0.76	0.64, 0.91

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (92.2%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.70, p = .40. Final model fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 6.39, p = .60 and Negelkerke R^2 in Model 1 = 0.4%; in Model 2 = 3.2%; and in Model 3 = 3.8%.

Predictors of participants rating their trans-related provider as knowing some or almost nothing about trans health care. A significant association was observed between gender identity and the participants' assessment of their provider's knowledge deficit such that transgender men were more likely than transgender women to rate their provider as knowing very little about trans care (OR = 1.16 and 1.18, respective unadjusted and adjusted models). Incidentally, non-binary individuals seemed at even greater risk (OR = 1.48). African Americans were observed to have decreased odds compared to non-Hispanic whites, which was counter-hypothetical. As hypothesized, disclosure of trans identity appeared to have a protective effect in that those who had disclosed to many or to everyone were similarly less likely to have rated their provider as having a knowledge deficit (both ORs = 0.76). None of the other main predictors nor any of their interactions were significant.

Predictors of having seen a doctor or health care provider during the past year. Transgender men were more likely to have seen a doctor or health care provider during the past year (OR = 1.59 and 1.71, respective unadjusted and adjusted models; Table 26). Three of the four other main predictor hypotheses were strongly supported. Those who lived in poverty were much less likely to have been seen by a physician or other health care provider during the past year (OR = 0.68). The odds of individuals with health insurance accessing such care were five times greater than among those who were uninsured (OR = 4.93). Again, the risks that attend transgender people living in poverty and the protections afforded to transgender people with health insurance seemed similar to those consistently observed among general, including cisgender, populations.

Table 26 Predictors of Having Seen a Doctor or Health Care Provider During the Past Year: Logistic Regression Models (*N* = 13,565)

Predictors	Model 1		Model 2		Model 3	
Categories	OR	95% CI	OR	95%	OR	95% CI
Gender Identity						
Transgender women	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.57	0.50, 0.64	0.70	0.62, 0.80	0.88	0.76, 1.02
Transgender men	1.59	1.38, 1.85	1.85	1.59, 2.16	1.71	1.45, 2.02
Age						
25 to 34			1.00	…	1.00	…
35 to 44			1.49	1.29, 1.73	1.36	1.16, 1.60
45 to 54			1.91	1.58, 2.30	1.60	1.31, 1.96
55 to 64			2.11	1.71, 2.62	1.60	1.27, 2.02
Health Status						
Excellent			1.00	…	1.00	…
Very good			1.14	0.95, 1.36	1.13	0.93, 1.37
Good			0.80	0.67, 0.96	0.93	0.76, 1.12
Fair/poor			0.73	0.60, 0.88	0.96	0.78, 1.18
Racialized group						
Non-Hispanic white					1.00	…
Hispanic					0.96	0.73, 1.26
African American					0.90	0.66, 1.23
Biracial/multiracial					0.84	0.66, 1.08
Others					1.19	0.85, 1.64

Lives in Poverty	0.68	0.60, 0.78
Has Health Insurance	4.93	4.33, 5.62
Disclosure of Transgender Identity Scale		
Disclosed to no one or a few	1.00	…
Disclosed to many	2.43	2.14, 2.77
Disclosed to everyone	2.91	2.28, 3.71

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (93.3%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.12, p = .73. Final model did not fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 17.31, p = .03 and Negelkerke R^2 in Model 1 = 2.8%; in Model 2 = 4.8%; and in Model 3 = 16.5%.

Table 27 Predictors of Transgender Participants Receiving Gender-Affirming Hormones or Surgery: Logistic Regression Models (*N* =12,756)

Predictors	Model 1		Model 2		Model 3		Model 4	
Categories	OR	95% CI	OR	95%	OR	95% CI	OR	95% CI
Gender Identity								
Transgender women	1.00	…	1.00	…	1.00	…	1.00	…
Nonbinary/gender queer	0.08	0.07, 0.09	0.09	0.08, 0.10	0.12	0.11, 0.14	0.14	0.12, 0.16
Transgender men	1.12	1.00, 1.25	1.37	1.22, 1.54	1.15	1.00, 1.31	1.47	1.23, 1.76
Age								
25 to 34			1.00	…	1.00	…	1.00	…
35 to 44			1.60	1.43, 1.80	1.56	1.37, 1.79	1.57	1.37, 1.79
45 to 54			1.74	1.52, 2.01	1.81	1.54, 2.12	1.82	1.55, 2.14
55 to 64			2.26	1.91, 2.68	2.28	1.88, 2.77	2.31	1.90, 2.81
Health Status								
Excellent			1.00	…	1.00	…		
Very good			0.86	0.74, 0.99	0.88	0.75, 1.04	0.88	0.74, 1.03
Good			0.63	0.54, 0.73	0.71	0.60, 0.84	0.71	0.60, 0.84
Fair/poor			0.49	0.41, 0.58	0.55	0.45, 0.66	0.55	0.45, 0.66
Any Disability			0.87	0.78, 0.96	0.83	0.74, 0.93	0.82	0.73, 0.92
Visual Conformity								
Conformers			1.00	…	1.00	…	1.00	…
Somewhat conforming			1.13	1.03, 1.24	0.78	0.70, 0.87	0.78	0.70, 0.87
Non-conformers			1.22	1.07, 1.40	0.64	0.55, 0.75	0.63	0.54, 0.73

Racialized group				
Non-Hispanic white	1.00	…	1.00	…
Hispanic	1.15	0.90, 1.46	1.14	0.90, 1.45
African American	1.22	0.91, 1.63	1.19	0.89, 1.60
Biracial/multiracial	1.06	0.84, 1.32	1.06	0.84, 1.33
Others	0.93	0.73, 1.20	0.94	0.73, 1.20
Lives in Poverty	0.70	0.62, 0.79	0.69	0.62, 0.78
Has Health Insurance	1.71	1.49, 1.97	1.72	1.50, 1.98
Disclosure of Transgender Identity Scale				
Disclosed to no one or a few	1.00	…	1.00	…
Disclosed to many	7.68	6.90, 8.55	9.24	8.01, 10.65
Disclosed to everyone	13.93	11.02, 17.61	19.09	14.23, 25.53
Gender Identity by Disclosure (3 x 3)				$p < .001$

Notes. CI, confidence interval; OR, odds ratio. An odds ratio of 1.00 is the baseline. Participants with valid data on all variables were included (87.7%). Missing data were completely at random: Little's MCAR χ^2 (1) = 0.07, p = .80. Final model did not fit the data well: Hosmer and Lemeshow goodness-of-fit test χ^2 (8) = 59.80, $p < .001$ and Negelkerke R^2 in Model 1 = 33.9%; in Model 2 = 36.8%; in Model 3 = 50.3%; and in Model 4 = 50.4%.

Large hypothesized protections, indicative of much greater health care access, were also observed among people who had disclosed their trans identity to many (OR = 2.43) or to everyone (OR = 2.91) in their social network. No significant interactions were observed.

Predictors of transgender participants receiving gender-affirming hormones or surgery. Like the service use pattern observed in the previous analytic run, transgender men were more likely to have received gender- affirming surgical or hormone treatments (OR = 1.12 and 1.47, respective unadjusted and adjusted models; Table 27). Again, three of the four other main predictor hypotheses were supported. Those who lived in poverty were much less likely to have received such gender-affirming treatments (OR = 0.69) whereas having health insurance increased the odds of such access (OR = 1.72). Again, extraordinarily large hypothesized protections, indicative of much greater trans care access, were also observed among people who had disclosed their trans identity to many (OR = 9.24) or to everyone (OR = 19.09) in their social network. Incidentally, visual non-conformers were again at significant risk of such service nonreceipt. The 3 x 3, gender identity by disclosure interaction, was again significant. The interaction in this medical transition care context was such that among those who had disclosed their identity to no one or to a few people, a relative advantage of transgender men compared to transgender women was observed (OR = 1.57, 95% CI 1.29, 1.90). Among those who had disclosed their identity to many people, there was no such between group difference (OR = 0.87, 95% CI 0.72, 1.05). Among those who had disclosed to everyone in their social networks, a relative disadvantage of transgender men was observed (OR = 0.53, 95% CI 0.31, 0.90). Finally, the full model accounted for more than half of the variability in medical trans care (Negelkerke R^2 in Model 4 = 50.4%).

Chapter 5: Discussion

Summary of Findings

Discussion of main effects. This study examined transgender men's access to health care, while considering the effects of race, health insurance, poverty and disclosure as risk or protective factors that may moderate the experience of health care access and quality of care. Guided by intersectionality theory and using the lenses of Levesque et al.'s (2013) and Carrillo et al.'s (2011) conceptual models of health care access, nine hypotheses were tested across nine different outcomes which reflected dimensions of health care access for transgender populations. This study offers several significant findings. First, consistent with prior research, it affirms that transgender people are not a homogeneous group and that their experiences of health care access varied based on their gender identity (Cruz, 2014; Jaffee et al., 2016; Shires & Jaffee, 2015). This was consistent across eight of the nine outcomes examined. Transgender men were more likely to engage in health care utilization. Yet, in their interface with health providers or health systems, they experienced greater disadvantages than trans women in many domains, after controlling for other factors. They were more likely to postpone care due to cost or fear of mistreatment, to be denied trans-related care, to be denied by their insurance carrier, and to rate their provider as having a knowledge deficit about trans-related care. These findings support the first hypothesis that transgender men experience less access to health care relative to transgender women.

Paradoxically, transgender men were more likely to report being respected by their provider after disclosure of their trans identity compared to transgender women. This finding may be reflective of the gender inequality which exists within U.S. culture in

that the increased odds of trans men receiving respect from health care providers may be a manifestation of their male privilege. This is aligned with other research and commentary on the increased advantages experienced by trans men in the workplace post-transition (Schilt, 2006; McBee, 2018, August 9). Consistent with intersectionality theory, there are commonalities in transgender people's experience of health care access produced by a culture of cisgenderism and cisnormativity. There are also varying degrees of privilege and oppression based on one's social location. Like cisgender people, trans people are impacted by the forces of sexism within a patriarchal power structure, wherein men experience greater advantage and privilege over women. The advantage that trans men may have relative to trans women in receiving respect from health providers may be further explained by the presence of trans-misogyny. That is, trans women experience intersecting axes of oppression based on their multiple marginalized identities as transgender and as women (Serano, 2007). Trans women experience barriers to accessing quality health care (Hudson, 2019) and are at greater risk of experiencing sexual violence and suffering its health consequences (Matsuzaka & Koch, 2019). Intersectionality does not preclude the existence of paradoxical findings, but rather, acknowledges that "microlevel and macrolevel experiences intersect at the nexus of multiple social inequalities and is broad enough to include populations who inhabit dimensions of social privilege and oppression simultaneously" (Bowleg, 2012, pg. 1270).

Second, this study provides hypothesis support that transgender individuals who live in poverty are less likely than non-poor trans people to have access to health care. This finding is consistent with extant knowledge about poverty and decreased health care access among general (presumably cisgender) populations (Hoffman & Paradise, 2008;

Institute of Medicine, 2009). Transgender people experience pervasive discrimination in other domains within their lives. Because of transphobia and cisgenderism, they are more likely to be underemployed or unemployed which contributes to their economic disparities (Grant et al., 2011; Institute of Medicine, 2011; James et al., 2016). Among this study sample, 22.8% of the participants were living in poverty, compared to 13.5% within the general U.S. adult population in 2015 (Proctor, Semega, & Kollar, 2016). The disproportionate prevalence of poverty among transgender people makes health care access even more challenging as they struggle with concerns regarding the affordability of care. In this present study, poverty had a main effect among seven of the nine outcomes examined and proved to be a substantial risk factor in transgender people's ability to access care. Those who lived in poverty were more likely to postpone care or to be denied health care. They were also less likely to utilize health care services or to be respected by their provider. Postponing care or being denied care can lead to worse general and mental health (Seelman et al., 2017). Not being able to access gender-affirming hormones or surgery can exacerbate feelings of dysphoria (Coleman et al., 2012). In the current climate, as politicians and policymakers continue the heated discourse on health care reform in the U.S., consideration must be given to underserved and vulnerable populations, particularly those who are not eligible for Medicaid and cannot afford private insurance. Transgender individuals who live in poverty are at great risk of having unmet health care needs.

Third, aligned with existing research on general populations in the U.S. (Blackwell et al., 2009; Hoffman & Paradise, 2008; Institute of Medicine, 2009), this study provides support that transgender people with health insurance are more likely to

have access to health care than those who do not have health insurance. Health insurance provides the means to finance health care expenses. In the U.S., most people have private health plans obtained primarily through an employer and many others have publicly funded health plans. The rate of health insurance coverage and the distribution of coverage types may vary over time, reflecting economic trends and changes in policy which affect access to health care (Barnett & Vornovitsky, 2016). Among the study sample, 13.7% did not have any health insurance coverage, compared to 9.1% of the U.S. general population during 2015 (Barnett & Vornovitsky, 2016). The increased prevalence of transgender people being uninsured is consistent with prior research (dickey et al., 2016). Among transgender people, health insurance is a protective factor that potentiates the ability to access health care (Cruz, 2014; Kattari & Hasche, 2016). Transgender participants who had health insurance were more likely to have seen a provider in the past year, to have received medical transition services, and to report being respected by their provider after disclosure of their trans identity. Conversely, they were less likely to have delayed care or to have been denied care. The implications of these results are significant, as having health insurance has been shown to decrease morbidity and mortality rates and contributes to overall quality of life (Hoffman & Paradise, 2008).

Fourth, extant studies have demonstrated the greater vulnerabilities experienced by racialized minority group members compared to non-Hispanic white people in accessing health care, both within the U.S. general population (Hausmann et al., 2008; Institute of Medicine, 2009) and among transgender people (Bradford et al., 2013; Cruz, 2014; dickey et al., 2016; Institute of Medicine, 2011; Kattari & Hasche, 2016; Kattari et al., 2015; Rodriguez et al., 2017; Shires & Jaffee, 2015; White Hughto et al., 2016). The

present study offers some hypothesis support that racialized minority group members are less likely than non-Hispanic white people to have access to health care. Specifically, biracial/multiracial people were observed to have increased odds in delaying care due to cost. Similarly, those who were in the "other" race category were at increased risk of delaying care due to possible mistreatment and being denied other health care. The lack of substantial and consistent support conveying the vulnerabilities experienced by racialized minority group members may be a result of this study sample's lack of representativeness of trans people of color. The sample consisted predominantly of non-Hispanic white people (83.4%). Still, the findings in the present study suggest that minority group members do not have equitable access to health care and that they carry the burden which racism produces. Transgender people of color hold multiple social identities and are confronted with discrimination in multiple domains (Erich, Tittsworth, Colton Meier et al., 2010). The barriers created by racism may complicate the barriers produced by cisgenderism. In the U.S., laws against discrimination based on race are more prevalent compared to laws protecting transgender people against discrimination based on their gender identity or expression. While the laws prohibiting racial discrimination may not eliminate racism, it may make the racism more covert, though not less harmful (Erich, Tittsworth, Colton Meier et al., 2010). Although racial group status did not surface as a consistently significant predictor in the present study, it remains an important factor in understanding the complexities of health care access.

Lastly, this study affirms the complex nature of disclosure about one's trans identity. The main effect of disclosure was observed to be both a protective factor and a risk factor depending on the outcome being examined. For example, those who were out

to everyone had 17-fold increased odds of experiencing respect from a health care provider compared to those who were not out or were out to only a few people. They were also more likely to engage in help-seeking behavior or to undergo medical transition services, depicting a sense of agency. Regrettably, disclosure was also found to be counter-hypothetical by increasing the risk of experiencing barriers to health care access. Transgender participants who were out to many or everyone in their support system had increased odds of being denied care (both trans-related and other health care), of being denied by their insurance, and of delaying care due to fear of mistreatment. These findings highlight some of the risks and benefits that transgender people must weigh when making the decision to be out or not.

Trans health researchers have noted the increased risk for health disparities and poor health outcomes among patients who keep their identity hidden. Health care providers who are not aware of their patients' anatomy and the presence/absence of specific organs may not consider gender-specific disorders. This can lead to delayed diagnosis and treatment which in turn, can result in increased morbidity and mortality (Lombardi & Banik, 2015; Unger, 2014). The observation that three quarters of the total sample was treated with respect by their health provider after disclosing their trans identity offers hope, in that individuals who take the risk of disclosure may experience acceptability by their provider. Yet, patients should not be the ones to bear the burden of responsibility to reveal their trans identity to their health providers. The burden of responsibility rests with providers to increase their medical and cultural competence to serve trans individuals, and with health systems to create a welcoming and inclusive environment so that trans people can feel safe to disclose their transition status. Those in

positions of power are responsible for advancing equity in health care access (Miller & Grollman, 2015).

Discussion of interaction effects. The main effects showed that transgender men were more likely than transgender women to experience barriers to health care access. The significant interaction effect of gender identity by disclosure was observed for five of nine outcomes in the present study. This interaction revealed that transgender men who engaged in limited to no disclosure about their trans status experienced relatively larger disadvantages in health care access. In contrast, among those who have disclosed their identity, the relative disadvantage of trans men compared to trans women were smaller. This finding was consistent across all the outcomes that had a significant interaction effect and provides support for the notion that disclosure may be a protective factor. It also affirms the need to consider intersectional approaches to serving trans men, with the understanding that those who keep their identities hidden may experience greater vulnerabilities. Future qualitative studies may shed light on the complex dynamics of disclosure and bolster theory about gender-based help seeking behavior.

The findings were null for the other interaction terms (gender identity by race; gender identity by poverty; and gender identity by health insurance). This suggests that among those who belonged to a racialized minority group, lived in poverty, or had health insurance, no differences based on gender identity were found. That is, trans men did not specifically experience a disadvantage compared to trans women. Extrapolating further, these findings suggest that the disadvantages experienced by the transgender people in this study's sample were more likely produced by a cultural milieu of cisgenderism and that their experience of health care access were not moderated by race, poverty, or health

insurance status. Yet, these null findings should also be interpreted with some caution. As stated earlier, this study's sample lacked representativeness from racialized minority groups. In addition, most of the sample had health insurance (86.3%) and most had a household income above the poverty line (77.2%).

Discussion of other findings. The findings in this study also unveiled non-binary/gender queer people's experiences of health care access in relation to trans women and trans men. Non-binary individuals were less likely to receive gender-affirming hormone treatments or surgery, to be denied trans-related care, or to be denied by their insurance carriers. Because they do not subscribe to the gender binary, they may have less need for these services. Yet, within a two-gender medical system, their queering of the gender binary places them at greater risk of experiencing certain barriers. For example, of the three gender identity subgroups, non-binary individuals were the least likely to feel respected by their providers and were the most likely to rate their providers as knowing some or almost nothing about trans health care. Non-binary people are another underrepresented subgroup in transgender research and additional inquiry is needed to explore their vulnerabilities and resiliencies.

Finally, visual conformity had a confounding influence across several of the outcomes in this study. Aligned with previous research (Miller & Grollman, 2015; Rodriguez et al., 2017), this study found that transgender individuals who were somewhat visually conforming or non-conforming experienced greater disadvantage in health care access. Specifically, they were more likely to report having delayed care due to cost or fear of mistreatment and to be denied trans-related care. They were less likely to utilize gender-affirming hormones or surgery. These findings align with the reality that many

transgender individuals experience economic disparities and compromised access to adequate health insurance coverage due to employment inequities. Thus, economically disadvantaged individuals are more likely to be visually non-conforming and more likely to under-utilize health care or trans care due to structural and interpersonal discrimination.

Within a culture of medicine which adheres to a binary model of gender, individuals who do not fit prescribed gender stereotypes in their presentation may perceive or anticipate a lack of acceptance by their providers and experience increased barriers to access. By passing as their affirmed gender, those who are visually conforming may be able to avoid direct interpersonal discrimination. However, like disclosure, the dynamics of visual conformity can be complex. While there are advantages to passing as one's affirmed gender, especially in social contexts where safety is a concern, passing and not disclosing one's trans status when seeking medical care does not guarantee positive health outcomes. As Cruz (2014) aptly stated:

> …disclosure plays a role that counteracts and complicates visibility. Being out when seeking care is crucial for the provision of certain forms of care…Disclosure, operating in conjunction with changes in visibility and perception that may be brought on by hormonal therapy, marks the point at which participants become discreditable or discredited, exposing them to direct stigma. (p. 72)

Future research should further explore the complex interplay between visual conformity and disclosure in health care access.

The Canadian Context

Health care systems exist within a socio-economic, political, and cultural context. Because the USTS dataset consists of transgender people residing in the U.S. only, the findings may be limited in their generalizability to transgender people in other countries such as Canada. For example, concerns about health insurance access may be less relevant for transgender people residing in Canada where a single payer health system exists. Yet, even in the Canadian context where health care access is intended to be universal, transgender people have a high prevalence of unmet medical need and encounter significant barriers. As Giblon and Bauer (2017) pithily noted, "it appears that equal recognition of the availability of health care…does not translate into equal access" (p. 6).

Results from the Trans PULSE Project revealed that one-third of transgender individuals in Ontario reported experiencing an unmet health need in the past year. Although trans men and trans women were equally as likely to rate the availability of health care in their community as poor, trans men were two times more likely than trans women to rate the quality of health care in their community as poor (Giblon & Bauer, 2017). Trans Ontarians were less likely to have a family physician than the general Ontario population, making them more likely to use walk-in clinics. Among the trans Ontarians who had a family physician, approximately half reported that they were uncomfortable talking to their physician about trans health issues. Over one-third of trans men and trans women respectively reported at least one negative experience with a family physician (Bauer, Zong, Scheim, Hammond, & Thind, 2015). Only 71% of those who needed emergency department (ED) services in the past year prior to the survey

reported that they were able to obtain such services. More than half of the trans ED users reported having a negative experience in the ED when they presented in their affirmed gender. One in five respondents reported that they have avoided using the ED for this reason (Bauer et al., 2014). Physicians in Ontario reported multiple barriers to providing care for trans patients including their trans-specific knowledge deficit, ability to access trans-friendly resources or referral networks, and the constraints of a medical system which relies on a binary model of gender (Snelgrove et al., 2012). Finally, this study's null interactions of gender identity with race, poverty or health insurance seem particularly instructive. It strongly suggests that one may anticipate observing similar vulnerabilities among diverse transgender Canadians who reside in diverse Canadian places. For now, though, this is probably best thought a developed hypothesis that remains for future research testing in Canada. Thus, although health care policy may vary between both countries (i.e., single payer system in Canada versus numerous private and public sources of health insurance in the U.S.), transgender people in Canada seem to experience similar interpersonal discrimination and systemic barriers from health care providers and health systems as their U.S. counterparts. Therefore, the findings of the present study can be used to cautiously inform health care providers in Canada as well as the U.S.

Access to medical transition services in Canada has been and continues to be challenging. Coverage for gender-affirming surgeries varies by province and public funding is not available for all types of surgeries. Highlighting the context in Ontario, for example, gender-affirming surgeries were delisted in the Health Insurance Act from 1998 to 2008, which meant that no public funding was available for trans people to receive

such surgeries during this period. From 2008 to 2016, the assessment of candidacy for gender-affirming surgeries was available only through the Centre for Addiction and Mental Health's Gender Identity Clinic located in Toronto, Ontario (see https://www.camh.ca/en/your-care/programs-and-services/gender-identity-clinic-adult). Moreover, only one hospital site in Canada provided publicly funded bottom surgeries: the GRS Montréal located in Quebec (Canadian Professional Association for Transgender Health, 2017). This limited availability meant that trans patients had to endure significant wait times and the burden of travelling long distances to receive their surgeries. Much change was needed to improve this service gap.

Some notable reforms have been made in Ontario within recent years. In March 2016, the Ministry of Health and Long-Term Care (MOHLTC) announced a regulatory change to increase access to gender-affirming care (see http://www.health.gov.on.ca/en/pro/programs/srs/). These new regulations allow qualified primary care providers (i.e., physicians and nurse practitioners) to coordinate referrals for gender-affirming surgeries. In addition, qualified health professionals can provide an assessment of candidacy for gender-affirming surgeries—hence minimizing the bottle neck for assessment and referral services at the Centre for Addiction and Mental Health. The Ontario Health Insurance Plan (OHIP) criteria for gender-affirming surgeries align with the WPATH's Standards of Care. To receive OHIP-funded gender-affirming surgery, the patient must obtain prior approval from the MOHLTC. The patient's physician or nurse practitioner must submit the Request for Prior Approval for Funding of Sex-Reassignment Surgery Form to the MOHLTC, along with the necessary supporting assessment(s). The number of supporting assessments required depend on the type of

surgery requested. For top surgery, one supporting assessment from a physician or nurse practitioner is required. For bottom surgery, two supporting assessments are required (one from a physician or nurse practitioner and a second assessment from a physician, nurse practitioner, psychologist, or a registered social worker with a master's degree). Once received, the MOHLTC will review the application and notify the patient and referring provider regarding the outcome of the funding application. If approved, OHIP will provide coverage for the following procedures, as outlined in the Schedule of Benefits: mastectomy, vaginectomy, salpingo-oophrectomy, hysterectomy, phalloplasty, metoidioplasty, scrotoplasty, erectile and/or testicular implant, orchidectomy, labiaplasty, clitoroplasty, vaginoplasty, and augmentation mammoplasty (if no breast enlargement has occurred following 12 consecutive months of hormone therapy). Unfortunately, the following procedures are not covered by OHIP as they are deemed to be cosmetic, rather than medically necessary procedures: liposuction, electrolysis, laser hair removal, hair implants, chest contouring/masculinization, tracheal shave, voice modification surgery, chin, nose, cheek or buttock implants, and facial feminization/masculinization (Ministry of Health and Long-Term Care, 2015).

Although the new regulations improved access for the assessment of candidacy and coordination of referrals, the availability of sites offering gender-affirming surgeries was still limited. In response to this need, the Trans Health Expansion Partnership (THEx) was formed, consisting of several organizations collaborating together: Women's College Hospital, Sherbourne Health Center (including its Rainbow Health Ontario program), and the Centre for Addiction and Mental Health. Beginning in 2018, the Women's College Hospital offers gender-affirming surgeries through its Transition-

Related Surgery Program, making it the second site in Canada to offer such services (Grant, 2017). Additionally, the Rainbow Health Ontario builds capacity for trans health care by providing clinical and cultural competency training to health care providers (see https://www.rainbowhealthontario.ca/trans-health/).

Having adequate capacity to accommodate the demand for services is important, as this can affect access to care. Inadequate capacity can translate into delayed care due to long waiting periods, which can prolong suffering. In Ontario, health providers recommending surgery are considered qualified if they have worked at a health care facility that provides primary health care for transgender patients in accordance with the WPATH Standards of Care. Qualifications can also be received through training in the assessment, diagnosis, and treatment of gender dysphoria in accordance with the WPATH's Standards of Care. Such training is available at the WPATH conference, the Canadian Professional Association for Transgender Health conference, or through Rainbow Health Ontario (Trans Health Expansion Partnership, n.d.).

Despite these improvements, access to transition-related care can still be impacted by poverty and financial barriers. Even if public funding for the top or bottom surgery was approved, trans patients must also consider out-of-pocket expenses such as the cost of the assessments, travel-related expenses, aftercare facilities, and aftercare supplies. Because many trans people experience economic disparities resulting from their marginalization, those who do not have the financial resources to absorb the out-of-pocket expenses are disadvantaged in their access to care. For example, any travel-related expenses involved in obtaining surgery are not covered by OHIP. Trans patients who live in northern Ontario may be eligible for the Northern Health Travel Grant Program, which

helps to defray cost for eligible Northern Ontarians seeking medical specialist services at a publicly funded health care facility (see http://health.gov.on.ca/en/public/publications/ohip/northern.aspx). However, trans individuals living in other parts of Ontario may not be able to afford the travel expenses to the Women's College Hospital located in Toronto. The long travel distance to Toronto can make transition surgery out of reach for economically disadvantaged trans Ontarians.

Moreover, trans Ontarians living in poverty can experience multiplicative disadvantages. As noted in previous studies (Miller & Gollman, 2015; Rodriguez et al., 2017) as well as in the present study, visually non-conforming individuals are at greater risk for experiencing discrimination. For transgender individuals, these so-called "cosmetic" surgeries can mean the difference between passing or not passing in their affirmed gender—and thus, decreasing or increasing their risk, respectively, of experiencing discrimination. Although public funding for top and bottom surgeries may be available, trans Ontarians who live in poverty experience greater disadvantages in their access to transition-related care, which can impact their overall quality of life.

Though the availability of resources has expanded in Ontario, trans people who live in other provinces continue to struggle with limited access. Public funding for transition-related medical care is not universally available across all provinces and territories, nor are all gender-affirming surgeries covered. Furthermore, the referral and assessment process to receive gender-affirming surgeries also varies by province. For example, trans people in Saskatchewan, Newfoundland, and Labrador must still receive approval from the Centre for Addiction and Mental Health in Ontario to receive transition-related surgeries. Conditional funding for out-of-country transition-related

surgical procedures is not available in Alberta, Quebec, New Brunswick, Nova Scotia, and Prince Edward Island. Public funding for gender-affirming surgeries are not available in the Northwest Territories and Nunavut (Canadian Professional Association for Transgender Health, 2017). Again, those who do not have the resources to pay privately or to absorb the out-of-pocket expenses are disadvantaged in their access to transition-related care.

Informational erasure about trans health care can result in a limited availability of qualified professionals to conduct surgery readiness assessments, thereby producing long wait times. In British Columbia, most surgeons require surgery readiness assessments regardless of whether the surgery was publicly or privately funded. A recent survey of trans people's experiences with surgery readiness assessments found that the average wait times for these assessments varied depending on the type of surgery being requested. Among trans people in British Columbia, the average wait time for an assessment visit ranged from 607 days for facial feminization surgery to 212 days for vaginoplasty. Approximately 40% of these participants reported that getting a referral for a surgery readiness assessor was "difficult" to "very difficult" (Frohard-Dourlent, Coronel Villalobos, & Saewyc, 2017). These long wait times translate to unmet need and individuals must suffer the effects of their gender dysphoria for a prolonged period before access is realized.

Implications for Policy and Practice

Advocates and scholars are gradually making strides to increase awareness and to close the gap on the inequities encountered by transgender people. This has begun to shape policy and practice. In 2011, the Institute of Medicine released a report entitled,

The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding which illuminated the physical and mental health disparities sexual and gender minority populations experience and specifically identified the need for increased representation of transgender people in health research. In the same year, The Joint Commission—an independent organization which accredits and certifies health care organizations and programs in the U.S.—revised their standards for patient-centered communication to prohibit discrimination based on sexual orientation, gender identity, and gender expression (The Joint Commission, 2011a). In addition, they published a monograph entitled, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide,* which was intended to be a self-assessment tool and educational resource that health care organizations can use to improve their health systems and care for LGBT communities and families (The Joint Commission, 2011b). To combat erasure and dislodge the cisgender experience from its place of privilege, multiple professional organizations have published best practice guidelines to promote cultural competency in serving transgender populations. Among these are:

- *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (American Psychological Association, 2015)
- *Competencies for Counseling with Transgender Clients* (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009)
- *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients* (Gay and Lesbian Medical Association, 2005)

- *Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff* (National LGBT Health Education Center, 2016)

Even the National Association of Social Workers (NASW) has published position statements explicating their stance on transgender issues (2006) and the use of conversion or reparative therapies to change a person's sexual orientation or gender identity (2015a), calling for affirmative practice methods which empowers clients to achieve self-actualization.

Lawmakers at the federal level have also made efforts to eliminate discrimination and inequities for gender minority populations which are reflected in the Affordable Care Act (2010) and the Department of Health and Human Services' regulations (2016) as outlined in Chapter 2 of this dissertation. Additionally, the U.S. Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology announced in October 2015 that sexual orientation and gender identity (SO/GI) data collection are included in their requirements for electronic health record systems certified under the Meaningful Use incentive program. This is a voluntary program intended to:

1. Improve quality, safety, efficiency, and reducing health disparities
2. Engage patients and families in their health
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protection for personal health information (see https://www.cdc.gov/ehrmeaningfuluse/introduction.html).

Taking effect in 2018, Stage 3 of the Meaningful Use program require all certified electronic health record systems and software to allow users to record and access SO/GI data, as the "inclusion of this information can help those within the patient's care team to have more information on the patient that can aid in identifying interventions and treatments most helpful to the particular patient" (Department of Health and Human Services, 2015, p. 408). The collection of SO/GI data is a crucial step to improving care for and understanding the health disparities among sexual and gender minority populations (Cahill, Baker, Deutsch, Keatley, & Makadon, 2016).

Yet, ongoing advocacy work and social activism are still needed. Despite these strides, structural barriers continue to exist which maintain transgender people's oppression. Under the current Administration, the Department of Health and Human Services will not investigate complaints about anti-transgender discrimination. On December 31, 2016, a court order was issued by the U.S. District Court for the Northern District of Texas enjoining the Health Care Rights Law's prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. Consequently, the Department of Health and Human Services' Office for Civil Rights may not enforce protections against anti-transgender discrimination while the injunction remains in place (Franciscan Alliance, Inc. et al v. Burwell, 2016). Moreover, there is a current proposal to adopt a uniform definition of gender as a "biological, immutable condition determined by genitalia at birth" (Green, Benner, & Pear, 2018, October 21). The injunction and the proposed redefinition render transgender identities invisible and threatens to unravel the efforts made in advancing equity.

As for SO/GI data collection in health systems, the new requirements of the Meaningful Use program apply to developers who are building certified electronic health record systems and health institutions who are participating in the Meaning Use program. The final ruling does not necessitate providers to collect SO/GI information from their patients. That is, the fields for SO/GI data need to be available in the electronic health records, but practitioners are not mandated to ask the questions during their patient visits to collect this information. Furthermore, improvements are needed in health care systems to make them more conducive to data collection. Many electronic health record systems do not allow providers to input a patient's preferred name other than the one used for billing or documentation purposes (Ducheny et al., 2019). Vendors of electronic health record software need to create an architecture with an intuitive workflow to support SO/GI data collection by clinicians (Cahill et al., 2016). Health care providers need to be trained on how to collect and use SO/GI data (Cahill et al., 2016). Lastly, policies within health care organizations need to be examined. Without robust non-discrimination policies in place, some transgender patients have de-transitioned (by shifting their gender presentation back to their sex assigned at birth) when they enter these health care systems (Ducheny et al., 2019). Much foundational work remains to promote health equity for transgender communities.

The social work profession is committed to encouraging respect for diversity, advancing equity and social justice for all people, and challenging the oppression of marginalized and vulnerable groups (NASW, 2017). The NASW *Code of Ethics* (2017) as well as the *Standards and Indicators for Cultural Competence in Social Work Practice* (2015b) specifically recognize gender identity and expression as dimensions of diversity

which should be respected and informs the discussion about implications for practice with transgender populations. Cultural competence is defined as "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes" (NASW, 2015b, p. 13). Cultural competence requires social workers to develop an awareness of their own position of power and privilege vis-à-vis the client populations that they serve. In addition, social workers must demonstrate cultural humility by engaging in continual learning and self-evolvement which bridges the social distance and power discrepancy between themselves and their client systems. Using an intersectionality approach to practice, culturally competent social workers examine "forms of oppression, discrimination, and domination through diversity components of race and ethnicity, immigration and refugee status, religion and spirituality, sexual orientation and gender identity and expression, social class, and abilities…The achievement of cultural competence is an ongoing process" (NASW, 2015b, p. 10).

This study acknowledges the barriers that transgender people experience and underscores the need to advance equity in health care access. Given the pervasive nature of cisnormativity and cisgenderism, creating a safe and trans-affirmative health care environment requires a multi-level and multi-faceted approach (Hatzenbuehler & Link, 2013; Link & Phelan, 2001; White Hughto, et al., 2015). Cultural competence is necessary for all levels of social work practice: micro, mezzo, and macro (Burdge, 2007; NASW, 2015b; Van Den Bergh & Crisp, 2004). Though social work practice is often conceptualized as consisting of three separate levels, they are intertwined and can be

practiced in tandem. Moreover, researchers have conceptualized stigma as occurring at different levels (Hatzenbuehler & Link, 2013; Link & Phelan, 2001, 2014) and have explained how each level of stigma resulting from a culture of cisnormativity and cisgenderism manifests for trans populations (White Hughto, et al., 2015). For change to be sustainable, interventions to combat stigma must occur at all levels (Link & Phelan, 2001; White Hughto et al., 2015). Examples of trans affirmative social work practice at each level and how they relate to combatting stigma are outlined below.

Change begins with self-awareness and knowledge. Social workers need to engage in an examination their own values and biases which may intentionally or unintentionally perpetuate cisgenderist practices (Van Den Bergh & Crisp, 2004). They are encouraged build a knowledge base about transgender people and their needs, which includes an understanding of the socio-political and historical context of transgender populations and how the experience of stigma may contribute to trans people's morbidity and mortality (NASW, 2016). Awareness of community resources (e.g., support groups, service organizations, referral networks, etc.) and other trans-friendly providers is important, as these resources can provide social support, promote resilience, and enhance trans individuals' self-affirmation (National LGBT Health Education Center, 2016). A stance of cultural humility necessitates ongoing education because the terminology about trans identities and the distinctions between various trans communities and their cultural norms often evolve (Collazo, et al., 2013; Witten, 2016).

At the micro level of practice, social workers serve as advocates, diagnosticians, educators, and therapists for patients and their families (Collazo et al., 2013). Culturally competent social workers engage in respectful communication by avoiding assumptions

about a person's gender identity and using affirming and inclusive language which is respectful of their patients' preferences (e.g., using their patients' preferred names and pronouns) (National LGBT Health Education Center, 2016; Transgender Law Center, 2016). They create a safe and welcoming environment which empowers trans patients to share their narratives (Martin & Yonkin, 2006). Social workers can play an important role in affirming their patients' trans identity such as providing access to personal items that assist with gender presentation, supporting patients in their coming out process, providing information about the legal transition process, and facilitating the medical transition process by making referrals to the necessary providers (Collazo et al., 2013). Social workers may mediate between trans patients and their families. By supporting families who are having difficulty coping with the patient's trans status, social workers can mitigate family rejection and enhance their trans patients' social support system (Collazo et al., 2013; White Hughto et al., 2015). Because many trans people experience rejection from their families of origin, many trans individuals create a surrogate family. Trans affirmative social workers use an expanded definition of family to include the patient's family of choice and recognize their legitimacy (Collazo et al., 2013).

Additionally, social workers may provide psychoeducational support groups for trans patients and their families, empowering these client groups with knowledge about available resources and building their collective self-esteem by enabling them to share their narratives. Through engagement with other transgender people, patients can share strategies for resilience and expand their support system. These connections can provide a pathway for trans patients to develop a collective identity and participate in collective activism (White Hughto et al., 2015). Interventions at the micro level of practice are

aimed at alleviating individual and interpersonal stigma by helping trans patients reduce their shame about their trans identity, improving their coping skills, and creating greater acceptance within family systems.

This study affirms the heterogeneity of transgender populations. Because oppression takes many forms, social workers should assess the intersection of their patients' gender identity with other identities which may impact their experience of minority stress (Burdge, 2007; Van Den Bergh & Crisp, 2004). Just as research on cisgender populations has shown differences between men and women's experiences of health and health care, differences also exist among trans men, trans women, and non-binary people. Whether cis or trans, the experience of gender matters. While there are commonalities in transgender people's experiences of oppression, culturally competent social workers are also mindful about the differences among trans populations and avoid the assumption that all trans people are the same. Furthermore, as this study demonstrates, the disclosure of one's trans identity is complicated. Social workers who embrace gender diversity and demonstrate empathy towards their trans patients can begin to minimize the risks associated with disclosure, where trans patients are not forced to choose between disclosing and risk being discriminated against, or not disclosing and risk not receiving the preventive care that they need.

Within many health care settings, social workers practice in team environments working alongside other professional disciplines to provide the psychosocial aspects of care (NASW, 2016). At the mezzo level of practice, social workers may mediate between their trans patients and other members of the interdisciplinary team or the health care institution (NASW, 2016). As advocates for social justice and equity, social workers

often serve as formal or informal leaders within health care organizations. Culturally competent social workers can educate their interdisciplinary colleagues about trans inclusivity and call for a self-assessment of the organization's policies and practices (Collazo et al., 2013; NASW, 2016; National LGBT Health Education Center, 2016). They can be involved in designing and implementing change and promoting proactive efforts within the organization to build a trans affirmative environment. Examples of such change efforts include: the development of patient and employee non-discrimination policies (to ban discrimination against sexual orientation, gender identity, and gender expression); creating a process for reporting and redressing discrimination if it occurs; creating trans affirmative policies (such as patient room assignments within sex segregated systems); incorporating inclusive language on intake forms and assessment tools; promoting a welcoming environment within the physical space of the organization (such as the availability of universal bathrooms or placing trans-friendly visual cues in the waiting area); and adding gender affirmative imagery and content on patient education and marketing materials. These efforts help to create a gender-affirming organizational culture (Gay and Lesbian Medical Association, 2005; Moone, Croghan, & Olson, 2016; National LGBT Health Education Center, 2016; Wilkerson, Rybicki, Barber, & Smolenski, 2011). The interventions at the mezzo level of practice are intended to combat interpersonal and structural stigma by promoting system-level change to improve access and service delivery.

More specifically, based on the findings from this study which showed greater disadvantage among trans men in their access to health care, social workers can motivate their teams to ask: Do our medical staff need training on effective screening methods for

trans men's bodies (e.g., pap smear, breast examinations/mammograms, etc.) based on the patient's transition status? What systems can we implement in our intake process or electronic health records to reduce the potential for denial by insurance companies? Can we create a list of community resources (e.g., support groups for trans men) to which we can refer based on our patients' identified needs? Can we create an educational brochure to be displayed in our waiting area which outlines some of the health issues relevant for trans men? Can we implement a safe and non-threatening process (e.g., a patient satisfaction survey) for our trans patients to provide feedback to us regarding the quality of the care they received from us? Though not an exhaustive list, addressing such questions can begin to improve access and quality of care for trans men.

At the macro level of practice, social workers can engage in activism to affect change at the community, state, or national levels. They can collaborate with trans activist organizations to promote equity in policies and laws affecting trans people (Lewis, 2017). They can bring attention to transgender people and their concerns by engaging in research and disseminating this knowledge through research reports, publications, policy recommendations, community discussion groups, and speaking with elected officials (Burdge, 2007). Social workers can participate in program development and creating outreach services tailored to the needs of trans people (Martin & Yonkin, 2006). Subsequent evaluation of these programs as well as intervention studies can be used to inform trans affirmative practice (NASW, 2016). Social workers can advocate for the inclusion of trans-specific content in the curricula within schools of social work, nursing, medicine, and other health and human service professions (Wheeler & Dodd, 2011; White Hughto et al., 2015). They can raise awareness among health care providers

in their community by offering workshops on trans issues (Martin & Yonkin, 2006). Extending this further, they can create—or become a part of—a coalition of trans-friendly providers in their communities (Burdge, 2007; National LGBT Health Education Center, 2016). Social workers can ask: How can our organization engage in—or improve—outreach efforts to the trans men in our community? What partnerships can we create with trans-specific organizations in our community to better serve the needs of our trans patients? What can these organizations teach us about how to improve our services for trans men? What initiatives can we participate in at the state or federal level to improve health care access for trans people? Social work practice at the macro level can mitigate structural stigma through the creation of policies and laws which protect transgender people's rights and advance equity in health care access.

Finally, much of the extant research on transgender populations has focused on their experiences of stigma and the resultant disparities, with less emphasis placed on their strengths and resilience. This can paint a disproportionate picture of transgender people as victims only, rather than recognizing their sense of agency. Because of their marginalization, transgender people have found creative ways to build their support network (such as through online communities) and to create a collective identity (Rachlin, 2007; Shapiro, 2004). These support networks facilitate the development of coping strategies, promote a sense of pride in their trans identities, and encourage resistance against transphobia, cisnormativity, and cisgenderism (Shapiro, 2004). The minority stress model acknowledges how systemic oppression can produce adverse mental health outcomes experienced by persons of minority status. Yet, this model also recognizes the resilience that can be found through a collective minority identity

(Hendricks & Testa, 2012; Meyer, 1995). As Meyer (1995) noted, "Minority coping may work in a variety of ways: by providing opportunities for social support, by affirming and validating minority persons' culture and values, and by allowing reappraisal and devaluation of the stigmatizing values of the dominant culture" (p. 52). This collective minority identity holds the potential for social activism.

Change does not occur in a vacuum. Self-advocacy and activism have often served as the impetus for change efforts. Advocacy organizations which represent, and are led by, transgender people have stood up to fight for trans rights. Examples of such organizations include the Transgender Law Center, which serves as an informational resource for trans individuals and their allies and advances the rights of transgender people through policy advocacy and litigation. The Transgender Law Center has partnered with the National Center for Transgender Equality (NCTE) to counter the current federal Administration's efforts to roll back the regulation in the Health Care Rights Law, which protects transgender people from health care discrimination (see https://protecttranshealth.org/). Notably, the NCTE has brought attention to trans issues through its research efforts, which have produced large, non-probability based samples of transgender participants (Grant et al., 2011; James et al., 2016). These databases have enabled researchers to advance understanding about the issues concerning trans people through secondary analysis. These organizations are examples of the social activism engaged by trans communities.

Relating to social work practice, it is essential for social workers to be aware of the impact of stigma on transgender people's lives. Yet, beyond the deficits and disparities that stigma produces, the narrative about transgender populations should also

include resilience and resourcefulness. By recognizing the power of the collective minority identity, social workers can provide hope to their transgender clients and empower them to engage in self-advocacy.

Implications for Social Work Education

The Council on Social Work Education's (CSWE) *2015 Educational Policy and Accreditation Standards* mandates respect for diversity to be reflected in the learning environments of accredited programs and enumerates gender identity and expression as key diversity content areas (CSWE, 2015). This aligns with the NASW's *Code of Ethics* (2017) and the *Standards and Indicators for Cultural Competence in Social Work Practice* (2015b). With professional and academic standards in place, social work educators are charged with preparing social work practitioners who are competent to serve diverse populations, including sexual and gender diverse communities. Yet, a survey of LGBTQ-identified social work students enrolled in BSW and MSW programs in the U.S. and Canada (N = 1018) reported low levels of self-assessed practice readiness to serve LGBTQ clients (Craig, McInroy, Dentato, Austin, & Messinger, 2015). Furthermore, a subgroup of trans-identified students from this survey (n = 97) perceived substantial levels of transphobia from students, faculty, and in their field placements (Austin, Craig, & McInroy, 2016). Trans-specific content was reported to be absent in social work courses. These students reported that faculty often conflated sexual orientation with gender identity, without a clear understanding of the differences between these identities (Austin, Craig, & McInroy, 2016; Craig et al., 2015). Other studies revealed that further faculty and program development are needed to integrate gender identity and expression into the discourse on diversity and oppression. Social work

faculty have reported being less knowledgeable about issues related to gender identity and expression than about sexual orientation (Martin et al., 2009), that they felt ambivalent or ill-prepared to teach about trans issues, that there was a dearth of trans-specific or trans-affirming teaching resources available, and that field placement opportunities related to transgender communities needed further development (Fredriksen-Goldsen, Woodford, Luke, & Gutiérrez, 2011). Inclusivity reflected in an institution's policies and programs is evidence of its values and cultural environment. Sadly, institutional equity is not universal for trans-identified students. In Craig et al.'s (2015) survey of LGBTQ-identified social work students in the U.S. and Canada, almost one in five students rated their institution as "somewhat not friendly" or "not friendly" towards transgender people; only 40.5% reported that their social work program had a non-discrimination policy based on gender identity; and only 30.1% of social work programs had an LGBTQ-specific student group. These large gaps in the educational environment and institutional context perpetuate the erasure and cisgenderism which exists in our society and produce social work practitioners who are ill-equipped to serve the needs of transgender communities.

Changing a culture which marginalizes trans people requires, in part, changing the environment in which social workers are trained and socialized. It is imperative for social workers to produce research and scholarship about trans issues, to promote institutional equity for trans students, and to ensure that course content and activities are trans inclusive and affirming. To support social work programs in fostering educational environments which are affirmative of diverse gender identities, the CSWE Council on Sexual Orientation and Gender Identity and Expression created the *Guidelines for*

Transgender and Gender Nonconforming Affirmative Education (Austin et al., 2016). These guidelines offer a platform for academic institutions and educators to reexamine their policies and practices, to promote a safe and more welcoming environment for trans students, and to increase students' preparedness to serve transgender clients. This research can be used to build students' knowledge base about trans issues by informing them of the heterogeneity which exists within trans communities and the ways in which systemic barriers within health care systems contribute to their oppression, especially for trans individuals who identify with more than one marginalized community. The present study intends to minimize informational erasure and serves as one prong in the efforts to advance equity for transgender people.

Strengths and Limitations of the Study

The NCTE is a respected organization which advocates on behalf of, and is led by, trans people. Their visibility and active engagement with trans communities enabled them to access these populations for sample recruitment. The 2015 USTS was the product of much collaboration among a team of researchers, many of whom were content experts in the field of trans research. The research team was creative and proactive in their sample recruitment methods, thereby producing an extraordinarily robust, national sample. This robustly-sized dataset enabled the construction of multiple models in the present study to examine the risk and protective factors, potential confounds, and interaction effects experienced by transgender people in their access to health care. As demonstrated by the *post hoc* power calculations, this sample size provided the ability to complete comparisons of gender identity subgroups, while controlling for sociodemographic factors that can influence health care access.

Yet, there are several limitations which should be noted. The primary study used non-probability sampling methods which limit the generalizability of the findings. That is, it is unclear if these findings hold true for the whole target population. The use of a unimodal, online-only platform for data collection relied on participants having access to the internet and thus, under-coverage is a concern. Because the target population was larger than those who had internet access, not all transgender individuals in the U.S. had equal opportunity to participate in this survey (Bethlehem, 2010). Researchers have previously acknowledged the bias that is often inherent in online surveys. Respondents to online surveys are more likely to be white, young, more educated, and with higher incomes (Hash & Spencer, 2007; Miner 2012; Rachlin, 2007; Shapiro, 2004). To illustrate further, Reisner, Conron et al. (2014) examined the impact of data collection methods on the responses from transgender participants by comparing in-person and online survey participants from the National Transgender Discrimination Survey, the precursor to the USTS which used bimodal data collection methods. Key differences were found in socio-economic and health characteristics between the two groups. In-person participants who completed hard copy questionnaires were more likely to be people of color, publicly insured, and of lower socio-economic status. They were also more likely to endorse substance use to cope with mistreatment and to self-report as HIV positive. This suggests that a multi-modal data collection method may yield a more diverse, potentially more representative, sample of transgender populations and have greater ability to reach those who may be particularly more vulnerable.

Within the USTS sample, there was a higher percentage of white, young, and more educated participants compared to the U.S. general population, which may be due,

in part, to internet survey bias. (James et al., 2016). Although the research team attempted to mitigate barriers to participation by collaborating with community organizations in hosting survey taking events, the sole use of an online platform for data collection may have prevented disadvantaged transgender individuals from responding to the survey because of their lack of access to the internet or a web-enabled device, lack of familiarity with the use of the internet, or inability to travel to a community organization to complete the survey. Furthermore, the self-selection method for survey completion can produce bias and impact the quality of the results (Bethlehem, 2010). Little is known about the transgender people who chose not to complete the survey. Therefore, the findings are representative of a specific subset of the transgender population—only those who volunteered to complete the survey and had access to the internet or could travel to a community organization to complete the survey. The survey results may, therefore, under-represent the true prevalence of disadvantages experienced by the transgender population (Wright, 2005).

The sample recruitment through outreach from LGBTQ or trans-specific and allied organizations may have also produced bias. Not all transgender individuals are connected to a community organization (Rachlin, 2007). Moreover, as noted previously, some trans individuals have distanced themselves from the transgender identity after having made their transition (Hardacker, Kelly, et al., 2019; Shapiro, 2004). Thus, individuals who are no longer interacting with the LGBTQ or trans communities, or who are no longer self-identifying as transgender, may also be underrepresented in this survey.

The cross-sectional nature of the 2015 USTS captured the experience of transgender people in the U.S. within only one point in time. This data was collected in

August 2015—at a period when the ACA was in full effect, but prior to the Department of Health and Human Services' ruling in 2016 which clarified the implementation of the nondiscrimination requirements of the ACA. Consequently, the experience of health care access may have changed since that time frame because policy has evolved. Additionally, public awareness about issues related to transgender people have grown and health care providers are beginning to recognize their knowledge deficit and the need for greater cultural and medical competency in caring for transgender patients. In some health care institutions, organizational policies have progressed. Some institutions now provide diversity training to their staff which include content on sexual and gender diversity. This too, can impact transgender people's experience of health care access. The cross-sectional data offered by this survey may be limited in its representativeness of transgender people's experiences in 2019 or of important longitudinal changes in their lives over the past decade, for example.

In any study involving secondary data analyses, the researcher is limited by the content of the survey questions, their respective response sets, and the size of its resultant dataset. The primary researchers of the USTS tried to be comprehensive in their scope and the sections on health care access provided a level of insight about transgender people's experiences in their interface with the health care system. However, the survey instrument did not offer much opportunity for respondents to provide narrative detail related to their experiences with health care access. For example, more information about how health care providers demonstrated respect after learning about the participants' trans identity can provide insight about specific provider behaviors or the context of the patient-provider interaction. This study about transgender people's experiences with

health care access is strictly quantitative and offers inferences about their experiences but lacks a contextual, narrative understanding of their experience.

Additional Future Research Needs

Much of the extant research on transgender people is over-represented by transgender women and further research on transgender men and nonbinary identities are needed to bring them from the margins to the center to gain a deeper understanding of their experiences. Research studies using qualitative or mixed methods approaches will be especially helpful to facilitate theory building—in particular, to understand trans men's advantages and disadvantages in their patient experience and to illuminate the challenges experienced by non-binary identities in the face of a dimorphic gender health care system. In the world of transgender health research, more work is needed to examine the health disparities experienced by transgender people, especially their risk for hormone-related cancers after prolonged exposure to gender-affirming hormone therapy. In addition, there is a lacuna of knowledge about HIV disease among trans men; extant research on the burden of HIV disease among transgender populations is currently over-represented by trans women of color. With the implementation of Stage 3 of the Meaningful Use program, an opportunity exists for researchers to collaborate with health systems to analyze the quality of the SO/GI data being gathered in electronic health record systems and to develop strategies to improve data collection processes. Although providers are not mandated to collect SO/GI data, preliminary analysis of the SO/GI data gathered thus far from electronic health record systems can provide insight about the disease burden faced by sexual and gender minority populations. Additionally, as the general U.S. population ages, so too, do transgender populations. The needs of

transgender older adults are beginning to gain attention (Finkenauer, Sherratt, Marlow, & Brodey, 2012; Fredriksen-Goldsen et al., 2013; Hardacker, Ducheny, & Houlberg, 2019). Transgender people have concerns about their quality of life during their older adulthood and their ability to receive adequate care in the face of advanced illness (Porter et al., 2016; Witten, 2014a, 2014b). Exploring hospice and palliative care providers' perspectives in caring for transgender patients can promote understanding about systemic barriers which may exist in health systems that provide end-of-life care. It can also be an opportunity to benefit from the providers' practice wisdom as they share their insights about ways to provide culturally competent care during the end-of-life journey. Finally, future research should consider methodological approaches that will provide greater representativeness among transgender respondents, such as the use of bimodal or multimodal data collection methods (Reisner, Conron et al., 2014). Secondary analyses of a probability-based sample, such as the BRFSS, can produce knowledge about transgender people's health behaviors and access to health care. Though not all states choose to use the optional Sexual Orientation and Gender Identity module, the data that has been collected from the states which do can serve as a launching point to understand the inequities and disparities that exist among transgender populations. It would also be intriguing to compare the responses related to health care access from transgender participants in the BRFSS with those from the USTS, to understand the effect of probability versus non-probability-based sampling methods for research on transgender populations. There are rich opportunities to engage in transgender health research which can make an impact on education, policy, and practice.

Additional research questions can be examined using the 2015 USTS dataset as it relates to health care access. For example, with the availability of the respondents' zip and other geographic codes, regional differences in the availability and accessibility of care can be explored. Comparisons can be made between states or large urban centers across the U.S., or between more remote, rural and urban settings. This information can be useful in identifying gaps in communities where access to transgender health care may be particularly challenging. Furthermore, some transgender individuals have de-transitioned as a result of pressure from their social network or in response to insurmountable discrimination. An exploration of factors contributing to the de-transitioning process would be enlightening. Despite its limitations, the 2015 USTS dataset provides extensive possibilities for further research. Lastly, the NCTE developed the current survey instrument with the plan to replicate this study again every five years. This will allow for an analysis of temporal trends which can add more confidence in causal inferences. With growing awareness and policy changes at the mezzo and macro levels, researchers can determine if there are significant changes in transgender people's ability to access health care over time. As an advocacy organization invested in advancing social justice for transgender communities, the NCTE desires collaboration with researchers so that the survey findings can be published and widely and diversely disseminated to counter the informational erasure about trans people and their needs.

Conclusion

Access to health care is a basic human right. Yet, for transgender people, such access is compromised by hegemonic systems which privilege cisgender identities and render trans identities and trans bodies invisible. Transgender people embody gender self-

determination in their journey towards lived authenticity. Transition-related services, like primary health care, are medically necessary services. In the current social and political climate, as public discourse about the rights of transgender people continue, social workers are challenged to expand awareness about the inequities that transgender people experience. The burden of the social costs resulting from these inequities is great and are carried not just by transgender individuals alone, but also by their families and communities. Difficulties in accessing health care can exacerbate health problems and denial of care can have devastating consequences (Lombardi & Banik, 2015). This study examined transgender people's access to health care and the factors which potentiated their access or increased their risk of experiencing barriers. In bringing transgender men's experiences to the foreground, it acknowledged the heterogeneity which exists in transgender communities. Though transgender people share commonalities in their experience of oppression, there are also differences based on their social location. Most importantly, this study is an urgent call to action to change the culture of our health care systems, to empower health care providers to embrace gender diversity, and to provide a safe, inclusive environment for all transgender people.

References

Acquaviva, K. D. (2017). *LGBTQ-inclusive hospice and palliative care: A practical guide to transforming professional practice*. New York, NY: Harrington Park Press.

Addis, S., Davies, M., Greene, G., MacBride-Stewart, S., & Shepherd, M. (2009). The health, social care and housing needs of lesbian, gay, bisexual, and transgender older people: A review of the literature. *Health and Social Care in the Community, 17*(6), 647-658. doi: 10.1111/j.1365-2524.2009.00866.x

Agénor, M. (2015). What are the numbers? The epidemiology of cancer by sexual orientation and gender identity. In U. Boehmer & R. Elk (Eds.), *Cancer and the LGBT Community: Unique Perspectives from Risk to Survivorship* (pp. 117-140). Switzerland: Springer International Publishing.

Albuquerque, G. A., de Lima Garcia, C., da Silva Quirino, G., Alves, M. J. H., Belém, J. M., dos Santos Figueiredo, F. W.,…Adami, F. (2016). Access to health services by lesbian, gay, bisexual, and transgender persons: Systematic literature review. *BMC International Health and Human Rights, 16*(2). doi: 10.1186/s12914-015-0072-9

Amato, P. (2016). Fertility options for transgender persons. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 100-102). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist, 70*(9), 832-864. doi: 10.1037/a0039906

Ansara, Y. G. (2015). Challenging cisgenderism in the ageing and aged care sector: Meeting the needs of older people of trans and/or non-binary experience. *Australasian Journal of Ageing, 34*(2), 14-18. doi: 10.1111/ajag.12278

APA (American Psychiatric Association). (1952). *Diagnostic and statistical manual of mental disorders.* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (1968). D*iagnostic and statistical manual of mental disorders (2nd ed.).* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.).* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (1987). *Diagnostic and statistical manual of mental disorders (3rd ed., revised).* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (1994). *Diagnostic and statistical manual of mental disorders (4th ed.).* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text revision).* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (2012a). *Position statement on cccess to care for transgender and gender variant individuals*. Retrieved from http://www.psychiatry.org/advocacy--newsroom

APA (American Psychiatric Association). (2012b). *Position statement on discrimination against transgender and gender variant individuals*. Retrieved from http://www.psychiatry.org/advocacy--newsroom

APA (American Psychiatric Association). (2013a). *Diagnostic and statistical manual of mental disorders (5th ed.).* Washington, DC: American Psychiatric Press.

APA (American Psychiatric Association). (2013b). *Gender dysphoria.* Retrieved from file:///C:/Users/luisa/Downloads/APA_DSM-5-Gender-Dysphoria%20(3).pdf

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2009). *Competencies for counseling with transgender clients*. Alexandria, VA: Author. Retrieved from https://www.counseling.org/resources/competencies/algbtic_competencies.pdf

Austin, A., Craig, S. L., Alessi, E. J., Wagaman, M. A., Paceley, M. S., Dziengel, L., & Balestrery, J. E. (2016). *Guidelines for transgender and gender nonconforming (TGNC) affirmative education: Enhancing the climate for TGNC students, staff and faculty in social work education.* Alexandria, VA: Council on Social Work Education.

Austin, A., Craig, S. L., & McInroy, L. B. (2016) Toward transgender affirmative social work education. *Journal of Social Work Education, 52*(3), 297-310. doi: 10.1080/10437797.2016.1174637

Barnett, J. C. & Vornovitsky, M. S. (2016). *Health Insurance Coverage in the United States: 2015.* Washington, D.C.: U.S. Government Printing Office. Retrieved https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K., M., & Boyce, M. (2009). ‘‘I don’t think this is theoretical; this is our lives’’: How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care, 20*(5), 348-361. doi:10.1016/j.jana.2009.07.004

Bauer, G. R., Scheim, A. I., Deutsch, M. B., & Massarella, C. (2014). Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: Results from a respondent-driven sampling survey. *Annals of Emergency Medicine, 63*(6), 713-720. doi: 10.1016/j.annemergmed.2013.09.027

Bauer, G. R., Zong, X., Scheim, A. I., Hammond, R., & Thind, A. (2015). Factors impacting transgender patients’ discomfort with their family physicians: A respondent-driven sampling survey. *PLoS ONE, 10*(12), e0145046. doi:10.1371/journal.pone.0145046

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

Bethlehem, J. (2010). Selection bias in web surveys. *International Statistical Review, 78*(2), 161-188. doi: 10.1111/j. 1751-5823.2010.00112.x

Bettcher, T. M. (2014). Transphobia. *Transgender Studies Quarterly, 1*(1-2), 249-251. doi: 10.1215/23289252-2399605

Blackless, M., Charuvastra, A., Derryck, A., Fausto-Sterling, A., Lauzanne, K., & Lee, E. (2000). How sexually dimorphic are we? Review and synthesis. *American Journal of Human Biology, 12,* 151–166. doi:10.1002=(SICI)1520–6300(200003=04)12:2<151::AID-AJHB1>3.0.CO;2-F

Blackwell, D. L., Martinez, M. E., Gentleman, J. F., Sanmartin, C., & Berthelot, J-M. (2009). Socioeconomic status and utilization of health care services in Canada and the United States: Findings from a binational health survey. *Medical Care, 47*(11), 1136-1146.

Boehmer, U. (2002). Twenty years of public health research: Inclusion of lesbian, gay, bisexual, and transgender populations. *American Journal of Public Health, 92*(7), 1125-1130. doi: 10.2105/AJPH.92.7.1125

Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267-1273. doi: 10.2105/AJPH.2012.300750

Bowling, A. (2005). Just one question: If one question works, why ask several? *Journal of Epidemiol Community Health, 59*, 342-345. doi: 10.1136/jech.2004.021204

Bradford, J., Reisner, S. L., Honnold, J. A., & Xavier, J. (2013). Experiences of transgender-related discrimination and implications for health: Results from the Virginia Transgender Health Initiative Study. *American Journal of Public Health, 103*(10), 1820-1829. doi: 10.2105/AJPH.2012.300796

Brandes, A. (2014). The negative effect of stigma, discrimination, and the health care system on the health of gender and sexual minorities. *Law & Sexuality, 23*, 155-178.

Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Counseling and Clinical Psychology, 81*(3), 545-557. doi: 10.1037/a0031774

Burdge, B. J. (2007). Bending gender, ending gender: Theoretical foundations for social work practice with the transgender community. *Social Work, 52*(3), 243-250.

Byne, W. Karasic, D. H., Coleman, E., Eyler, A. E., & Kidd, J. D. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health, 3*(1), 57-73. doi: 10.1089/trgh.2017.0053

Cahill, S. R., Baker, K., Deutsch, M. B., Keatley, J., & Makadon, H. J. (2016). Inclusion of sexual orientation and gender identity in stage 3 meaningful use guidelines: A huge step forward for LGBT health. *LGBT Health, 3*(2), 100-102. doi: 10.1089/lgbt.2015.0136

Cahill, S. R. & Makadon, H. J. (2017). If they don't count us, we don't count: Trump administration rolls back sexual orientation and gender identity data collection. *LGBT Health, 4*(3), 1-3. doi: 10.1089/lgbt.2017.0073

Canadian Professional Association for Transgender Health. (2017). Publicly Funded Transition-Related Medical Care in Canada. Retrieved from https://drive.google.com/file/d/14ERGli-1BNkU-SVed5WHk73Zk57oQQSM/view

Canner, J. K., Harfouch, O., Kodadek, L. M., Pelaez, D., Coon, D., Offodile, A. C., …Lau, B. D. (2018). Temporal trends in gender-affirming surgery among transgender patients in the United States. *JAMA Surgery, 153*(7), 609-616. doi:10.1001/jamasurg.2017.6231

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., & Scott, M. (2015). Does your organization use gender inclusive forms? Nurses' confusion about trans*

terminology. *Journal of Clinical Nursing, 24*(21-22), 3306-3317. doi: 10.1111/jocn.12942

Carbado, D., Crenshaw, K., Mays, V., & Tomlinson, B. (2013). Intersectionality: Mapping the movements of a theory. *Du Bois Review: Social Science Research on Race, 10*(2), 303-312. doi:10.1017/S1742058X13000349

Carrillo, J. E., Carrillo, V. A., Perez, H. R., Salas-Lopez, D., Natale-Pereira, A., Byron, A. T. (2011). Defining and targeting health care access barriers. *Journal of Health Care for the Poor and Underserved, 22*(2), 562-575. doi: 10.1353/hpu.2011.0037

Carmel, T., Hopwood, R., & dickey, l. m. (2014). Mental health concerns. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 80-101). New York, NY: Oxford University Press.

Chisolm-Straker, M., Jardine, L., Bennouna, C., Morency-Brassard, N., Coy, L., Egemba, M. O., & Shearer, P. L. (2017). Transgender and gender nonconforming in emergency departments: A qualitative report of patient experiences. *Transgender Health, 2*(1), 8-16. doi: 10.1089/trgh.2016.0026

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society, 38*(4), 785-810.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … Zucker, K. (2012). Standards of care for health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165-232. doi: 10.1080/15532739.2011.700873

Collazo, A., Austin, A., & Craig, S. L. (2013). Facilitating transition among transgender clients: Components of effective clinical practice. *Journal of Clinical Social Work, 41*, 228-237. doi: 10.1007/s10615-013-0436-3

Cook-Daniels, L. & munson, m. (2010). Sexual violence, elder abuse, and sexuality of trangender adults, age 50+: Results of three surveys. *Journal of GLBT Family Studies, 6*(2), 142-177. doi: 10.1080/15504281003705238

Cooper, H. M. (2017). *Research synthesis and meta-analysis: A step-by-step approach* (5th ed.). Thousand Oaks, CA: Sage.

Craig, S. L., McInroy, L. B., Dentato, M. P., Austin, A., & Messinger, L. (2015). *Social work students speak out! The experiences of lesbian, gay, bisexual, transgender, and queer students in social work programs: A study report from the CSWE Council on Sexual Orientation and Gender Identity and Expression*. Toronto, Canada: Author.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), 139-167.

Crissman, H. P., Berger, M. B., Graham, L. F., & Dalton, V. K. (2017). Transgender demographics: A household probability sample of US adults, 2014. *American Journal of Public Heath, 107*(2), 213-215. doi: 10.2105/AJPH.2016.303571

Cruz, T. M. (2014). Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination. *Social Science & Medicine 110*, 65-73. doi: 10.1016/j.socscimed.2014.03.032

CSWE (Council on Social Work Education). (2015). *2015 Educational policy and accreditation standards for baccalaureate and master's social work programs*. Alexandria, VA: Council on Social Work Education.

Davidson, T. (2015). A review of transgender health in Canada. *University of Ottawa Journal of Medicine, 5*(2), 40-45. doi:http://dx.doi.org/10.18192/uojm.v5i2.1280

DeNavas-Walt, C., & Proctor B. D (2015). *U.S. Census Bureau, Current Population Reports (P60-252): Income and poverty in the United States: 2014*. Washington, DC: U.S. Government Printing Office.

Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017, 42 CFR §§ 412, 495 (2015).

Department of Health and Human Services, Nondiscrimination in Health Programs and Activities, 45 CFR § 92 (2016).

Deutsch, M. B. (Ed.). (2016a). *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people*. San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Deutsch, M. B. (2016b). General approach to cancer screening in transgender people. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 103). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Diamond, L. M., Pardo, S. T., & Butterworth, M. R. (2011). Transgender experience and identity. In S. J. Schwartz, K. Luyckx, & V. L., Vignoles (Eds.), *Handbook of Identity Theory and Research* (pp. 629-647). New York, NY: Springer.

dickey, l. m., Budge, S. L., Katz-Wise, S. L., & Garza, M. V. (2016). Health disparities in the transgender community: Exploring differences in insurance coverage. *Psychology of Sexual Orientation and Gender Diversity, 3*(3), 275-282. doi: 10.1037/sgd0000169

Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual. *Archives of Sexual Behavior, 39*(2), 427-460. doi:10.1007/s10508-009-9531-5

Drescher, J. (2015). Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD. *International Review of Psychiatry, 27*(5), 386-395. doi: 10.3109/09540261.2015.1053847

Drescher, J. (2016). Gender diagnoses in the DSM and ICD. *Psychiatric Annals, 46*(6), 350-354. doi: 10.3928/00485713-20160415-01

Ducheny, K., Hardacker, C. T., Claybren, K. T., & Parker, C. (2019). The essentials: Foundational knowledge to support affirmative care for transgender and gender nonconforming (TGNC) older adults. In C. Hardacker, K. Ducheny, & M. Houlberg (Eds.), *Transgender and gender nonconforming health and aging* (pp. 1-20). Cham, Switzerland: Springer.

Erich, S., Tittsworth, J., Colton Meier, S. L., & Lerman, T. (2010). Transsexual of color: Perceptions of discrimination based on transsexual status and race/ethnicity status.

Journal of GLBT Family Studies, 6(3), 294-314. doi: 10.1080/1550428X.2010.490900

Erich, S., Tittsworth, J., & Kersten, A. S. (2010). An examination and comparison of transsexuals of color and their white counterparts regarding personal well-being and support networks. *Journal of GLBT Studies, 6*(1), 25-39. doi: 10.1080/15504280903472493

Erickson-Schroth, L., Gilbert, M. A., & Smith, T. E. (2014). Sex and gender development. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 80-101). New York, NY: Oxford University.

Farmer, D. F. & Yancu, C. N. (2015). Hospice and palliative care for older lesbian, gay, bisexual, and transgender adults: The effect of history, discrimination, health disparities and legal issues on addressing service needs. *Palliative Medicine and Hospice Care, 1*(2), 36-43. doi: 10.17140/PMHCOJ-1-107

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. Behavior Research Methods, 41(4), 1149-1160.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2013). G*Power (version 3.1.9 [computer software]). Uiversität Kiel, Germany.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, G. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. Behavior Research Methods, 39(2), 175-191.

Fausto-Sterling, A. (2000). *Sexing the body: Gender politics and the construction of sexuality*. New York, NY: Basic Books.

Feder, S. & Hollar, J. (Producers). (2006). *Boy I Am* [Documentary Film].

Finkenauer, S., Sherratt, J., Marlow, J., & Brodey, A. (2012). When injustice gets old: A systematic review of trans aging. *Journal of Gay & Lesbian Social Services, 24*(4), 311-330. doi: 10.1080/10538720.2012.722497

Fish, J. (2010). Conceptualising social exclusion and lesbian, gay, bisexual, and transgender people: The implications for promoting equity in nursing policy and practice. *Journal of Research in Nursing, 15*(4), 303-312. doi: 10.1177/1744987110364691

Flores, A. R., Herman, J. L., Gates, G. J., & Brown, T. N. T. (2016). *How many adults identify as transgender in the United States?* Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

Franciscan Alliance, Inc. et al v. Burwell, Civil Action No. 7:16-cv-00108-O (2016).

Franklin, C. (2014). Marrying liberty and equality: The new jurisprudence of gay rights. *Virginia Law Review*, 100 (5), 817-891.

Fredriksen-Goldsen, K.I., Cook-Daniels, L., Kim, H., Erosheva, E.A., Emlet, C.A., Hoy-Ellis, C.P., …Muraco, A. (2013). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist, 54*(3), 488-500. doi: 10.1093/geront/gnt021

Fredriksen-Goldsen, K. I., Kim, H.-J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., … Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults.* Seattle: Institute for Multigenerational Health. Retrieved from

http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf

Fredriksen-Goldsen, K. I., Woodford, M. R., Luke, K. P., & Gutiérrez, L. (2011). Support of sexual orientation and gender identity content in social work education: Results from national surveys of US and Anglophone Canadian faculty. *Journal of Social Work Education. 47*(1), 19-35.

Frohard-Dourlent, H., Coronel Villalobos, M., & Saewyc, E. (2017). *A survey of experiences with surgery readiness assessment and gender-affirming surgery among trans people in Canada: Focus on British Columbia.* Vancouver, BC: Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia.

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual and transgender?* Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf

Gay and Lesbian Medical Association. (2005). *Guidelines for care of lesbian, gay, bisexual, and transgender patients.* San Francisco, CA: Gay and Lesbian Medical Association. Retrieved from http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf

Giblon, R. & Bauer, G. R. (2017). Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Services Research, 17,* 283. doi: 10.1186/s12913-017-2226-z

Glynn, T. R. & van den Berg, J. J. (2017). A systematic review of interventions to reduce problematic substance use among transgender individuals: A call to action. Transgender Health, 2(1), 45-59. doi: 10.1089/trgh.2016.0037

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs, N.J.: Prentice-Hall.

Gonzales, G. & Henning-Smith, C. (2017). Barriers to care among transgender and gender noncomforming adults. *The Milbank Quarterly, 95*(4), 726-748. doi: 10.1111/1468-0009.12297

Gonzalez-Salzberg, D. A. (2014). The accepted transsexual and the absent transgender: A queer reading of the regulation of sex/gender by the European court of human rights. *American University International Law*, *29*(4), 797-829.

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality. Retrieved from http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

Grant, K. (2017, June 27). Toronto hospital to become second in Canada offering genital-reconstruction surgery. *The Globe and Mail*, retrieved from https://www.theglobeandmail.com/news/national/toronto-hospital-to-become-second-in-canada-offering-genital-reconstruction-surgery/article35441753/

Green, E. L., Benner, K., & Pear, R. (2018, October 21). 'Transgender' could be defined out of existence under Trump Administration. *The New York Times*. Retrieved

from https://www.nytimes.com/2018/10/21/us/politics/transgender-trump-administration-sex-definition.html

Hardacker, C. T., Chyten-Brennan, J., & Komar, A. (2019). Transgender physiology, anatomy, and aging: A provider's guide to gender affirming surgeries. In C. Hardacker, K. Ducheny, & M. Houlberg (Eds.), *Transgender and gender nonconforming health and aging* (pp. 37-60). Cham, Switzerland: Springer.

Hardacker, C., Ducheny, K., & Houlberg, M. (Eds.). (2019). *Transgender and gender nonconforming health and aging*. Cham, Switzerland: Springer.

Hardacker, C. T., Kelly, L., Booth, R., Simonello, J., Martin, E., Harris, J., … Houlberg, M. (2019). Voices: Stories of Resilience. In C. Hardacker, K. Ducheny, & M. Houlberg (Eds.), *Transgender and gender nonconforming health and aging* (pp. 217-232). Cham, Switzerland: Springer.

Harrell, F. E., Jr. (2015). *Regression modeling strategies: With applications to linear models, logistic and ordinal regression, and survival analysis* (2nd ed). New York: Springer.

Hash, K. M., & Spencer, S. M. (2007). "You've got subjects": The promise of the internet in research with lesbian, gay, bisexual, and transgender populations. In W. Meezan & J. I. Martin (Eds.), *Handbook of research with lesbian, gay, bisexual, and transgender populations* (pp. 238-257). Oxfordshire, United Kingdom: Taylor & Frances Ltd.

Hatzenbuehler, M. L. & Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine, 103*, 1-6. doi: 10.1016/j.socscimed.2013.12.017

Hausmann, L. R. M., Jeong, K., Bost, J. E., Ibrahim, S. A. (2008). Perceived discrimination in health care and health status in a racially diverse sample. *Med Care, 46*(9): 905-914. doi: doi:10.1097/MLR.0b013e3181792562.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H.,…T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology and Metabolism, 102*(11), 3869–3903. doi: 10.1210/jc.2017-01658

Hendricks M. L. & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice, 43*(5), 460-467. doi: 10.1037/a0029597

Herdt, G. (1993). Introduction: Third sexes and third genders. In G. Herdt (Ed.), *Third sex third gender: Beyond sexual dimorphism in culture and history* (pp. 21-81). New York, NY: Zone Books.

Houlberg, M. (2019). Endocrinology, hormone replacement therapy (HRT), and aging. In C. Hardacker, K. Ducheny, & M. Houlberg (Eds.), *Transgender and gender nonconforming health and aging* (pp. 21-36). Cham, Switzerland: Springer.

Hoffkling, A., Obedin-Maliver, J., & Sevelius, J. (2017). From erasure to opportunity: A qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. *BMC Pregnancy and Childbirth, 17*(2), 332. doi: 10.1186/s12884-017-1491-5

Hoffman, C. & Paradise, J. (2008). Health insurance and access to health care in the United States. *Annals of the New York Academy of Sciences, 1136,* 149-160. doi: 10.1196/annals.1425.007

Hosmer, D. W., Lemeshow, S., & Sturdivant, R. X. (2013). *Applied logistic regression* (3rd ed.). New York: John Wiley & Sons.

Hoy-Ellis, C. P. & Fredriksen-Goldsen, K. I. (2017). Depression among transgender older adults: general and minority stress. *American Journal of Community Psychology, 0,* 1-11. doi: 10.1002/ajcp.12138

Hsiao, K. T. (2016). Screening for cervical cancer in transgender men. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 111-114). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Hudson, K. D. (2019). (Un)doing transmisogynist stigma in health care settings: Experiences of ten transgender women of color. Journal of Progressive Human Services, 30(1), 69-87. doi: 10.1080/10428232.2017.1412768

Hulko, W. (2009). The time- and context-contingent nature of intersectionality and interlocking oppressions. *Journal of Women and Social Work, 24*(1), 44-55. doi: 10.1177/0886109908326814

IBM Corporation (2018). SPSS statistics for windows (version 25.0). Armonk, NY: IBM.

Institute of Medicine. (1993). *Access to health care in America.* Washington, DC: National Academy Press.

Institute of Medicine. (2009). *America's uninsured crisis: Consequences for health and health care*. Washington, DC: The National Academies Press.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: Institute of Medicine. Retrieved from https://iom.nationalacademies.org/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx

Jaffee, K. D., Shires, D. A., & Stroumsa, D. (2016). Discrimination and delayed health care among transgender women and men: Implications for improving medical education and health care delivery. *Medical Care, 54*(11), 1010-1016. doi: 10.1097/MLR.0000000000000583

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. Transgender Survey.* Washington, DC: National Center for Transgender Equality. Retrieved from http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf

Kattari, S. K. & Hasche, L. (2016). Differences across age groups in transgender and gender non-conforming people's experiences of health care discrimination, harassment, and victimization. *Journal of Aging and Health, 28*(2), 285-306. doi: 10.1177/0898264315590228

Kattari, S. K., Walls, N. E., Whitfield, D. L., & Langenderfer-Magruder, L. (2015). Racial and ethnic differences in experiences of discrimination in accessing health services among transgender people in the United States. *International Journal of Transgenderism, 16*, 68-79. doi: 10.1080/15532739.2015.1064336

Kattari, S. K., Walls, N. E., Whitfield, D. L., & Langenderfer-Magruder, L. (2017). Racial and ethnic differences in experiences of discrimination in accessing social services among transgender/gender nonconforming people. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(3), 217-235. doi: 10.1080/15313204.2016.1242102

Kcomt, L. (2018). Profound health care discrimination experienced by transgender people: Rapid systematic review. *Social Work in Health Care, 58*(2), 201-219. doi: 10.1080/00981389.2018.1532941

Kcomt, L. & Gorey, K. (2017). End-of-life preparations among lesbian, gay, bisexual and transgender people: Integrative review of prevalent behaviors. *Journal of Social Work in End-of-Life and Palliative Care, 13*(4), 284-301. doi: 10.1080/15524256.2017.1387214

Kleinbaum, D. G. & Klein, M. (2010). *Logistic regression: A self-learning text*. New York, NY: Springer.

Kosenko, K., Rintamaki, L., Raney, S., & Maness, K. (2013). Transgender patient perceptions of stigma in health care contexts. *Medical Care, 51*(9), 819-822. doi: 10.1097/MLR.0b013e31829fa90d

Lambda Legal. (2010). *When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people with HIV*. New York, NY: Lambda Legal. Retrieved from https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf

Lawrence, A. A. (2014). Gender Assignment Dysphoria in the DSM-5. *Archives of Sexual Behavior, 43*(7), 1263-1266. doi: 10.1007/s10508-013-0249-z

Lawrence v. Texas, 539 U. S. 558 (2003).

Lennon, E. & Mistler, B. J. (2014). Cisgenderism. *Transgender Studies Quarterly, 1*(1-2), 63-64. doi: 10.1215/23289252-2399605

Lerner, J. E. & Robles, G. (2017). Perceived barriers and facilitators to health care utilization in the United States for transgender people: A review of recent literature. *Journal of Health Care for the Poor and Underserved 28*, 127-152. doi: 10.1353/hpu.2017.0014

Levesque, J., Harris, M. F., & Russell, G. (2013). Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. *Journal for Equity in Health, 12*(18), 1-9. doi: 10.1186/1475-9276-12-18

Levin, R. (2014). Research on the biology of the trans* identity. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 85). New York, NY: Oxford University Press.

Levitt, N. (2015). Clinical nursing care for transgender patients with cancer. *Clinical Journal of Oncology Nursing, 19*(3), 362-367. doi: 10.1188/15.CJON.362-366

Lewis, C. P. (2017). The road to trans-inclusive health care: Policy implications and the critical role of social work. *Health & Social Work, 42*(1), 60-62. doi: 10.1093/hsw/hlw056

Lindroth, M. (2016). ‘Competent persons who can treat you with competence, as simple as that’—an interview study with transgender people on their experiences of

meeting health care professionals. *Journal of Clinical Nursing, 25*(23-24), 3511-3521. doi: 10.1111/jocn.13384

Link, B. G. & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.

Link, B. G. & Phelan, J. C. (2014). Stigma power. *Social Science & Medicine, 103*, 24-32. doi: 10.1016/j.socscimed.2013.07.035

Little, R. J. A. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American Statistical Association, 83*:(404), 1198-1202.

Logie, C. H., James, L., Tharao, W., & Loutfy, M. R. (2012). "We don't exist": A qualitative study of marginalization experienced by HIV-positive lesbian, bisexual, queer, and transgender women in Toronto, Canada. *Journal of the International AIDS Society, 15*, 1-11. doi: 10.7448/IAS.15.2.17392

Lombardi, E. (2001). Enhancing transgender health care. *American Journal of Public Health, 91*(6), 869-872.

Lombardi, E. & Banik, S. (2015). Cancer care needs of transgender, transsexual, and other gender nonconforming populations. In U. Boehmer & R. Elk (Eds.), *Cancer and the LGBT Community: Unique Perspectives from Risk to Survivorship* (pp. 245-260). Switzerland: Springer International Publishing.

Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. *International Journal of Transgenderism, 8*(2-3), 93-112. doi: 10.1300/J485v08n02_09

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health, 3*(6), 434-442. doi: 10.1089/lgbt.2015.0124

Manne, K. (2017). *Down girl: The logic of misogyny*. New York, NY: Oxford University Press.

Martin, J. I., Messinger, L., Kull, R., Holmes, J., Bermudez, F., & Sommer, S. (2009). *Sexual orientation and gender expression in social work education: Results from a national survey-Executive summary*. Alexandria, VA: Council on Social Work Education. Retrieved from https://www.cswe.org/CSWE/media/APM-2012/SexualOrientationAndGenderExpression.pdf

Martin, J. I., & Yonkin, D. R. (2006). Transgender identity. In D. F. Morrow & L. Messenger (Eds.), *Sexual orientation and gender expression in social work practice* (pp. 105–128). New York: Columbia University.

Matsuzaka, S. & Koch, D. E. (2019). Trans feminine sexual violence experiences: The intersection of transphobia and misogyny. Journal of Women and Social Work, 43(1), 28-47. Doi: 10.1177/0886109918790929

McBee, T. P. (2018, August 9). My voice got deeper. Suddenly, people listened. *The New York Times.* Retrieved from https://www.nytimes.com/2018/08/09/style/transgender-men-voice-change.html

McCann, E. & Brown, M. (2017). Discrimination and resilience and the needs of people who identify as Transgender: A narrative review of quantitative research studies. *Journal of Clinical Nursing, 26,* 4080-4093. doi: 10.1111/jocn.13913

Meezan, W. & Martin, J. I. (2007). Doing research on LGBT Populations: Moving the field forward. In W. Meezan & J. I. Martin (Eds.), *Handbook of research with lesbian, gay, bisexual, and transgender populations* (pp. 415-427). Oxfordshire, United Kingdom: Taylor & Frances Ltd.

Meier, S.C., & Labuski, C. (2013). The demographics of the transgender population. In A. Baumle (Ed.), *The international handbook on the demography of sexuality* (pp. 289-327). New York, NY: Springer Press.

Meltzer, T. (2016). Vaginoplasty procedures, complications and aftercare. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 140-146). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*, 38-56. doi: doi:10.2307/2137286

Miilunpalo, S., Vuori, I., Oja, P., Pasanen, M., & Urponen, H. (1997). Self-rated health status as a health measure: The predictive value of self-reported health status on the use of physician services and on mortality in the working-age population. *Journal of Clinical Epidemiology, 50*(5), 517-528. doi: 10.1016/S0895-4356(97)00045-0

Miller, L. R. & Grollman, E. A. (2015). The social costs of gender nonconformity for transgender adults: Implications for discrimination and health. *Sociological Forum, 30*(3), 809-831. doi: 10.1111/socf.12193

Miner, M. H., Bockting, W. O., Swinburne Romine, R., & Raman, S. (2012). Conducting internet research with the transgender population: Reaching broad samples and collecting valid data. *Social Science Computer Review, 30*(2), 202-211. doi: 10.1177/0894439311404795

Ministry of Health and Long-Term Care. (2015). *Schedule of Benefits: Physician Services Under the Health Insurance Act*. Ontario: Ministry of Health and Long-Term Care. Retrieved from http://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master20181115.pdf

Moolchaem, P., Liamputtong, P., O'Halloran, P., & Muhamad, R. (2015). The lived experiences of transgender persons: A meta-synthesis. *Journal of Gay & Lesbian Social Services, 27*, 143-171. doi: 10.1080/10538720.2015.1021983

Moone, R. P., Croghan, C. F., & Olson, A. M. (2016). Why and how providers must build culturally competent, welcoming practices to serve LGBT elders. *American Society on Aging*, 40(2), 73-77.

Mullaly, B. (2010). *Challenging oppression and confronting privilege: A critical social work approach*. Don Mills, ON: Oxford University Press.

Namaste, V. K. (2000). *Invisible lives: The erasure of transsexual and transgendered people.* Chicago, IL: The University of Chicago Press.

Nanda, S. (1993). Hijras: An alternative sex and gender role in India. In G. Herdt (Ed.), *Third sex third gender: Beyond sexual dimorphism in culture and history* (pp. 373-417). New York, NY: Zone Books.

NASW (National Association of Social Workers). (2006). Transgender and gender identity issues. *Social Work Speaks,* 366-370. Retrieved from https://www.socialworkers.org/assets/secured/documents/da/da2008/reffered/Transgender.pdf

NASW (National Association of Social Workers). (2015a). *Sexual orientation change efforts (SOCE) and conversion therapy with lesbians, gay men, bisexuals, and transgender persons.* Washington, DC: National Association of Social Workers. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=yH3UsGQQmYI%3d&portalid=0

NASW (National Association of Social Workers). (2015b). *Standards and indicators for cultural competence in social work practice.* Washington, DC: National Association of Social Workers. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=7dVckZAYUmk%3D&portalid=0

NASW (National Association of Social Workers). (2016). *NASW standards for social work practice in health care settings.* Washington, DC: National Association of Social Workers. Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=fFnsRHX-4HE%3D&portalid=0

NASW (National Association of Social Workers). (2017). *Code of Ethics of the National Association of Social Workers*. Washington, DC: National Association of Social

Workers. Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Center for Transgender Equality. (n.d.). *Final HHS regulations on health care discrimination: Frequently asked questions*. Washington, DC: National Center for Transgender Equality. Retrieved from http://www.transequality.org/sites/default/files/HHS-1557-FAQ.pdf

National LGBT Health Education Center. (2016). *Affirmative care for transgender and gender non-conforming people: Best practices for front-line health care staff*. Boston, MA: The Fenway Institute. Retrieved from https://www.lgbthealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf

National Resource Center on LBGT Aging. (2012). *Inclusive services for LGBT older adults: A practical guide to creating welcoming agencies.* Retrieved from http://www.lgbtagingcenter.org/resources/resource.cfm?r=487

Northridge, M. E. (1995). Public health methods: Attributable risk as a link between causality and public health action. *American Journal of Public Health, 85*, 1202-1203.

Obergefell v. Hodges, 135 S. Ct. 2584 (2015).

One Colorado. (2014). *Transparent: The state of transgender health in Colorado*. Denver, CO: One Colorado Education Fund.

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

Peate, I. (2008). Caring for transgendered people: Opportunities and challenges. *British*

Journal of Nursing 17(8), 540-543. doi: 10.12968/bjon.2008.17.8.29210

Pechansky, R. & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140.

Peitzmeier, S. M., Reisner, S. L., Harigopal, P., & Potter, J. (2014). Female-to-male patients have high prevalence of unsatisfactory Paps compared to non-transgender females: Implications for cervical cancer screening. *Journal of General Internal Medicine, 29*(5), 778–784. doi: 10.1007/s11606-013-2753-1

Pfeffer, C. A. (2014). "I don't like passing as a straight woman": Queer negotiations of identity and social group membership. *American Journal of Sociology, 120*(1), 1-44. doi: 10.1086/677197

Porter, K. E., Brennan-Ing, M., Chang, S. C., dickey, l. m., Singh, A. A., Bower, K. L., & Witten, T. M. (2016). Providing competent and affirming services for transgender and gender nonconforming older adults. *Clinical Gerontologist, 39*(5), 366-388. doi: 10.1080/07317115.2016.1203383

Poteat, T. (2016a). Transgender health and hepatitis C. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 87-89). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Poteat, T. (2016b). Transgender health and HIV. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 82-86). San Francisco, CA: Center of Excellence for Transgender

Health, Department of Family and Community Medicine, University of California.

Poteat, T. (2016c). Transgender people and sexual transmitted infections (STIs). In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 90-92). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine, 84*, 22-29. doi: 10.1016/j.socscimed.2013.02.019

Prieur, A. (1998). *Mema's house, Mexico City: On transvestites, queens, and machos.* Chicago: The University of Chicago Press.

Proctor, B. D., Semega, J. L., & Kollar, M. A. (2016*). Income and Poverty in the United States: 2015*. Washington D.C.: U. S. Census Bureau. Retrieved from: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-256.pdf

Proctor, K., Haffer, S. C., Ewald, E., Hodge, C., & James, C. V. (2016). Identifying the transgender population in the Medicare program. *Transgender Health, 1*(1), 250-265. doi: 10.1089/trgh.2016.0031

Pyne, J. (2011). Unsuitable bodies: Trans people and cisnormativity in shelter services. *Canadian Social Work Review, 28*(1), 129-137.

Quinn, G. P., Sanchez, J. A., Sutton, S. K., Vadaparampil, S. T., Nguyen, G. T., Green, B. L., …Schabath, M. B. (2015). Cancer and lesbian, gay, bisexual,

transgender/transsexual, and queer/questioning (LGBTQ) populations. *CA: A Cancer Journal for Clinicians, 65*(5), 384-400.

Rachlin, K. (2007). The questions we ask: Conducting socially conscious research with transgender individuals. In W. Meezan & J. I. Martin (Eds.), *Handbook of research with lesbian, gay, bisexual, and transgender populations* (pp. 261-279). Oxfordshire, United Kingdom: Taylor & Frances Ltd.

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

Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, M. B., … Saxena, S. (2016). Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*, *15*, 205–22.

Reeves, C., Deutsch, M., & Wilson Stark, J. (2016). Hair removal. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 156-160). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Reisner, S. L., Conron, K., Scout, N., Mimiaga, M. J., Haneuse, S., & Austin, S. B. (2014). Comparing in-person and online survey respondents in the U.S. National Transgender Discrimination Survey: Implications for Transgender Health Research. *LGBT Health, 1*(2), 98-106. doi: 10.1089/lgbt.2013.0018

Reisner, S. L., White, J. M., Dunham, E. E., Heflin, K., Begenyi, J., Cahill, S., & The Project Voice Team. (2014). *Discrimination and health in Massachusetts: A statewide survey of transgender and gender nonconforming adults*. Boston, MA: The Fenway Institute, Fenway Health.

Reisner, S. L., White Hughto, J. M., Dunham, E. E., Heflin, K. J., Begenyi, J. B. G., Coffey-Esquivel, J., & Cahill, S. (2015). Legal protections in public accommodations settings: a critical public health issue for gender minority people. *Milbank Quarterly*, *93*(3), 1-32.

Ringrose, K. M. (1993). Living in the shadows: Eunuchs and gender in Byzantium. In G. Herdt (Ed.), *Third sex third gender: Beyond sexual dimorphism in culture and history* (pp. 85-110). New York, NY: Zone Books.

Rodriguez, M. F., Grande, M. M., & Gonzalez, V. (2018). Gender incongruence is no longer mental disorder. *Journal of Mental Health & Clinical Psychology, 2*(5), 6-8.

Rodriguez, A., Agardh, A., & Asamoah, B. O. (2017). Self-reported discrimination in health-care settings based on recognizability as transgender: A cross-sectional study among U.S. citizens. *Archives of Sexual Behavior*. doi: 10.1007/s10508-017-1028-z

Roen, K. (2002). "Either/or" and "both/neither": Discursive tensions in transgender politics. *Signs: Journal of Women in Culture and Society, 27*(2), 501-522.

Scasta, D. & Bialer, P. (2013). *APA official actions: Position Statement on Issues Related to Homosexuality*. American Psychiatric Association. Retrieved from https://webcache.googleusercontent.com/search?q=cache:ZH2nn3tkT-

UJ:https://www.psychiatry.org/File%2520Library/About-APA/Organization-Documents-Policies/Policies/Position-2013-Homosexuality.pdf+&cd=3&hl=en&ct=clnk&gl=us

Schilt, K. (2006). Just one of the guys? How transmen make gender visible at work. *Gender & Society*, *20*(4), 465-490.

Schnarch, B. (1992). Neither man nor woman: Berdache—a case for non-dichotomous gender construction. *Anthropologica*, *34*(1), 105-121.

Schneider, S. & Courey, M. (2016). Transgender voice and communication—vocal health and considerations. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 161-171). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Seelman, K. L., Colón-Diaz, M. J. P., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. *Transgender Health*, *2*(1), 17–28. http://doi.org/10.1089/trgh.2016.0024

Seelman, K. L., Miller, J. F., Fawcett, Z. E. R., & Cline, L. (2018). Do transgender men have equal access to health care and engagement in preventive health behaviors compared to cisgender adults? *Social Work in Health Care*. doi: 10.1080/00981389.2018.1462292

Serano, J. (2007). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Emeryville, CA: Seal Press.

Shapiro, E. (2004). 'Trans'cending barriers: Transgender organizing on the internet. *Journal of Gay & Lesbian Social Services, 16*(3-4), 165-179. doi: 10.1300/J041v16n03_11

Shields, M., & Shooshtari, S. (2001). Determinants of self-perceived health. *Health Reports, 13*(1), 35.

Shires, D. A. & Jaffee, K. (2015). Factors associated with health care discrimination experiences among a national sample of female to male transgender individuals. *Health & Social Work, 40*(2),134-141. doi:10.1093/hsw/hlv025

Silverschanz, P. (2007). What's "queer" got to do with it?: Enlightening mainstream research. In W. Meezan & J. I. Martin (Eds.), *Handbook of research with lesbian, gay, bisexual, and transgender populations* (pp. 3-16). Oxfordshire, United Kingdom: Taylor & Frances Ltd.

Simmons, H. & White, F. (2014). Our many selves. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 3-23). New York, NY: Oxford University Press.

Snelgrove, J. W., Jasudavisius, A. M., Rowe, B. W., Head, E. M., & Bauer, G. R. (2012). "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Services Research, 12*, 110. doi: 10.1186/1472-6963-12-110

Stotzer, R. L. (2009). Violence against transgender people: A review of the United States data. *Aggression and Violent Behavior, 14*, 170-179. doi: 10.1016/j.avb.2009.01.006

Stotzer, R. L., Ka‘opua, L. S. I., & Diaz, T. P. (2014). Is healthcare caring in Hawai‘i? Preliminary results from a health assessment of lesbian, gay, bisexual, transgender, questioning, and intersex people in four counties. *Hawai‘i Journal of Medicine & Public Health, 73*(6), 175-180.

Strain, J. D. & Shuff, I. M. (2010). Psychological well-being and level of outness in a population of male-to-female transsexual women attending a national transgender conference. *International Journal of Transgenderism, 12*(4), 230-240. doi: 10.1080/15532739.2010.544231

Stryker S. & Currah P. (2014). Introduction. *Transgender Studies Quarterly 1*(1-2), 1-18. doi: 10.1215/23289252-2398540

Teich, N. M. (2012). *Transgender 101: A simple guide to a complex issue.* New York, NY: Columbia University Press.

The Joint Commission. (2011a). *2011 Comprehensive Accreditation Manual for Hospitals the Official Handbook*. Oak Brook, IL: The Joint Commission.

The Joint Commission. (2011b). *Advancing effective communication, cultural competence, and patient-and-family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: A field guide.* Oak Brook, IL: The Joint Commission. Retrieved from https://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

Transgender Law Center. (2016). *10 Tips for Working with Transgender Patients*. Oakland, CA: Author.

Trans Health Expansion Partnership. (n.d.). *Transition-related surgery (TRS)*: Frequently asked questions.* Toronto, Ontario: Trans Health Expansion Partnership. Retrieved from https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2017/06/TransRelatedSurgery-FAQ-2017-final.pdf

Trumbach, R. (1993). London's sapphists: From three sexes to four genders in the making of modern culture. In G. Herdt (Ed.), *Third sex third gender: Beyond sexual dimorphism in culture and history* (pp. 111-136). New York, NY: Zone Books.

Unger, C. A. (2014). Care of the transgender patient: The role of the gynecologist. American *Journal of Obstetrics and Gynecology, 210*(1), 16-26. doi: 10.1016/j.ajog.2013.05.035

Vittinghoff, E., Glidden, D. V., Shiboski, S. C., & McCulloch, C. E. (2012). *Regression methods in biostatistics: Linear, logistic, survival, and repeated measures models.* New York, NY: Springer

Van Den Bergh, N. & Crisp, C. (2004). Defining culturally competent practice with sexual minorities: Implications for social work education and practice. *Journal of Social Work Education, 40*(2), 221-238. doi: 10.1080/10437797.2004.10778491

Von Vogelsang, A. C., Milton, C., Ericsson, I., Strömberg, L. (2016). 'Wouldn't it be easier if you continued to be a guy?' – A qualitative interview study of transsexual persons' experiences of encounters with healthcare professionals. *Journal of Clinical Nursing, 25,* 3577-3588. doi: 0.1111/jocn.13271

Wesp, L. (2016). Prostate and testicular cancer considerations in transgender women. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 108-109). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Wheeler, D. P. & Dodd, S. (2011). LGBTQ capacity building in health care systems: A social work perspective. *Health & Social Work, 36*(4), 307-309.

White Hughto, J. M., Murchison, G. R., Clark, K., Pachankis, J. E., & Reisner, S. L. (2016). Geographic and individual differences in healthcare access for U.S. transgender adults: A multilevel analysis. *LGBT Health, 3*(6), 424-433. doi: 10.1089/lgbt.2016.0044

White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma, determinants, mechanisms, and interventions. *Social Science & Medicine, 147*, 222-231. doi: 10.1016/j.socscimed.2015.11.010

WHO (World Health Organization). (1965). *International classification of diseases and related health problems (8th revision).* Geneva, Switzerland: Author.

WHO (World Health Organization). (1975). *International classification of diseases and related health problems (9th revision).* Geneva, Switzerland: Author.

WHO (World Health Organization). (1990). *International classification of diseases and related health problems (10th revision).* Geneva, Switzerland: Author.

WHO (World Health Organization). (2015). *Transgender people and HIV*. Geneva, Switzerland: Author.

WHO (World Health Organization). (2019, May 17). *Moving one step closer to better health and rights for transgender people.* World Health Organization. Retrieved from http://www.euro.who.int/en/health-topics/health-determinants/gender/news/news/2019/5/moving-one-step-closer-to-better-health-and-rights-for-transgender-people

Wilkerson, J. M., Rybicki, S., Barber, C. A., & Smolenski, D. J. (2011). Creating a culturally competent clinical environment for LGBT patients. *Journal of Gay & Lesbian Social Services, 23*(3), 376-394. doi: 10.1080/10538720.2011.589254

Wilson, A. A. & Green, J. (2016). Health insurance coverage issues for transgender people in the United States. In M. B. Deutsch, (Ed.), *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (pp. 172-178). San Francisco, CA: Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California.

Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., & Wylie K. (2016). Transgender people: Health at the margins of society. *The Lancet*, 388(10042), 390-400. doi: 10.1016/S0140-6736(16)00683-8

Witten, T. M. (2009). Graceful exits: Intersection of aging, transgender identities, and the family/community. *Journal of GLBT Family Studies, 5*(1-2), 35-61. doi: 10.1080/15504280802595378

Witten, T. M. (2014a). End of life, chronic illness, and trans-identities. *Journal of Social Work in End of Life and Palliative Care, 10*(1), 34-58. doi: 10.1080/15524256.2013.877864

Witten, T. M. (2014b). It's not all darkness: Robustness, resilience, and successful transgender Aging. *LGBT Health, 1*(10), 24-33. doi: 10.1089/lgbt.2013.0017

Witten, T. M. (2016). The intersectional challenges of aging and of being a gender non-conforming adult. *Generations, 40*(2), 63-70.

Wright, K. B. (2005). Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication, 10,* 3. doi: 10.1111/j.1083-6101.2005.tb00259.x

Wylie, K., Knudson, G., Khan, S. I., Bonierbale, M., Watanyusakul, S., & Baral, S. (2016). Serving transgender people: Clinical care considerations and service delivery models in transgender health. *The Lancet, 388*, 401-411. doi: 10.1016/S0140-6736(16)00682-6

Zucker, K. J. (2015). The DSM-5 diagnostic criteria for gender dysphoria. In C. Trombetta, G. Liguori, & M. Bertolotto (Eds.), *Management of gender dysphoria* (pp. 33-37). Verlag, Italy: Springer.

Appendix A

English Questionnaire

Contents

National Center for Transgender Equality Website: http://www.ustranssurvey.org/ Email: ustranssurvey@transequality.org

Introduction

The National Center for Transgender Equality welcomes you to the 2015 U.S. Trans Survey, the follow up to the National Transgender Discrimination Survey: Injustice At Every Turn. We thank you for participating in this survey. Every voice counts in documenting and better understanding the lives and experiences of trans people in the United States, and we appreciate yours.

Sincerely,
The National Center for Transgender Equality Survey Team

UNIVERSITY OF CALIFORNIA LOS ANGELES
STUDY INFORMATION SHEET

2015 U.S. Trans Survey

This study has been commissioned by the National Center for Transgender Equality (NCTE). A research team made up of Jody L. Herman, Ph.D. and Susan Rankin, Ph.D. are conducting this study. Your participation in this study is voluntary.

WHY IS THIS STUDY BEING DONE?
This study is being conducted to better understand the demographics, health, and experiences of trans people in the United States. The findings of this study will be used for the benefit of the trans community and the research community.

WHAT WILL HAPPEN IF I TAKE PART IN THIS RESEARCH STUDY?
If you volunteer to participate in this study, the researchers ask that you participate in an online survey. The purpose of the survey is to gather information about you and your experiences as a trans person in the United States. You will be one of over 700,000 possible participants who may take part in this survey, which is the current best estimate of the total number of trans-identified adults in the United States.

HOW LONG WILL I BE IN THE RESEARCH STUDY?
Participation in the study will take between 30-60 minutes.

ARE THERE ANY RISKS OR DISCOMFORTS THAT I CAN EXPECT FROM THIS STUDY?
Participating in this study poses no risks that are not ordinarily encountered in daily life. Any information you provide in the survey will be confidential. Some of the questions asked of you as part of this survey may make you feel uncomfortable. You may refuse to answer questions posed to you by skipping the question. You may stop your participation in this study at any time by exiting the survey. Should you need them, there will be a list of resources, including hotlines, provided at the end of the survey.

ARE THERE ANY BENEFITS IF I PARTICIPATE?
The results of the research will be used for the benefit of the trans community in the United States and the research community. You will not directly benefit from your participation in the research.

WILL I BE PAID FOR MY PARTICIPATION?
You will receive no payment for your participation. You will have the option to voluntarily enter a drawing to win one of three cash prizes: one prize of $500 and two prizes of $250.

HOW WILL INFORMATION ABOUT ME AND MY PARTICIPATION BE KEPT CONFIDENTIAL?
Your survey response will be anonymous, so no information that can be used to identify you will be collected unless you voluntarily provide it. Any information that is obtained in connection with this study and that can identify you will remain confidential. If you do voluntarily provide any information that could be used to identify you, the research team will maintain your confidentiality by taking precautions to minimize any risk to your privacy from participating in this survey.

You will be given the option at the end of the survey to be directed to a separate page on a secure website if you wish to provide your contact information to receive survey results from NCTE, be entered into the drawing for one of three cash prizes, or share your personal story with NCTE. NCTE will NOT be provided with any responses from your survey in connection with your contact information. NCTE will only know that you have participated in the survey. NCTE will not provide to the research team any information that could be used to identify you, such as your name. Therefore, you will remain anonymous to the research team.

Results of this research study that are reported in published form will not name you or identify you as a participant. If you choose to self-identify anywhere on the survey and provide a written response, a different name will be created and used instead of your name if quoting you directly in any publication and any content of quotes that could be used to identify you will be removed.

CAN THE RESEARCHERS REMOVE ME FROM THIS STUDY?
The researchers will not remove you from the study. You may remove yourself from the study by exiting the survey. If you exit the survey, your responses will not be recorded or used in the study.

WHAT ARE MY RIGHTS IF I TAKE PART IN THIS STUDY?
Taking part in this study is your choice. You can choose whether or not you want to participate. Whatever decision you make, there will be no penalty to you.

- You have a right to have all of your questions answered before deciding whether to take part in the study.
- If you decide to take part in the study, you have the right to exit the study at anytime by exiting the survey.
- If you decide at any point to stop participating in this study, you have the right to exit the study at any time by exiting the survey.

WHO CAN I CONTACT IF I HAVE QUESTIONS ABOUT THIS STUDY?

The Research Team:
You may contact Jody L. Herman at (310) 267-4382 or Susan Rankin at (814) 625-2780 with any questions or concerns about the research or your participation in this study.

UCLA Office of the Human Research Protection Program (OHRPP):
If you have questions about your rights while taking part in this study, or you have concerns or suggestions and you want to talk to someone other than the researchers about the study, you may contact the UCLA OHRPP by phone: (310) 825-7122 or U.S. mail: UCLA OHRPP, 11000 Kinross Ave., Suite 102, Box 951694, Los Angeles, CA 90095-1694.

If you agree to take part in this study, as described in detail above, please click on the "**I AGREE**" button below. By clicking on the "**I AGREE**" button, you will indicate your consent to participate in this study.

If you do not agree to take part in this study, as described above, please click on the "**I DO NOT AGREE**" button below.

☐ **I AGREE**
I agree and give my consent to participate in this study.

☐ **I DO NOT AGREE**
I do not agree to participate in this study.
[*PROGRAMMING NOTE: Respondents who do not agree to participate are sent to Disqualification page #2*]

Survey Instructions

Please read and answer each question carefully. For each answer, click on the appropriate oval and/or fill in the appropriate blank. If you want to change an answer, click on the oval of your new answer and/or edit the appropriate blank, and your previous response will be erased.

You may decline to answer specific questions. The survey will take between 30-60 minutes to complete.

There will be several places in the survey where you will see a word or phrase that is underlined and bolded. You can click on those words or phrases and a definition or additional information will be offered.

In order to clear a response choice, please use the back button on your browser.

WARNING: If you use the back button on your browser to return to a previous question, the responses you have entered for each page you clicked back on will be erased. For instance, if you click back three pages in the survey, your answers on those three pages will be erased. Responses before those three pages would stay the same.

In the survey, please do not provide any information that could be used to identify you, such as your name or contact information. All of your answers are confidential and cannot be used against you.

You must hit the "submit" button on the last page of the survey for your responses to be included in the final analyses.

Section 1

1.1
Please make an ID in question 1.1. The research team will use the ID for their analysis. It will not be used to identify you.

Enter the first and last letter of your preferred first name.
For example, if your first name is “Robert”, enter "RT".
[Text box]

Enter the first letter of your preferred last name.
For example, if your last name is “Smith”, enter "S".
[Text box]

1.2 [MUST ANSWER TO PROCEED IN SURVEY]
It is important that people only complete this survey one time so that we can gather accurate information. You will only be entered into the prize drawing once, even if you complete this survey more than once. Have you already completed this survey before?

- ○ No
- ○ Yes [Send respondent to Disqualification Page #1]

1.3 [MUST ANSWER TO PROCEED IN SURVEY] Are you 18 years of age or older?

- ○ No [Send respondent to Disqualification Page #2]
- ○ Yes

1.4 [MUST ANSWER TO PROCEED IN SURVEY]
What U.S. state or territory do you currently live in?

- ○ I do not live in a U.S. state or territory.

[Insert drop down of all U.S. states and territories for other response choices]

[*PROGRAMMING NOTE: Direct those to who do not live in U.S. states and territories out of survey –send to Disqualification Page #1*]

1.5
How did you hear about this survey? **(Mark all that apply).**

- ○ Email from an organization (listserv, e-newsletter)
- ○ Social networking site (such as Facebook)
- ○ Organization website (such as NCTE)
- ○ I was told about it in person (at an organization, event, or support group)
- ○ Flier or print advertisement
- ○ Word of mouth (e-mail from a friend, a friend told you about it)
- ○ Not listed above (please specify)

1.6
Are you taking this survey at a survey event or meeting, such as one hosted by an LGBTQ or Trans organization or meeting?

- No
- Yes

1.7
How are you taking this survey?

- On my home computer/laptop
- On my work computer
- On a public computer (such as in a computer lab or library)
- On my mobile phone or tablet
- On a friend's or family member's mobile phone, tablet, or computer
- Not listed above (please specify) _____

1.8
Not including for this survey, do you use the internet or email, at least occasionally? (**Mark all that apply**).

- No

[*PROGRAMMING NOTE: Respondents cannot select the "no" option and any other option.*]

- Yes, the internet
- Yes, email

1.9
If a national survey company, like Gallup, asked you the following question:
"We are asking only for statistical purposes: Do you, personally, identify as lesbian, gay, bisexual, or transgender?"

How would you answer?

- I would answer No
- I would answer Yes
- I would not answer the question

PLEASE READ AND RESPOND CAREFULLY TO THE FOLLOWING QUESTIONS.

This is a survey for people who are transgender, trans, or non-binary. It doesn't matter if you have transitioned gender or if you plan to. To see if this survey is for you, please answer the following questions.

1.10 [MUST ANSWER TO PROCEED IN SURVEY]
Do you think of yourself as transgender?

- No
- Yes

1.11 [MUST ANSWER TO PROCEED IN SURVEY]
Do you identify as more than one gender or as no gender (such as genderqueer or non-binary)?

- No
- Yes

1.12 [MUST ANSWER TO PROCEED IN SURVEY]
Do you currently live full-time in a gender that is different from the one assigned to you at birth?

- No [Skip to **1.14**]
- Yes

1.13 [Skip to **1.17** after answering]
How old were you when you started to live full-time in a gender that is different from the one assigned to you at birth?
[Drop down list of all ages: "1" through "99" and then "100 and above" as final response option]

1.14 [IF NO IN 1.12, MUST ANSWER TO PROCEED IN SURVEY]
Someday do you want to live full-time in a gender that is different from the one assigned to you at birth?

- No [Skip to **1.16**]
- Yes [Proceed to **1.15**]
- Not sure [Proceed to **1.15**]

1.15 [Skip to **1.17** after answering]
What are the main reasons that you don't live full-time in a gender that is different from the one assigned to you at birth? **(Mark all that apply).**

- My spouse and/or kids might reject me.
- My parents might reject me.
- I might lose my job or not be able to get a job.
- I might face mistreatment at school.
- My friends might reject me.
- I might not get the medical care I need.
- I might be hurt financially.
- I might become homeless.
- My church or faith community might reject me.
- I might face violence.
- I am not ready to transition.
- A reason not listed above (please specify) _____

1.16 [IF ANSWERED NO TO 1.13, MUST ANSWER TO PROCEED IN SURVEY]
Have you seriously thought about living in a gender that is different from the one assigned to you at birth (transitioning gender)?

- No
- Yes

1.17 [MUST ANSWER TO PROCEED IN SURVEY] Do you consider yourself to be a cross-dresser?

- No
- Yes

1.18 [MUST ANSWER TO PROCEED IN SURVEY]
Do you live part of the time in one gender and part of the time in another gender?

- No
- Yes

[*PROGRAMMING NOTE FOR ELIGIBILITY SCREENING: If no on **1.10**, **1.11**, **1.12**, **1.14**, **1.16**, **1.17**, and **1.18** THEN respondent is sent to Disqualification Page #1. Everyone else continues.*]

Section 2

2.1 [MUST ANSWER TO PROCEED IN SURVEY]
What sex were you assigned at birth, on your original birth certificate?

- Female
- Male

2.2
Which of these terms do you identify with? **(Mark all that apply).**

- A.G. or aggressive
- Agender
- Androgynous
- Bi-gender
- Butch
- Bulldagger
- Cross dresser
- Drag performer (king/queen)
- Fa'afafine
- Gender non-conforming or gender variant
- Genderqueer
- Gender fluid/fluid
- Intersex
- Mahu
- Multi-gender
- Non-binary
- Third gender
- Stud
- Transgender
- Trans
- Trans man (FTM, female to male)
- Transsexual
- Trans woman (MTF, male to female)
- Travesti
- Two-spirit
- A gender not listed above (please specify)_____

2.3

If you had to choose only one of the following terms, which best describes your current gender identity? **(Please choose only one answer.)** [*PROGRAMMING NOTE: Only allow one selection*]

- Cross-dresser [Skip to **2.4**]
- Woman [Skip to **2.4**]
- Man [Skip to **2.4**]
- Trans woman (MTF) [Skip to **2.4**]
- Trans man (FTM) [Skip to **2.4**]
- Non-binary/Genderqueer [Proceed to **2.3_1**, **2.3_2**, and **2.3_3** (based on **2.3_2**)]

2.3_1

For people in your life who don't know that you're non-binary/genderqueer, what gender do they usually think you are?

- Man
- Woman
- Trans Man
- Trans Woman
- Non-Binary/Genderqueer
- They can't tell
- It varies

2.3_2 [Response of "always" will skip to **2.4**]

When people in your life assume you are something other than non-binary/genderqueer (such as a man or a woman), how do you respond?

- I **usually** let them assume I am a man or a woman
- I **sometimes** tell them I identify as non-binary/genderqueer (or whatever words I use)
- I **always** tell them I identify as non-binary/genderqueer (or whatever words I use)

2.3_3

What are the main reasons that you don't tell people you identify as non-binary/genderqueer? **(Mark all that apply).**

- Most people don't understand so I don't try to explain it.
- Most people dismiss it as not being a real identity or a "phase."
- It is just easier not to say anything.
- I am not ready to tell people I identify as non-binary/genderqueer.
- I might lose my job or not be able to get a job.
- I might face mistreatment at school.
- My friends might reject me.
- I might not get the medical care I need.
- I might be hurt financially.
- I might become homeless.
- My church or faith community might reject me.
- I might face violence.
- A reason not listed above (please specify) _____

2.4

How comfortable are you with the word "transgender" being used to describe you?

- ○ Very comfortable
- ○ Somewhat comfortable
- ○ Neutral
- ○ Somewhat uncomfortable
- ○ Very uncomfortable

We know that not everyone is comfortable with the word "transgender," but for this survey, we must use one word to refer to all trans and non-binary identities. Because of this we will use the word "trans" in this survey to refer to all trans and non-binary identities.

2.5

What gender pronouns do you ask people to use to refer to you?

[*PROGRAMMING NOTE: Allow respondents to mark all that apply*]

- ○ He, his
- ○ She, hers
- ○ They, their
- ○ Ze, hir
- ○ No pronouns. I ask people only to use my name.
- ○ I don't ask people to use specific pronouns.
- ○ Pronouns not listed above (please specify) _____

2.6

What gender do you currently live in on a day-to-day basis?

- ○ Man
- ○ Woman
- ○ Neither man nor woman/Genderqueer/Non-binary
- ○ Part time one gender/part time another gender

2.7

People can tell I am trans even if I don't tell them.

- ○ Always
- ○ Most of the time
- ○ Sometimes
- ○ Rarely
- ○ Never

2.8

What best describes your current sexual orientation?

- Asexual
- Bisexual
- Gay
- Heterosexual/Straight
- Lesbian
- Same-gender loving
- Pansexual
- Queer
- A sexual orientation not listed above (please specify)_____

2.9 [Skip to **2.12** after answering, unless directed to a follow-up (**2.10** or **2.11**)]

Although the choices listed below may not represent your full identity or use the language you prefer, for this survey please select the choice that most accurately describes your racial/ethnic identity. **(Please choose only one answer.)**

- Alaska Native
  - [Drop down if selected] Enter your enrolled or principal corporation: ____ [*PROGRAMMING NOTE: Will force something to be written here for choice to count*]
- American Indian
  - [Drop down if selected] Enter your enrolled or principal tribe: _____ [*PROGRAMMING NOTE: Will force something to be written here for choice to count*]
- Asian/Asian American
- Biracial/Multiracial [Proceed to **2.10**]
- Black/African American
- Latino/a/Hispanic
- Middle Eastern/North African
- Native Hawaiian/Pacific Islander
- White/European American
- A racial/ethnic identity not listed above (please specify)_____[Skip to **2.11**]

2.10 [Skip to **2.12** after answering]
You said that you are biracial or multiracial. Please choose the racial/ethnic identities that best describe you. **(Mark all that apply).**

- Alaska Native
  - [Drop down if selected] Enter your enrolled or principal corporation: _____ [*PROGRAMMING NOTE: Will force something to be written here for choice to count*]
- American Indian
  - [Drop down if selected] Enter your enrolled or principal tribe: _____ [*PROGRAMMING NOTE: Will force something to be written here for choice to count*]
- Asian/Asian American
- Black/African American
- Latino/a/Hispanic
- Middle Eastern/ North African
- Native Hawaiian/ Pacific Islander
- White/European American
- A racial/ethnic identity not listed above (please specify) _____

2.11
You said that you had a racial/ethnic identity that was not listed above. Please choose the racial/ethnic identities that best describe you. **(Mark all that apply).**

- Alaska Native
  - [Drop down if selected] Enter your enrolled or principal corporation: _____ [*PROGRAMMING NOTE: Will force something to be written here for choice to count*]
- American Indian
  - [Drop down if selected] Enter your enrolled or principal tribe: _____ [*PROGRAMMING NOTE: Will force something to be written here for choice to count*]
- Asian/Asian American
- Black/African American
- Latino/a/Hispanic
- Middle Eastern/ North African
- Native Hawaiian/ Pacific Islander
- White/European American

2.12

What is your current religious or spiritual identity? **(Mark all that apply).**

- Agnostic
- Atheist
- Baha'i
- Buddhist
- Christian (Please click here to specify) [If selected, drop down list asfollows]
  - African Methodist Episcopal
  - African Methodist Episcopal Zion
  - Assembly of God
  - Baptist
  - Catholic/Roman Catholic
  - Church of Christ
  - Church of God in Christ
  - Christian Orthodox
  - Christian Methodist Episcopal
  - Christian Reformed Church (CRC)
  - Episcopalian
  - Evangelical
  - Greek Orthodox
  - Lutheran
  - Mennonite
  - Moravian
  - Nondenominational Christian
  - Pentecostal
  - Presbyterian
  - Protestant
  - Protestant Reformed Church (PR)
  - Quaker
  - Reformed Church of America (RCA)
  - Russian Orthodox
  - Seventh Day Adventist
  - The Church of Jesus Christ of Latter-day Saints
  - United Methodist
  - Unitarian Universalist
  - United Church of Christ
  - A Christian affiliation not listed above (please specify) _____
- Confucianist
- Druid
- Hindu
- Jain
- Jehovah's Witness
- Jewish (Please click here to specify) [If selected, drop down list asfollows]

    - Conservative
    - Orthodox
    - Reform
  - Muslim (Please click here to specify) [If selected, drop down list asfollows]
    - Ahmadi
    - Shi'ite
    - Sufi
    - Sunni
  - Native American Traditional Practitioner or Ceremonial
  - Pagan
  - Rastafarian
  - Scientologist
  - Secular Humanist
  - Shinto
  - Sikh
  - Taoist
  - Tenrikyo
  - Wiccan
  - Spiritual, but no religious affiliation
  - No affiliation
  - A religious affiliation or spiritual identity not listed above (please specify) _____

2.13
What is your current age?
[Drop down list of all ages: "18" through "99" and then "100 and above" as final response]

2.14
What month and year were you born?
Month [Drop down list January through December] Year [Drop down list 1997-1915 or older]

2.15
What is your current relationship status?
- Partnered, living together
- Partnered, not living together
- Single
- Not listed above (please specify) _____

2.16

What is your current legal marital status?

- Married
- Legally recognized civil union
- Registered domestic partnership
- Widowed
- Divorced
- Separated
- Single, never married

2.17

Have you ever served on **active duty*** in the U.S. Armed Forces, Reserves, or National Guard? *As a reminder, your answers are confidential and cannot be used against you.*
[*PROGRAMMING NOTE: Respondents who answer anything other than "never served in the military" are directed to Section 8.*]

- Never served in the military
- Only on active duty for training in the Reserves or National Guard
- Now on active duty
- On active duty in the past, but not now

***Hyperlinked text for "active duty"**: Active duty means full-time service, other than active duty for training as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration, or its predecessors, the Coast and Geodetic Survey or Environmental Science Service Administration. Active duty also applies to a person who is a cadet attending one of the five United States Military Service Academies. For a person with service in the military Reserves or National Guard, mark the "Only on active duty for training in the Reserves or National Guard" box if the person has never been called up for active duty, mobilized, or deployed. For a person whose only service was as a civilian employee or civilian volunteer for the Red Cross, USO, Public Health Service, or War or Defense Department, mark the "Never served in the military" box. For Merchant Marine service, count only the service during World War II as active duty and no other period of service.*

2.18

What is your citizenship or immigration status in the U.S.?

As a reminder, your answers are confidential and cannot be used against you.

[*PROGRAMMING NOTE: If select anything other than "U.S. citizen, birth," respondent will receive questions on Section 9.*]

- U.S. citizen, birth
  [*PROGRAMMING NOTE: Direct these respondents to **2.19**. All others skip to **2.20***]
- U.S. citizen, naturalized
- Permanent Resident
- A visa holder (such as F-1, J-1, H1-B, and U)
- DACA (Deferred Action for Childhood Arrival)
- DAPA (Deferred Action for Parental Accountability)
- Refugee status
- Other documented status not mentioned above
- Currently under a withholding of removal status
- Undocumented resident

2.19

In what U.S. state or territory were you born?

- I was not born in a U.S. state or territory.
  [Drop down list of all U.S. states and territories for other response choices. For New York add a drop down "New York City"]

2.20

Please answer each question below (**Please provide an answer in each row.**)

	No	**Yes**
Are you deaf or have serious difficulty hearing?	O	O
Are you blind or have serious difficulty seeing even when wearing glasses?	O	O
Because of a physical mental or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	O	O
Do you have serious difficulty walking or climbing stairs?	O	O
Do you have difficulty dressing or bathing?	O	O
Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?	O	O
Do **YOU** identify as a person with a disability?	O	O

2.21

What is the main language that people speak in your home?

- English only
- Language(s) other than English [If selected, drop down list as follows]
  - Armenian
  - Chinese
  - French
  - German
  - Greek
  - Italian
  - Japanese
  - Korean
  - Persian
  - Polish
  - Portuguese or Portuguese Creole
  - Russian
  - Serbo-Croatian
  - Spanish or Spanish Creole
  - Tagalog
  - Vietnamese
  - Yiddish
  - A language not listed above (_____)
- English and other language(s) [If selected, drop down list as follows]
  - Armenian
  - Chinese
  - French
  - German
  - Greek
  - Italian
  - Japanese
  - Korean
  - Persian
  - Polish
  - Portuguese or Portuguese Creole
  - Russian
  - Serbo-Croatian
  - Spanish or Spanish Creole
  - Tagalog
  - Vietnamese
  - Yiddish
  - A language not listed above (_____)

2.22

What is the highest level of school or degree you have completed?

- Less than 8th grade
- 8th grade
- Some high school, no diploma or GED
- GED
- High school graduate
- Some college, no degree (including currently in college)
- Associate degree in college – Occupational/vocational program
- Associate degree in college - Academic program
- Bachelor's degree
- Some graduate work, no graduate degree
- Master's degree (M.A, M.S., MBA)
- Doctoral degree (e.g., Ph.D., Ed.D.)
- Professional degree (e.g., MD, JD)

2.23

What are your current living arrangements?

- Living in house/apartment/condo I OWN alone or with others (with a mortgage or that you own free and clear)
- Living in house/apartment/condo I RENT alone or with others
- Living with a partner, spouse, or other person who pays for the housing
- Living temporarily with friends or family because I can't afford my own housing
- Living with parents or family I grew up with because I have not yet left home
- Living in a foster group home or other foster care
- Living in campus/university housing
- Living in a nursing home or other adult care facility
- Living in a hospital
- Living in military barracks
- Living in a hotel or motel that I pay for myself
- Living in a hotel or motel with an emergency shelter voucher
- Living in transitional housing/halfway house
- Living on the street, in a car, in an abandoned building, in a park, or a place that is NOT a house, apartment, shelter, or other housing [Skip to **2.25**]
- Living in a homeless shelter [Skip to **2.25**]
- Living in a domestic violence shelter [Skip to **2.25**]
- Living in a shelter that is not a homeless shelter or domestic violence shelter [Skip to **2.25**]
- A living arrangement not listed above (please specify) _____

2.24

Is there at least one telephone INSIDE your home that is currently working and is not a cell phone?

- No
- Yes

2.25

Do you have a cell phone?

- No
- Yes

2.26

What is the zip code where you currently live? [Text box to fill in ZIP code]

Section 3

3.1

At about what age did you begin to feel that your gender was "different" from your assigned birth sex?

[Drop down list of ages]

3.2

At about what age did you start to think you were trans (even if you did not know the word for it)?

[Drop down list of ages]

3.3

At about what age did you first start to tell others that you were trans (even if you did not use that word)?

[Drop down list of ages with first option that reads:
I have not told others that I am trans.]

3.4

How do you socialize with other trans people? **(Mark all that apply).**

- ○ In political activism
- ○ Socializing in person
- ○ Socializing on-line (such as Facebook or Twitter)
- ○ In support groups
- ○ I don't socialize with other trans people
  [*PROGRAMMING NOTE: Respondents cannot select this answer option and any other option.*]
- ○ Not listed above (please specify) _____

Section 4

These are questions about the people in your life and whether they know you are trans.

4.1

Have any of your spouses/partners known that you are trans during your relationship with them? **(Mark all that apply).**

- I have never had a spouse/partner [Skip to **4.3**]
  [*PROGRAMMING NOTE: Respondent cannot check this response AND any other response choice*]
- No [Skip to **4.3**]
  [*PROGRAMMING NOTE: Respondent cannot check this response AND any other response choice*]
- Yes, my current spouse/partner knows I am trans [Proceed to **4.2**]
- Yes, at least one of my former spouses or partners knew I was trans [Proceed to **4.2**]

4.2

Have any of your spouses/partners ended your relationship because you are trans?

- No
- Yes, only because I was trans.
- Yes, because I was trans and other reasons.

4.3

Do any of your children know you are trans?

- I do not have any children [Skip to **4.5**]
- No [Skip to **4.5**]
- Yes [Proceed to **4.4**]

4.4

Have any of your children ever stopped speaking to you or spending time with you because you are trans?

- No
- Yes

4.5

How many people in each group below currently know you are trans? (**Please provide an answer in each row.**)

	I currently have no people like this in my life	**All know that I am trans**	**Most know that I am trans**	**Some know that I am trans**	**None know that I am trans**
Immediate family you grew up with (mother, father, sisters, brothers, etc.)	O	O	O	O	O
Extended family (aunts, uncles, cousins, etc.)	O	O	O	O	O
Lesbian, gay, bisexual, or trans (LGBT) friends	O	O	O	O	O
Straight, non-trans (non-LGBT) friends	O	O	O	O	O
Current Boss/Manager/Supervisor	O	O	O	O	O
Current Co-workers	O	O	O	O	O
Current Classmates	O	O	O	O	O
Current Health Care Providers	O	O	O	O	O

4.6

[This question only for respondents who have some, most, or all immediate family members who know they are trans in **4.5**]

You said some or all of your immediate family you grew up with (mother, father, sisters, brothers, etc.) know that you are trans. On average, how supportive are they of you being trans?

- ○ Very supportive
- ○ Supportive
- ○ Neither supportive nor unsupportive
- ○ Unsupportive
- ○ Very unsupportive

4.7
[This question only for respondents who have some, most, or all immediate family members who know they are trans in **4.5**]
Did any of your immediate family members you grew up with (mother, father, sisters, brothers, etc.) do any of these things to you because you are trans? **(Mark all that apply).**

- Stopped speaking to you for a long time or ended your relationship
- Were violent towards you
- Kicked you out of the house
- Did not allow you to wear the clothes that matched your gender
- Sent you to a therapist, counselor, or religious advisor to stop you from being trans
- None of the above [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

4.8
[This question only for respondents who have some, most, or all immediate family members who know they are trans in **4.5**]
Did any of your immediate family members you grew up with (mother, father, sisters, brothers, etc.) do any of these things to **support** you? **(Mark all that apply).**

- Told you that they respect and/or support you
- Used your preferred name
- Used your correct pronouns (such as he/she/they)
- Gave you money to help with any part of your gender transition
- Helped you change your name and/or gender on your identity documents (ID), like your driver's license (such as doing things like filling out papers or going with you to court)
- Did research to learn how to best support you (such as reading books, using online information, or attending a conference)
- Stood up for me with family, friends, or others
- Supported you in another way not listed above (please specify) _____
- None of the above [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

4.9
[This question only for respondents who have some, most, or all immediate family members who know they are trans in **4.5**]
Did you ever run away from home because you are trans?

- No [Skip to **4.11**]
- Yes

4.10 At what age did you run away from home because you are trans?
[Drop down list of ages]

4.11

[This question only for respondents who have some, most, or all co-workers who know they are trans in **4.5**]

On average, how supportive are your co-workers with you being trans?

- ○ Very supportive
- ○ Supportive
- ○ Neither supportive nor unsupportive
- ○ Unsupportive
- ○ Very unsupportive

4.12

[This question only for respondents who have some, most, or all classmates who know they are trans in **4.5**]

On average, how supportive are your classmates with you being trans?

- ○ Very supportive
- ○ Supportive
- ○ Neither supportive nor unsupportive
- ○ Unsupportive
- ○ Very unsupportive

Section 5

These questions are about your experiences with your church, synagogue, mosque, or other faith community.

5.1
Have you ever been part of a spiritual/religious community (such as a church, synagogue, mosque, or other faith community)?

- ○ No [Skip to **6.1**]
- ○ Yes

5.2
Have you ever left your spiritual/religious community because you **were afraid** they might reject you because you are a trans person?

- ○ No
- ○ Yes

5.3
Have you ever left your spiritual/religious community because they **did reject** you because you are a trans person?

- ○ No [Skip to **5.5**]
- ○ Yes

5.4
After you stopped attending, did you find a spiritual/religious community that welcomed you as a trans person?

- ○ No
- ○ Yes

5.5
Now just thinking about the past year, have you been part of a spiritual/religious community?

- ○ No [Skip to **6.1**]
- ○ Yes

5.6
In the past year, did any leaders or other members of your spiritual/religious community think or know you were trans?

- ○ No [Skip to **6.1**]
- ○ Yes

5.7

In the past year, how often did leaders or other members of your spiritual/religious community… (**Please provide an answer in each row.**)

In the past year…	**Never**	**Once or twice**	**A few times**	**Many times**
Make you feel welcome as a trans person attending services/faith community functions?	O	O	O	O
Accept you for who you are as a trans person?	O	O	O	O
Tell you that your religion/faith accepts you as a trans person?	O	O	O	O
Tell you that your being trans is a sin or that your religion does not approve of your being trans?	O	O	O	O
Ask you to meet with spiritual/religious leaders to stop you from being trans?	O	O	O	O
Ask you to seek medical/psychological help to stop you from being trans?	O	O	O	O
Ask you to stop coming to services or faith community functions?	O	O	O	O

Section 6

These are questions about work for pay in the sex industry and sex work. As a reminder, your answers are confidential and cannot be used against you.

6.1

Have you ever engaged in sex or sexual activity **for money** (sex work) or worked in the sex industry (such as erotic dancing, webcam work, or porn films)?

- ○ No [Skip to **6.4**]
- ○ Yes

6.2

Now just thinking about the past year, have you engaged in sex or sexual activity for money (sex work) or worked in the sex industry (such as erotic dancing, webcam work, or porn films) in the past year?

- ○ No
- ○ Yes

6.3

What type of sex work or work in the sex industry have you **ever** done**?** (**Mark all that apply**).

- ○ Street-based sex work
- ○ Sex work advertised online
- ○ Sex work advertised in magazines or newspapers
- ○ Informal sex work through word of mouth, occasional hook ups with dates in my networks, or things like that
- ○ Escort/call girl/rent boy with an agency
- ○ Pornography/picture or video
- ○ Phone sex
- ○ Webcam work
- ○ Erotic dancer/stripper
- ○ Fetish work (Domme, sub, switch)
- ○ Not listed above (please specify) _____

6.4

Have you engaged in sex or sexual activity for any of the following? (**Please mark all that apply in each row.**)

[*PROGRAMMING NOTE: Respondents cannot select the "no" option and any other option.*]

	No	**Yes, within the past year**	**Yes, but more than a year ago**
I engaged in sex or sexual activity for food	O	O	O
I engaged in sex or sexual activity for a place to sleep in someone's bed, at their home, or in their hotel room	O	O	O
I engaged in sex or sexual activity for drugs	O	O	O
For something not listed above (please specify)_____ [*PROGRAMMING NOTE: Automatically select "No" response if left blank*]	O	O	O

6.5

Did you ever interact with the police while doing sex work or **when police thought** you were doing sex work?

- O No [Skip to **6.11**]
- O Yes, while I was doing sex work.
- O Yes, when the police thought I was doing sex work.

[*PROGRAMMING NOTE: Respondents cannot select the "no" option and any other option.*]

6.6

When you interacted with police while doing sex work or when police thought you were doing sex work, did you experience any of the following? (**Please provide an answer in each row**.)

	No	**Yes**
Officers kept calling me by the wrong gender pronouns (such as he/him or she/her) or the wrong title (such as Mr. or Ms.).	O	O
Officers asked me questions about my gender transition (such as hormones and surgical status).	O	O
Officers verbally harassed me.	O	O
Officers physically attacked me.	O	O
Officers forced me to have sex or sexual activity to avoid arrest.	O	O
I experienced unwanted sexual contact from an officer (such as fondling, sexual assault, or rape).	O	O
I was arrested for drugs in my possession when police stopped me for doing sex work.	O	O

6.7

Have you ever been arrested for doing sex work or **when police thought** you were doing sex work?

- No [Skip to **6.11**]
  [*PROGRAMMING NOTE: Respondents cannot select this answer option and any other option.*]
- Yes, while I was doing sex work
- Yes, when the police thought I was doing sex work

6.8

How many times have you been arrested for doing sex work or when police thought you were doing sex work?

[Drop down of number of times from "1" to "11 or more"]

6.9

When police arrested you, did they consider things in your possession such as condoms or sex toys as "evidence of prostitution"? **(Mark all that apply).**

- No
- Yes, condoms
- Yes, sex toys
- Yes, items not listed above (please specify) _____
- I don't know

6.10

Did any of these things happen when you were arrested? **(Mark all that apply).**

- The charges were dropped.
- I pled guilty.
- I went to trial and was found not guilty.
- I went to trial and was found guilty.
- Something not listed above (please specify) _____

6.11

Have you ever been paid for selling drugs or other work that is currently considered illegal? **(Mark all that apply).**

- ○ No [Skip to **7.1**]
  [*PROGRAMMING NOTE: Respondents cannot select this answer option and any other option.*]
- ○ Yes, selling drugs
- ○ Yes, other work (please specify) _____

6.12

Now just thinking about the past year, were you paid for selling drugs or other work that is currently considered illegal in the past year? **(Mark all that apply).**

- ○ No
  [*PROGRAMMING NOTE: Respondents cannot select this answer option and any other option.*]
- ○ Yes, selling drugs
- ○ Yes, other work (please specify) _____

Section 7

These questions are about your household, your income, and your current job. As a reminder, your answers are confidential and cannot be used against you. These questions are based on national surveys that we will use to compare with the U.S. population.

7.1

How many adults (age 18 or older) live in your **household***, including yourself? (Do not include neighbors or others who do not live with you in your house, apartment, or single housing unit.) For more information, click on **household** above.

- o 1 [Skip to **7.5**]
- o 2
- o 3
- o 4
- o 5
- o 6
- o 7
- o 8
- o 9 or more

Hyperlinked text for "household": *A household Includes all the adults who live with you in the same house, apartment, group of rooms, or room that is used as one home. If you live in group housing, such as a dormitory, only include yourself and your adult family members who live with you.*

7.2

How are the other adults (age 18 or older) who live in your household related to you? **(Mark all that apply).**

- o Spouse (legally married)
- o Partner (not legally married)
- o Child or children
- o Grandchild or grandchildren
- o Parent(s) (Mother/Father/Step-Parent(s))
- o Brother(s)/Sister(s)/Step-Brother(s)/Step-Sister(s)
- o Other relative(s) (Aunt, Cousin, Nephew, Mother-in-law, etc.)
- o Foster child or foster children
- o Housemate(s)/Roommate(s)
- o Roomer(s)/Boarder(s)
- o Other non-relative(s)
- o Not listed above (please specify) _____

7.3

How many adults in your household are **related to you*** by birth (blood relatives), adoption, or legal marriage? Don't include partners who aren't legally married to you or adults who aren't related to you. We will ask about them later.

- o 0 [Skip to **7.5**]
- o 1
- o 2
- o 3
- o 4
- o 5
- o 6
- o 7
- o 8
- o 9 or more

****Hyperlinked text for "related to you"**: *Include only adults you're related to by blood, legal adoption, or legal marriage that is recognized by the U.S. government. Do not include your unmarried partner or unrelated adults. Later we will ask about the people not included here.*

7.4

Is any person aged 65 or older **named on the lease, mortgage, or deed*** for your household?

- o No
- o Yes

****Hyperlinked text for "named on the lease, mortgage, or deed"**: *This includes people who are listed on the lease, mortgage, or deed for your home. If your home is not owned or rented by anyone who lives with you, include any adult in the home except roomers, boarders, or paid employees.*

7.5

How many babies and other children under age 18 live in your household?

- o 0 [Skip to **7.7**]
- o 1
- o 2
- o 3
- o 4
- o 5
- o 6
- o 7
- o 8
- o 9 or more

7.6

How many of the children under age 18 who live in your household are **related to you*** by birth (blood relatives) or adoption? Don't include children who aren't related to you by birth or legal adoption. We will ask about them later.

- o 0
- o 1
- o 2
- o 3
- o 4
- o 5
- o 6
- o 7
- o 8
- o 9 or more

***Hyperlinked text for "related to you"**: Do not include children that are not related to you by birth or by legal adoption. For instance, your unmarried partner's children would not be included here unless you have legally adopted them. We ask about these members of your household elsewhere in the survey.*

7.7

What is your current employment status? **(Mark all that apply).**

- o Work for pay from sex work, selling drugs, or other work that is currently considered illegal
  - ○ [Drop down if selected] Are you actively looking for legal work outside sex work, selling drugs, or other work that is currently considered illegal
    - ○ No
    - ○ Yes
- o Work full-time for an employer
  - ○ [Drop down if selected] Do you have more than one full-time job?
    - ○ No
    - ○ Yes
- o Work part-time for an employer
  - ○ [Drop down if selected] Do you have more than one part-time job?
    - ○ No
    - ○ Yes
- o Self-employed in your own business, profession or trade, or operate a farm (not including sex work, selling drugs, or other work that is currently considered illegal)
- o Unemployed but looking for work
- o Unemployed and have stopped looking for work
- o Not employed due to disability
- o Student
- o Retired
- o Homemaker or full-time parent
- o Not listed above (please specify) _____

7.8

[This question only those who work full-time or part-time in **7.7**]

On any of your full-time or part-time jobs, are you a member of a labor union or of an employee association similar to a union?

- No
- Yes in a part-time job [Skip to **7.10**]
- Yes in a full-time job [Skip to **7.10**]

[*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]

7.9

On any of your full-time or part-time jobs, are you covered by a union or employee association contract?

- No
- Yes a part-time job
- Yes a full-time job

[*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]

7.10

Do you currently receive assistance from FOOD STAMPS **(SNAP)*** or **WIC***? (**Mark all that apply**).

o No

[*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]

o Yes, assistance from food stamps (SNAP)

[*PROGRAMMING NOTE: If respondent checks "yes" they receive the following message: "Please note that for upcoming questions about income, don't include food stamps (SNAP) as income." Respondent must click "OK" button to proceed*]

o Yes, assistance from WIC

[*PROGRAMMING NOTE: If respondent checks "yes" they receive the following message: "For upcoming questions about income, don't include assistance from WIC as income." Respondent must click "OK" button to proceed*]

[*PROGRAMMING NOTE: If respondent checks "yes" to both food stamps and WIC they receive the following message: "Please note that for upcoming questions about income, don't include assistance from food stamps (SNAP) or WIC as income." Respondent must click "OK" button to proceed*]

**Hyperlinked text for "SNAP"*: *The Supplemental Nutrition Assistance Program (SNAP) is sometimes called the Food Stamp program. It helps people who have low or no income to buy food, usually with an EBT card.*

**Hyperlinked text for "WIC"*: *"WIC" stands for "Women, Infants, and Children." It's the short name for the Special Supplemental Nutrition Program for Women, Infants, and Children. WIC is a federal program to help women who are pregnant or breastfeeding and children less than five years old get health care and healthy food.*

7.11

What are your current sources of income? (**Mark all that apply**).

- o Pay from sex work, selling drugs, or other work that is currently considered illegal
- o Pay from your full-time or part-time job
- o Pay from your partner's/spouse's full-time or part-time job
- o Self-employment income from your own business, profession or trade, or farm (not including underground economy)
- o Income from dividends, estates or trusts, royalties, or rental income
- o Interest income (on savings or bonds)
- o Cash assistance from welfare (such as TANF) or other public cash assistance program (DO NOT include food stamps (SNAP) or WIC)
- o Unemployment benefits
- o Child support or alimony
- o Social security retirement or railroad retirement income
- o Private pension or government employee pension
- o Other retirement income
- o Social security disability benefits (SSDI)
- o Supplemental security income (SSI)
- o Workers' comp or other disability
- o Veteran's disability benefits and other Veteran's benefits
- o Regular contributions from people who don't live in the household
- o Income not listed above, (please specify) _____

7.12

What was your total combined **Individual Income*** (before taxes) **in 2014**? This includes all income sources **except** food stamps (SNAP) or WIC.

- o No income
- o $1 to $5,000
- o 5,000 to 7,499
- o 7,500 to 9,999
- o 10,000 to 12,499
- o 12,500 to 14,999
- o 15,000 to 17,499
- o 17,500 to 19,999
- o 20,000 to 24,999
- o 25,000 to 29,999
- o 30,000 to 34,999
- o 35,000 to 39,999
- o 40,000 to 49,999
- o 50,000 to 59,999
- o 60,000 to 74,999
- o 75,000 to 99,999
- o 100,000 to 149,999
- o 150,000 or more

****Hyperlinked text for "Individual Income"**: *"Individual income" includes money from jobs, employment, net income from business, income from farms or rentals, income from self-employment, pensions, dividends, interest, social security payments, and other money income that you personally received in 2014. Do not include assistance from food stamps (SNAP) or WIC as income.*

7.13

[This question is only for those who have related adults **(7.3 is greater than 0**) AND/OR have related children **(7.6 is greater than 0)**.]

What was your total combined **Family Income*** (before taxes) **in 2014**? This includes all income from all family members who are related to you by legal marriage, birth, or adoption and who have lived with you during the last 12 months. **Don't include** food stamps (SNAP) or WIC.

- o No income
- o $1 to $5,000
- o 7,500 to 9,999
- o 10,000 to 12,499
- o 12,500 to 14,999
- o 15,000 to 17,499
- o 17,500 to 19,999
- o 20,000 to 24,999
- o 25,000 to 29,999
- o 30,000 to 34,999
- o 35,000 to 39,999
- o 40,000 to 49,999
- o 50,000 to 59,999
- o 60,000 to 74,999
- o 75,000 to 99,999
- o 100,000 to 149,999
- o 150,000 or more

** **Hyperlinked text for "Family Income"**: "Family income" includes you and members of your family related by legally-recognized marriage, by birth, or by adoption who have lived with you during the last 12 months and includes money from jobs, employment, net income from business, income from farms or rentals, income from self-employment, pensions, dividends, interest, social security payments, and any other money income received by you and family members in your household who are 15 years of age or older in 2014. Do not include assistance from food stamps (SNAP) or WIC as income.*

7.14

[This question is only for those with non-related adults and/or non-related children in the household (either alone or in combination with married/related adults or children) will get this question. Skip logic: number of adults is 2 or greater from **7.1** and answer to **7.3** is less than the answer to **7.2**. (This means they have more total adults than related adults.) AND/OR **7.5** is 1 or greater and **7.6** is less than the answer to **7.5.** (This means they have more total children than related children.)]

How much was your total combined **HOUSEHOLD INCOME*** (before taxes) **in 2014**? This includes income from all members of your household from all sources **except** food stamps (SNAP) or WIC.

- o No income
- o $1 to $5,000
- o 5,000 to 7,499
- o 7,500 to 9,999
- o 10,000 to 12,499
- o 12,500 to 14,999
- o 15,000 to 17,499
- o 17,500 to 19,999
- o 20,000 to 24,999
- o 25,000 to 29,999
- o 30,000 to 34,999
- o 35,000 to 39,999
- o 40,000 to 49,999
- o 50,000 to 59,999
- o 60,000 to 74,999
- o 75,000 to 99,999
- o 100,000 to 149,999
- o 150,000 or more

***Hyperlinked text for "HOUSEHOLD INCOME"**: "Household income" includes you and all members of your household who have lived with you during the past 12 months and includes money from jobs, employment, net income from business, income from farms or rentals, income from self-employment, pensions, dividends, interest, social security payments, and any other money income received by you and members of your household who are 15 years of age or older in 2014. Do not include assistance from food stamps (SNAP) or WIC as income.*

Section 8

[*PROGRAMMING NOTE: Respondents who checked anything other than the first response choice "never served in the military" in 2.17 receive Section 8 questions*]

You said earlier that you currently serve or have served on active duty in U.S. Armed Forces, Reserves, or National Guard. These are questions about your military service. As a reminder, your answers are confidential and cannot be used against you.

8.1

What is your current or most recent branch of service?

- ○ Air Force
- ○ Air Force Reserve
- ○ Air National Guard
- ○ Army
- ○ Army Reserve
- ○ Army National Guard
- ○ Coast Guard
- ○ Coast Guard Reserve
- ○ Marine Corps
- ○ Marine Corps Reserve
- ○ Navy
- ○ Navy Reserve

[*PROGRAMMING NOTE: 8.2-8.3: These questions are only for respondents who selected "on active duty in the past, but now" in **2.17***]

8.2

Are you still serving in the military?

- ○ No
- ○ Yes [Skip to **8.4**]

8.3

Did you separate from military service within the last 10 years?

- ○ Yes
- ○ No [Skip to **8.12**]

[*PROGRAMMING NOTE:*
***Questions 8.4 – 8.5** are only for respondents who in **2.17** responded:*
(1)** "only on active duty for training in the Reserves or National Guard, **OR
(2)** "active duty/currently serving," **OR
(3) "on active duty in the past, but not now"

AND

IF IN #3 ABOVE** ["on active duty in the past, but not now"] **respondents in 8.2 and 8.3:
(1) still serving
(2) separated within the last 10 years]

8.4
While serving in the military, have you ever received **mental health** treatment related to a gender transition from a military provider (do not include VA)?

- ○ No
- ○ Yes

8.5
While serving in the military, have you ever received **medical** treatment related to a gender transition from a military provider (do not include VA)?

- ○ No
- ○ Yes

[*PROGRAMMING NOTE:*
***Questions 8.6 and 8.7** are only for respondents who in **2.17** responded:*

(1) "only on active duty for training in the Reserves or National Guard," OR
(2) "active duty/currently serving," OR
(3) "on active duty in the past, but not now"

AND

***IF IN #3 ABOVE** ["on active duty in the past, but not now"]*
*(1) "still serving" in **8.2***]

8.6
Has any military medical or mental health provider reported to your commanding officer that you are trans or recommended you for discharge? **(Mark all that apply).**

- No

[*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]

- Yes, reported that I was trans
- Yes, recommended me for discharge
- Does not apply to me, none of these providers knew that I was trans

8.7
If trans people were allowed to serve openly, which of these would apply to you?

- I would start to transition while still serving
- I would finish the transition that I have already started while still serving
- I would not finish the transition that I have already started while still serving
- I would leave military service so that I could transition, and not return.
- I would leave military service so that I could transition, then return to service after transition
- I do not want to transition
- I have already transitioned
- None of the options listed above

[*PROGRAMMING NOTE:*
Questions 8.8 *are only for respondents who in* ***2.17*** *responded:*

(1) "On active duty in the past, but not now"

AND

(1) "Separated within the last 10 years in ***8.3*** *only*]

8.8
If trans people were allowed to serve openly, I would return to service:

- Yes
- No
- Maybe

[*PROGRAMMING NOTE:*
Questions 8.9. - 8.11 *are only for respondents who in* ***2.17*** *responded:*

(1) "only on active duty for training in the Reserves or National Guard," OR
(2) "active duty/currently serving," OR
(3) "on active duty in the past, but not now"

AND

IF IN #3 ABOVE *["on active duty in the past, but not now"]*
(1) *"still serving" in* ***8.2***]

8.9
How many people in the military (who aren't trans) believe you are trans?

- None [Skip to next section that applies to this respondent]
- A few
- Some
- Most
- All

8.10
Does your leadership or commanding officer (or both) think or know you are trans?

- No [Skip to next section that applies to this respondent]
- Yes

8.11
How has your leadership or commanding officer (or both) reacted to you being trans? **(Mark all that apply).**

- Supported my name change
- Supported my medical treatment
- Ignored it or looked the other way
- Took actions to discharge me
- Not listed above (please specify) _____

[*PROGRAMMING NOTE:*
***Questions 8.12-8.21** are only for respondents who in **2.17** responded:*

(1) "on active duty in the past, but not now"

***AND** who responded*

(1)** "no" to **8.2** (are you still serving in the military" **AND
*(2) "no" to **8.3** (did you separate from the military in the last 10 years)*

8.12
What was your character of discharge?
- ○ Entry Level Separation
- ○ Honorable
- ○ General
- ○ Medical
- ○ Other-than-honorable
- ○ Bad Conduct
- ○ Dishonorable
- ○ None of the options listed above. (please specify) _____

8.13
Do you believe your discharge was related to being trans?
- ○ No
- ○ Yes, partially
- ○ Yes, completely

8.14
Did you leave the service in order to transition?
- ○ No
- ○ Yes

8.15
Did you leave the service to avoid mistreatment/harassment?
- ○ No
- ○ Yes

8.16
Did any military medical or mental health provider tell your commander that you are trans or recommend you for discharge? **(Mark all that apply)**.
- ○ No [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- ○ Yes, reported that I was trans.
- ○ Yes, recommended me for discharge.
- ○ Does not apply to me, none of these providers knew that I was trans.

8.17

Did you ever get any type of health care through the VA?

- No [Skip to **8.21**]
- Yes

8.18

Did you ever get health care related to a gender transition through the VA?

- No
- Yes

8.19

Do you currently get any type of health care through the VA?

- No
- Yes

8.20

As a trans person, have you received respectful care at the VA?"

- Never
- Sometimes
- Mostly
- Always
- Does not apply to me, the VA staff do not know I'm trans

8.21

Have you changed your name on your DD214 military discharge papers?

- Yes, I received an updated DD214 with new name.
- Yes, I received a DD215 (amended) with new name.
- No, I was denied.
- No, I never tried.

Section 9

[*PROGRAMMING NOTE: Only respondents who checked "yes" to anything but "U.S. citizen, birth" in 2.18 receive this section of questions*]

You said earlier that you are not a U.S. citizen by birth. These are questions about immigration experiences you may have had. As a reminder, your answers are confidential and cannot be used against you.

9.1

Have you ever been held in immigration detention (such as being held in an Immigration and Customs Enforcement (ICE) detention center or local jail just for immigration court proceedings)?

- ○ No [Skip to **9.6**]
- ○ Yes

9.2

While you were in immigration detention, do you believe staff, guards, or others thought or knew you were trans or lesbian, gay, or bisexual (LGB)?

- ○ No
- ○ Yes

9.3

When you were in immigration detention, separated from others who were also in detention? (**Mark all that apply**).

- ○ No [Skip to **9.5**]
  [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- ○ Yes, in solitary confinement [Proceed to **9.4**]
- ○ Yes, in a separate area for trans or LGB people (such as a pod, unit, tank, or other housing area) [Skip to **9.5**]
- ○ Not listed above (please specify)_____[Skip to **9.5**]

9.4

In total, how long were you held in solitary confinement?

- ○ Up to 14 days (up to two weeks)
- ○ 15 days to 30 days (three or four weeks)
- ○ 31 days to 90 days (1-3 months)
- ○ 91 days to 180 days (3-6 months)
- ○ 181 days to one year (more than 6 months up to a year)
- ○ More than 1 year

9.5

When you were in immigration detention, did any of these things happen to you? (**Mark all that apply).**

- I was physically assaulted.
    - Were you physically assaulted by:
        - Staff or detention officers
        - Other detainees or inmates
- I was sexually assaulted.
    - Were you sexually assaulted by:
        - Staff or detention officers
        - Other detainees or inmates
- I was threatened with sexual assault
    - Were you threatened with sexual assault by:
        - Staff or detention officers
        - Other detainees or inmates
- I was denied access to hormones that I use.
- I was denied gender-appropriate clothing.
- None of these things happened to me. [*PROGRAMMING NOTE: Respondents cannot select "None of these things happened to me." and any other option.*]

9.6

Have you ever applied for asylum in the United States?

- No [Skip to **9.8**]
  [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- Yes, because I am trans or LGB
- Yes, for another reason

9.7

Did you receive asylum in the United States?

- Yes [Skip to **10.1**]
- No [Skip to **9.9**]
- No, but I received a "withholding of removal" status. [Skip to **10.1**]

9.8

Why didn't you apply for asylum?

- I didn't know how to apply.
- I have access to other legal statuses.
- I didn't want to apply.
- I was afraid to apply.
- I believed I was past the 1 year deadline.
- A reason not listed above (please specify) _____

9.9

Why didn't you receive asylum?

- I was past the 1 year deadline.
- The immigration official decided that I didn't face danger in my country.
- A reason not listed above (please specify) _____

Section 10

These are questions about legal name change and your current identification documents, such as your birth certificate or driver's license.

10.1
Did you ever try **OR** complete the process to get a legal name change to match your gender identity?

- ○ No [Skip to **10.12**]
- ○ Yes

10.2
How did you try to change your name?

- ○ With a court order [Proceed to **10.3**]
- ○ During the immigration/naturalization process [Skip to **10.13**]
- ○ By another method (Please tell us what method)_____[Skip to **10.13**]

10.3
For your legal name change, did you interact with judges or court staff?

- ○ No [Skip to **10.7**]
- ○ Yes

10.4
Do you believe the judges or court staff you interacted with thought or knew you were trans?

- ○ No [Skip to **10.7**]
- ○ Yes

10.5
When you interacted with judges or court staff, were you treated with respect?

- ○ I was never treated with respect
- ○ I was sometimes treated with respect
- ○ I was always treated with respect

10.6
When you interacted with judges or court staff, did you experience any of the following? (**Please provide an answer in each row.**)

	No	**Yes**
I was verbally harassed.	O	O
I received unequal treatment/service.	O	O
They kept calling me by the wrong gender pronouns (such as he/him or she/her) or a wrong title (Mr. or Ms.).	O	O
I was asked questions about my gender transition (such as hormones and surgical status).	O	O

10.7

Did the court grant your name change?

- ○ No, the court denied my name change. [Proceed to **10.8**]
- ○ No, I ran out of money to complete the process. [Skip to **10.9**]
- ○ No, I gave up. [Skip to **10.9**]
- ○ Yes, the court granted my name change. [Skip to **10.9**]
- ○ Not sure yet. I am still in the process of getting my court ordered name change. [Skip to **10.9**]
- ○ Not listed above (please specify)_____[Skip to **10.9**]

10.8

Why did the court deny your name change?

[Text Box]

10.9

How old were you when you went to court to get your legal name change?

[Drop down list of ages]

10.10

Did you get legal help to change your name?

- ○ No
  [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- ○ Yes, I got legal help from a paid attorney.
- ○ Yes, I got help for free from a legal clinic or non-profit organization.
- ○ Yes, I got help from a friend.
- ○ Yes, I got help from some other source.

10.11

[*This question is only for respondents who responded "*Yes, the court granted my name change." in **10.7**.] How much did your legal name change cost? Please include the cost of legal help, court fees, newspaper publication, etc.

- ○ $0
- ○ $1 - $99
- ○ $100 - $249
- ○ $250 - $499
- ○ $500 - $749
- ○ $750 - $999
- ○ $1,000 - $2,000
- ○ More than $2,000
- ○ I do not remember the cost of my legal name change.

10.12 [*This question is only for respondents who responded "No" in **10.1**.*]
Why you have not tried to legally change your name? **(Mark all that apply).**

- ○ I feel like my name doesn't conflict with my gender identity or expression.
- ○ I am not ready.
- ○ I cannot afford it.
- ○ I don't know how.
- ○ I believe I am not allowed (for example, because of my criminal record, immigration status, or residency).
- ○ I am worried that changing my name would out me.
- ○ A reason not listed above (please specify) _____

10.13
Thinking about how your **NAME** is listed on all of your IDs and records that list your name, such as your birth certificate, driver's license, passport, etc. Which of the statements below is most true?

- ○ All of my IDs and records list the name I prefer.
- ○ Some of my IDs and records list the name I prefer.
- ○ None of my IDs and records list the name I prefer. [Skip to **10.15**]

10.14
Which of these IDs/records have you changed to list your preferred **NAME**? (**Please provide an answer in each row.)**

	I do not have this ID/ record	**I changed my NAME on this ID/record**	**I was denied a NAME change on this ID/record**	**I am in the process of changing my NAME on this ID/record**	**I have not tried to change my NAME on this ID/record but I want to**	**I do not want to change my NAME on this ID/ record**
Birth certificate	O	O	O	O	O	O
Driver's license and/or state issued non-driver ID	O	O	O	O	O	O
Social Security records	O	O	O	O	O	O
Passport	O	O	O	O	O	O
Student records (current or last school attended)	O	O	O	O	O	O
Work ID	O	O	O	O	O	O

10.15

Thinking about how your **GENDER** is listed on all of your IDs and records that list your gender, such as your birth certificate, driver's license, passport, etc. Which of the statements below is most true?

- All of my IDs and records list the gender I prefer.
- Some of my IDs and records list the gender I prefer.
- None of my IDs and records list the gender I prefer. [Skip to **10.17**]

10.16

Which of these IDs/records have you changed to list your preferred **GENDER**? (**Please provide an answer in each row.)**

	I do not have this ID/ record	**I changed my GENDER on this ID/record**	**I was denied a GENDER change on this ID/record**	**I am in the process of changing my GENDER on this ID/record**	**I have not tried to change my GENDER on this ID/record but I want to**	**I do not want to change my GENDER on this ID/ record**
Birth certificate	O	O	O	O	O	O
Driver's license and/or state issued non-driver ID	O	O	O	O	O	O
Social Security records	O	O	O	O	O	O
Passport	O	O	O	O	O	O
Student records (current or last school attended)	O	O	O	O	O	O

10.17

[*This question is only for respondents who responded "None" in **10.15**.*]

You said that none of your IDs or records list the gender you prefer. Why haven't you changed your gender on your IDs or records? **(Mark all that apply).**

- ○ The gender options that are available (male or female) do not fit my gender identity.
- ○ I have not tried yet.
- ○ My request was denied.
- ○ I am not ready.
- ○ I cannot afford it.
- ○ I do not know how.
- ○ I believe I am not allowed. (For example, I have not had the medical treatment needed to change my gender on ID. Or I can't get a doctor's letter or other letter that is needed to update the gender.)
- ○ I am worried that if I change my gender, I might not be able to get some benefits or services. These might include medical, insurance, employment, etc.
- ○ I am worried that changing my gender would out me.
- ○ A reason not listed above (please specify) _____

10.18

When I have shown IDs with my name or gender that do not match the gender I present as… **(Mark all that apply).**

o I have been verbally harassed.
o I have been assaulted/attacked.
o I have been asked to leave.
o I have been denied services or benefits.
o I have had none of the above problems.
[*PROGRAMMING NOTE: Respondents cannot select this answer option and any other response option.*]
o This does not apply to me. I have only shown IDs that match.
[*PROGRAMMING NOTE: Respondents cannot select this answer option and any other response option.*]

Section 11

These are questions about your current health insurance coverage, your health care providers, and the health insurance marketplace (such as healthcare.gov).

11.1

Are you currently covered by any health insurance or health coverage plan?

- ○ No [Skip to **11.4**]
- ○ Yes

11.2

What type of health insurance or health coverage plan do you have? **(Mark all that apply).**

- ○ Insurance through my current or former employer or union
- ○ Insurance through someone else's current or former employer or union
- ○ Insurance I or someone else purchased through HealthCare.Gov or a Health Insurance Marketplace (sometimes called "Obamacare")
- ○ Insurance I or someone else purchased directly from an insurance company
- ○ Medicare (for people 65 and older, or people with certain disabilities)
- ○ Medicaid (government-assistance plan for those with low incomes or a disability)
- ○ TRICARE or other military health care
- ○ VA (including those who have ever used or enrolled for VA health care)
- ○ Indian Health Service
- ○ Any other type of health insurance or health coverage plan (please specify) _____

11.3

In the past year, did any of these things happen with your health insurance company? (**Please provide an answer in each row.** If you didn't try to get the kind of care listed or if you never tried to change your records, choose "I have not asked for this")

In the past year…	Yes	No	I have not asked for this
My health insurance company wouldn't change my records to list my current name or gender.	O	O	O
My health insurance company denied me hormone therapy for transition.	O	O	O
My health insurance company denied me surgery for transition.	O	O	O
My health insurance company covers only some of the surgical care I need for my transition.	O	O	O
My health insurance company covers surgery for transition, but has no surgery providers in their network.	O	O	O
My health insurance company denied me gender-specific health care (such as Pap smears, prostate exams, mammogram, etc.) because I am trans.	O	O	O
My health insurance company denied me other routine health care because I am trans.	O	O	O

11.4

Thinking about the doctor or provider you go to for your **trans-related** health care (such as hormone treatment), how much do they know about providing health care for trans people?

- I don't have a trans-related doctor or health care provider right now [Skip to **11.7**]
- They know almost everything about trans healthcare
- They know most things about trans healthcare
- They know some things about trans healthcare
- They know almost nothing about trans healthcare
- I am not sure

11.5

How far do you travel to see your **trans-related** health care provider?

- Less than 10 miles
- 10-25 miles
- 25-50 miles
- 50-75 miles
- 75-100 miles
- Over 100 miles

11.6

Do you also go to your **trans-related** health care provider for your routine health care, like physicals, flu, diabetes, etc.?

- Yes, I see my trans health care provider for my routine health care [Skip to **11.9**]
- No, I see a different doctor or health care provider for my routine healthcare
- No, I do not get any routine health care [Skip to **11.9**]

11.7

How much does your *routine health care* provider (who you see for physicals, flu, diabetes, etc.) know about health care for trans people?

- I don't have a routine health care provider [Skip to **11.9**]
- They know almost everything about trans health care
- They know most things
- They know some things
- They know almost nothing
- I am not sure

11.8

How far do you travel to see your routine health care provider?

- Less than 10 miles
- 10-25 miles
- 25-50 miles
- 50-75 miles
- 75-100 miles
- Over 100 miles

11.9

In the past year, did you look for health insurance from a state or federal health insurance marketplace? (Health insurance marketplaces are part of the new health care law, sometimes called "Obamacare" or the "Affordable Care Act," where people can get insurance online, such as through healthcare.gov, over the phone, or in person.)

- No [Skip to **12.1**]
- Yes

11.10

Did you buy insurance or enroll in a state Medicaid program through a health insurance marketplace?

- No [Skip to **12.1**]
- Yes

11.11

What type of insurance coverage did you buy?

- Coverage through a state Medicaid program
- Coverage through a private plan with a subsidy, so I pay a lower price because of my income
- Coverage through a private plan without a subsidy
- Not listed above (please specify) _____

Section 12

These are questions about your health, experiences with doctors or health care providers, and health care.

12.1

Would you say that in general your health is…

- o Excellent
- o Very good
- o Good
- o Fair
- o Poor

12.2

The following questions ask about how you have been feeling **during the past 30 days**. For each row, please select the column that best describes how often you had this feeling. (**Please provide an answer in each row.**)

During the past 30 days, how often did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
…so sad that nothing could cheer you up?	O	O	O	O	O
…nervous?	O	O	O	O	O
…restless or fidgety?	O	O	O	O	O
…hopeless?	O	O	O	O	O
…that everything was an effort?	O	O	O	O	O
…worthless?	O	O	O	O	O

12.3

[*PROGRAMMING NOTE: This question is only for respondents who selected "a little of the time" or more on any of the questions in Question **12.2***]

We just asked about a number of feelings you had **during the past 30 days**. Altogether, how MUCH did these feelings interfere with your life or activities?

- o A lot
- o Some
- o A little
- o Not at all

12.4

Was there a time **in the past 12 months** when you needed to see a doctor but could not because of cost?

- No
- Yes

12.5

Was there a time in the **past 12 months** when you needed to see a doctor but did not because you thought you would be disrespected or mistreated as a trans person?

- No
- Yes

12.6

In the past year, have you seen a doctor or health care provider?

- No [Skip to **12.8**]
- Yes

12.7

In the past year, did you have any of these things happen to you, as a trans person, when you went to see a doctor or health care provider? (**Please provide an answer in each row.**)

In the past year…	**No**	**Yes**
My doctor knew I was trans and treated me with respect.	O	O
I had to teach my doctor or other health care provider about trans people so that I could get appropriate care.	O	O
A doctor or other health care provider refused to give me trans-related care.	O	O
A doctor or other health care provider refused to give me other health care (such as for like physicals, flu, diabetes).	O	O
My doctor asked me unnecessary/invasive questions about my trans status that were not related to the reason for my visit.		
A doctor or other health care provider used harsh or abusive language when treating me.	O	O
A doctor or other health care provider was physically rough or abusive when treating me.	O	O
I was verbally harassed in a health care setting (such as a hospital, office, clinic).	O	O
I was physically attacked by someone during my visit in a health care setting (such as a hospital, office, clinic).	O	O
I experienced unwanted sexual contact (such as fondling, sexual assault, or rape) in a health care setting (such as a hospital, office, clinic).	O	O

12.8

Have you **ever wanted** any of the health care listed below for your gender identity or gender transition? **(Mark all that apply).**

- Counseling/Therapy
- Hormone Treatment/HRT
- Puberty Blocking Hormones (usually used by youth ages 9-16)
- None of the above

[*PROGRAMMING NOTE: Respondents cannot select "None of the above" and any other response option.*]

12.9

Have you **ever had** any of the health care listed below for your gender identity or gender transition? **(Mark all that apply).**

- Counseling/Therapy [Skip to **12.15** if only this answer option is selected]
- Hormone Treatment/HRT [Proceed to **12.10**]
- Puberty Blocking Hormones (usually used by youth ages 9-16) [Skip to **12.11**]
- None of the above [Skip to **12.15**]

[*PROGRAMMING NOTE: Respondents cannot select "None of the above" and any other response option.*]

12.10

At what age did you begin hormone treatment/HRT treatment?

[Drop down list of ages]

12.11

At what age did you begin taking Puberty Blocking Hormones?

[Drop down list of ages]

12.12

Are you currently taking hormones for your gender identity or gender transition?

- No [Skip to **12.15**]
- Yes

12.13

[*PROGRAMMING NOTE*: *This question should not be seen by those who selected "Now on active duty" in **2.17***]

Where do you currently get your hormones?

- I only go to licensed professionals (like a doctor) for hormones
- In addition to licensed professionals, I also get hormones from friends, online, or other non-licensed sources
- I ONLY get hormones from friends, online, or other non-licensed sources

12.14

[*PROGRAMMING NOTE*: *This question is only for respondents who selected "Now on active duty" in **2.17** and who selected "Yes" in **12.12***]

Where do you currently get your hormones? **(Mark all that apply).**

- On-post medical doctor
- Off-post medical doctor
- On-post pharmacy
- Off-post pharmacy
- Through friends, online, or other non-licensed sources (not through a doctor or medical provider)
- Another source not listed above (please specify) _____

12.15

[*PROGRAMMING NOTE*: *This question is only for respondents who selected "Female" in **2.1***]

Have you had or do you want any of the health care listed below for gender transition? **(Please give an answer in each row.)**

	Have had it	Want it some day	Not sure if I want this	Do not want this
Top/chest surgery reduction or reconstruction	O	O	O	O
Hysterectomy/"hysto" (removal of the uterus, ovaries, fallopian tubes, and/or cervix)	O	O	O	O
Clitoral release/metoidioplasty/centurion procedure	O	O	O	O
Phalloplasty (creation of a penis)	O	O	O	O
Other procedure not listed: _____	O	O	O	O

12.16

[*PROGRAMMING NOTE*: *This question is only for respondents who selected "Have had it" for any procedure in **12.15***]

You said that you had at least one procedure for your gender transition. At what age did you have your first procedure (other than hormones)?

[Drop down list of ages]

12.17

[*PROGRAMMING NOTE*: *This question is only for respondents who selected "Female" in **2.1***]

Have you had a Pap smear or Pap test in the past year?

- No
- Yes

12.18

[*PROGRAMMING NOTE*: *This question is only for respondents who selected "Male" in **2.1***]

Have you had or do you want any of the health care listed below for gender transition? **(Please provide an answer in each row.)**

	Have had it	Want it some day	Not sure if I want this	Do not want this
Hair removal/electrolysis	O	O	O	O
Breast augmentation / top surgery	O	O	O	O
Silicone injections	O	O	O	O
Orchidectomy / "orchy" / removal of testes	O	O	O	O
Vaginoplasty/labiaplasty/SRS/GRS/GCS	O	O	O	O
Trachea shave (Adam's apple or thyroid cartilage reduction)	O	O	O	O
Facial feminization surgery (such as nose, brow, chin, cheek)	O	O	O	O
Voice therapy (non-surgical)	O	O	O	O
Voice surgery	O	O	O	O
Other procedure not listed:	O	O	O	O

12.19

[*PROGRAMMING NOTE*: *This question is only for respondents who selected "Have had it" for any procedure in **12.18***]

You said that you had at least one procedure for your gender transition. At what age did you have your first procedure (other than hormones)?

[Drop down list of ages]

12.20

Have you ever de-transitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?

- I have never transitioned. [Skip to **13.1**]
- No [Skip to **13.1**]
- Yes

12.21

Why did you de-transition? In other words, why did you go back to living as your sex assigned at birth? **(Mark all that apply).**

- Pressure from spouse or partner
- Pressure from a parent
- Pressure from other family members
- Pressure from friends
- Pressure from my employer
- Pressure from a religious counselor
- Pressure from a mental health professional
- I had trouble getting a job.
- I realized that gender transition was not for me.
- I faced too much harassment/discrimination.
- It was just too hard for me.
- Not listed above (please specify)_____

Section 13

These are questions about experiences you may have had with some professionals, such as psychologists, counselors, religious advisors.

13.1
Did you ever discuss your gender identity or trans identity with a professional (such as a psychologist, counselor, religious advisor)?

- No [Skip to **13.5**]
- Yes

13.2
Did any professional (such as a psychologist, counselor, religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?

- No [Skip to **13.5**]
- Yes

13.3
How old were you the first time a professional tried to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?

[Drop down list of ages]

13.4
Was this person a religious or spiritual counselor/advisor?

- No
- Yes

13.5
Did you ever discuss your **sexual orientation** with any professional (such as a psychologist, counselor, religious advisor)?

- No [Skip to **14.1**]
- Yes

13.6
Did any professional (such as a psychologist, counselor, religious advisor) ever try to change your **sexual orientation** or who you are attracted to (such as try to make you straight/heterosexual)?

- No
- Yes

Section 14

These are questions about HIV testing and care.

14.1

This question is about the test for HIV, the virus that causes AIDS. Except for tests you may have had as part of blood donations, have you ever been tested for HIV?

- No [Skip to **14.3**]
- Yes

14.2

What was the result of your most recent HIV test?

- HIV positive or reactive, meaning I have HIV. [Skip to **14.4**]
- HIV negative, meaning I do not have HIV. [Skip to **14.4**]
- HIV test results were unclear, meaning the test could not determine if I have HIV. [Skip to **14.4**]
- I don't know. I never received the results. [Skip to **14.4**]

14.3

Here is a list of reasons why some people have not been tested for HIV (the virus that causes AIDS). Which one of these would you say is the MAIN reason why you have not been tested? [After answering this question, skip to **15.1**]

- It's unlikely I've been exposed to HIV.
- I was afraid to find out if I was HIV positive (that you had HIV).
- I didn't want to think about HIV or about being HIV positive.
- I was worried my name would be sent to the government if I tested positive.
- I didn't know where to get tested.
- I don't like needles.
- I was afraid of losing my job, insurance, home, friends, or family if people knew I was tested for AIDS infection.
- My doctor/health care provider never mentioned getting an HIV test.
- Some other reason
- No particular reason

14.4_1
Where were you last tested?

- Private doctor or HMO office
- Counseling and testing site
- Emergency room
- Hospital inpatient
- Clinic
- Jail or prison (or other correctional facility)
- Drug treatment facility
- At home
- Somewhere else
- A place not listed above (please specify) _____

14.4_2
Not including blood donations, in what month and year was your last HIV test?
Month [Drop down January through December] Year [Drop down 2015-1984 or before]

[*PROGRAMMING NOTE: Questions **14.5 through 14.14** are only for respondents who selected "HIV positive or reactive, meaning I have HIV" in **14.2***]

14.5
In the past 12 MONTHS, have you seen a doctor or health care provider for HIV care? Don't include care you received during emergency room visits or while staying in the hospital.

- No
- Yes [Skip to **14.7**]

14.6
What is the main reason you haven't seen a doctor or health care provider for HIV care in the past 12 months? [After answering this question, skip to **14.9**]

- I couldn't afford it.
- I have no health insurance.
- I only recently found out I have HIV.
- I have needed other types of medical or mental health care.
- I didn't know where to go for HIV care.
- I wasn't ready to look for health care for HIV.
- I didn't feel sick enough to look for health care.
- My family or partner would find out I have HIV.
- I believed that I would be mistreated because I am trans.
- I rely on a higher power/God to help my HIV.
- A reason not listed above (please specify) _____

14.7

In the past 6 MONTHS, have you seen a doctor or health care provider for HIV care? Don't include care you received during emergency room visits or while staying in the hospital.

- No
- Yes [Skip to **14.9**]

14.8

What is the main reason that you haven't seen a doctor or health care provider for HIV care in the past 6 months?

- I couldn't afford it.
- I have no health insurance.
- I have needed other types of medical or mental health care.
- I didn't know where I could go for HIV care.
- I wasn't ready to find health care for HIV.
- I didn't feel sick enough to look for health care.
- My family or partner would find out I have HIV.
- I believed that I would be mistreated because I am trans.
- I rely on a higher power/God to help my HIV.
- A reason not listed above (please specify) _____

14.9

When was your last blood test to determine your viral load and CD4 counts?

- Within the past 6 months
- Within the past year
- More than a year ago
- I have never had a blood test for my viral load and CD4 count.

14.10

Have you ever been prescribed anti-retroviral therapy, which are the pills that reduce the amount of HIV in your body (often called ART)?

- No
- Yes

14.11

Are you currently taking anti-retroviral therapy (ART)?

- No [Skip to **14.13**]
- Yes

14.12

Do you take your anti-retroviral therapy (ART) like you're supposed to (regularly and as prescribed)?

- Never
- Rarely
- Most of the time
- All of the time [Skip to **15.1**]

14.13

What is the main reason that are you not taking or not regularly taking anti-retroviral therapy (ART) all of the time?

- I can't afford it.
- I have no health insurance.
- I only recently found out I have HIV.
- My doctor or health care provider said I didn't need it.
- I am afraid it would conflict with my hormones.
- I am afraid it would conflict with my other medications.
- I would gain weight.
- I don't know where to get it.
- I don't want to take anti-retroviral therapy (ART).
- I don't feel sick enough to take anti-retroviral therapy (ART).
- My family, partner, or friends would find out I have HIV.
- I rely on a higher power/God to help my HIV.
- A reason not listed above (please specify) _____

Section 15

These are questions about your use of alcohol, tobacco, marijuana, or other drugs.

15.1

Have you **ever had a drink*** of any type of alcoholic beverage, smoked part or all of a cigarette, or used any of the other following substances? (**Please provide an answer in each row.**)

	No	Yes
Alcohol (such as beer, wine, or hard liquor) [*PROGRAMMING NOTE: If Yes, respondent will receive Alcohol follow-up questions*]	O	O
Cigarettes (tobacco only) [*PROGRAMMING NOTE: If Yes, respondent will receive Cigarette follow-up questions*]	O	O
E-Cigarettes or vaping products [*PROGRAMMING NOTE: If Yes, respondent will receive E-Cigarette follow-up questions*]	O	O
Marijuana or hashish (such as weed, joints, hash, hash oil) [*PROGRAMMING NOTE: If Yes, respondent will receive Marijuana follow-up questions*]	O	O
Illegal or illicit drugs (such as cocaine, crack, heroin, LSD, meth, inhalants like poppers or whippits) [*PROGRAMMING NOTE: If Yes, respondent will receive Illegal Drug follow-up questions*]	O	O
Prescription drugs (such as Oxycontin, Xanax, Adderall, Ambien**)** that **weren't prescribed to you, or that you didn't take as prescribed**. [*PROGRAMMING NOTE: If Yes, respondent will receive Illegal Drug follow-up questions*]	O	O

*** See next page for hyperlink definitions.**

***Hyperlink text for "had a drink"**: Please do not include any time when you only had a sip or two from a drink)*

Hyperlink definitions linked for each row are as follows:

- ***Alcohol**: Alcoholic beverages, such as beer, wine, brandy, and mixed drinks.*
- ***Cigarettes**: Cigarettes made of tobacco. Do not include electronic cigarettes (E-cigs).*
- ***E-Cigarettes or vaping products**: This includes electronic cigarettes (e-cigs or e-cigarettes), personal vaporizer (PV), or electronic nicotine delivery system (ENDS), all of which are battery-powered vaporizers that feel similar to tobacco smoking.*
- ***Marijuana or Hashish**: Marijuana is also called pot or grass. Marijuana is usually smoked, either in cigarettes, called joints, or in a pipe. It is sometimes cooked in food. Hashish is a form of marijuana that is also called "hash." It is usually smoked in a pipe. Another form of hashish is hash oil.*
- ***Illegal or Illicit Drugs**: Drugs like cocaine, crack, heroin, LSD, and meth that are considered to be illegal. Inhalants are liquids, sprays, and gases that people sniff or inhale to get high or to make them feel good, like poppers or whippits. We are not interested in times when you inhaled a substance accidentally— such as when painting, cleaning an oven, or filling a car with gasoline.*
- ***Prescription Drugs**: Use of prescription drugs in any way a doctor did not direct you to use them. When you answer this question, please think only about your use of the prescription drug in any way a doctor did not direct you to use it, including:*
  - *Using it without a prescription of your own*
  - *Using it in greater amounts, more often, or longer than you were told to take it*
  - *Using it in any other way a doctor did not direct you to use it*

Alcohol follow-up questions

15.2

How long has it been since you **last drank an alcoholic beverage***?

- Within the past 30 days
- More than 30 days ago but within the past 12 months [Skip remaining alcohol follow-up questions]
- More than 12 months ago [Skip remaining alcohol follow-up questions]

***Hyperlink text for "drank an alcoholic beverage"**: A can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. We are not asking about times when you only had a sip or two from a drink.*

15.3

During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

[Drop down number of days from 1-30 days]

**Hyperlink text for "drink one or more drinks"*: *A can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. We are not asking about times when you only had a sip or two from a drink.*

15.4

During the past 30 days, on how many days did you have 5 or more drinks on the same occasion? By 'occasion,' we mean at the same time or within a couple of hours of each other.

[Drop down number of days from 0-30 days]

**Hyperlink text for "drinks"*: *A can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. We are not asking about times when you only had a sip or two from a drink.*

Cigarettes follow-up questions

15.5

How long has it been since you last smoked part or all of a cigarette?

- Within the past 30 days
- More than 30 days ago but within the past 12 months [Skip remaining cigarette follow-up questions]
- More than 12 months ago [Skip remaining cigarette follow-up questions]

15.6

During the past 30 days, on how many days did you smoke part or all of a cigarette?

[Drop down number of days from 1-30 days]

15.7

On the days you smoked cigarettes during the past 30 days, how many cigarettes did you smoke per day, on average?

O Less than one cigarette per day
O 1 cigarette per day
O 2 to 5 cigarettes per day
O 6 to 15 cigarettes per day (about ½ pack)
O 16 to 25 cigarettes per day (about 1 pack)
O 26 to 35 cigarettes per day (about 1 ½ packs)
O More than 35 cigarettes per day (about 2 packs or more)

E-cigs follow-up questions

15.8

How long has it been since you last used E-Cigarettes or vaping products?

- Within the past 30 days
- More than 30 days ago but within the past 12 months
- More than 12 months ago

Marijuana or Hashish follow-up questions 15.9

How long has it been since you **last** used marijuana or hashish?

- Within the past 30 days
- More than 30 days ago but within the past 12 months
  [Skip remaining marijuana/hashish follow-up questions]
- More than 12 months ago
  [Skip remaining marijuana/hashish follow-up questions]

15.10

During the past 30 days, on how many days did you use marijuana or hashish?

[Drop down number of days from 1-30 days]

Illegal/Illicit Drugs follow-up question 15.11

How long has it been since you last used any illegal/illicit drug? (such as cocaine, crack, heroin, LSD, meth, inhalants like poppers or whippits)

- Within the past 30 days
- More than 30 days ago but within the past 12 months
- More than 12 months ago

Prescription Drug follow-up question 15.12

How long has it been since you last used any prescription drugs not as prescribed or not prescribed to you?

- Within the past 30 days
- More than 30 days ago but within the past 12 months
- More than 12 months ago

Section 16

These are questions about suicidal thoughts and behaviors. Talking about suicidal thoughts or behaviors sometimes brings up difficult emotions. If you experience any difficult emotions because of these questions we encourage you to get help from someone you trust or call one of the anonymous helplines listed at the end of the section.

16.1

The next few questions are about thoughts of suicide. **At any time in the past 12 months** did you **seriously think about trying to kill yourself**?

- ○ No [Skip to **16.6**]
- ○ Yes

16.2

During the past 12 months, did you **make any plans** to kill yourself?

- ○ No
- ○ Yes

16.3

During the past 12 months, did you **try** to kill yourself?

- ○ No [Skip to **16.8**]
- ○ Yes

16.4

During the past 12 months, did you get medical attention from a doctor or other health professional as a result of an attempt to kill yourself?

- ○ No [Skip to **16.9**]
- ○ Yes

16.5

Did you stay in a hospital overnight or longer because you tried to kill yourself?

- ○ No [Skip to **16.9**]
- ○ Yes [Skip to **16.9**]

16.6

At any time in your life, have you **seriously thought** about trying to kill yourself?

- ○ No [Skip to **17.1**]
- ○ Yes

16.7

At any time in your life, did you **make any plans** to kill yourself?

- ○ No
- ○ Yes

16.8

At any time in your life, did you **try** to kill yourself?

- No [Skip to **17.1**]
- Yes

16.9

How many times have you tried to kill yourself in your lifetime?

[Drop down list of 1 to 25 with last option "more than 25"]

[Response of more than one time will skip to **16.11**]

16.10

How old were you when you tried to kill yourself?

[Drop down list of ages]

[Response of one time in **16.9** should receive this question, then skip to **17.1**]

16.11

How old were you the **first time** you tried to kill yourself?

[Drop down list of ages]

16.12

How old were you the **last time** you tried to kill yourself?

[Drop down list of ages]

If you are experiencing any difficult emotions after answering these questions and would like to talk to someone, please contact one of the anonymous resources below:

National Suicide Prevention Helpline
1-800-273-8255
http://www.suicidepreventionlifeline.org/

Veterans Crisis Line (for veterans, military personnel, and their families)
1-800-273-8255 and Press 1
http://veteranscrisisline.net/

The Trevor Project
The Trevor Project is a phone and internet chat hotline for LGBTQ people. For those participating in this survey, The Trevor Project will speak or chat with people of all ages.
1-866-488-7386
http://www.thetrevorproject.org/section/get-help

Section 17

These are questions about being treated unequally, harassed, or physically attacked.

17.1

In the past year, have you been denied equal treatment or service, such as at a place of business, government agency, or public place for any reason?

- No
- Yes

17.2

In the past year, did anyone verbally harass you for any reason?

- No
- Yes

17.3

In the past year, did anyone physically attack you (such as grab you, throw something at you, punch you, use a weapon) for any reason?

- No
- Yes

[*PROGRAMMING NOTE: Question **17.4** is only for respondents who selected "Yes" in **17.1***]

17.4

You said that you were denied equal treatment or service **in the past year.** Do you believe any of those experiences were because of your…(**Mark all that apply**).

- Age
- Disability
- Income level or education
- Trans status/gender identity
- Gender expression/appearance
- Race/ethnicity
- Religion/spirituality
- Sexual orientation
- None of the above

[*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

[*PROGRAMMING NOTE: Questions **17.5 and 17.6** is only for respondents who selected "Yes" in **17.2***]

17.5

You said that you have been verbally harassed **in the past year.** Do you believe any of those experiences were because of your … (**Mark all that apply**).

- ○ Age
- ○ Disability
- ○ Income level or education
- ○ Trans status/gender identity
- ○ Gender expression/appearance
- ○ Race/ethnicity
- ○ Religion/spirituality
- ○ Sexual orientation
- ○ None of the above

[*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

17.6

[*PROGRAMMING NOTE:* This question is only for respondents who selected either "Trans status/gender identity" or "gender expression/appearance" in **17.5**]

In the past year, did strangers verbally harass you in public because of your trans status, gender identity, or gender expression?

- ○ No
- ○ Yes

[*PROGRAMMING NOTE: Question **17.7 through 17.10** is only for respondents who selected "Yes" in **17.3***]

17.7

In the past year, how many times were you physically attacked? _____

17.8

How were you physically attacked? **(Mark all that apply).**

- ○ With a gun
- ○ With a knife
- ○ With another weapon (like a baseball bat, frying pan, scissors, or stick)
- ○ By something thrown (such as a rock or bottle)
- ○ By someone grabbing, punching, or choking you
- ○ Unwanted sexual contact (such as rape, attempted rape, being forced to penetrate)
- ○ Not listed above

17.9

When you were physically attacked **in the past year,** do you believe any of those experiences were because of your … (**Mark all that apply**).

- Age
- Disability
- Income level or education
- Trans status/gender identity
- Gender expression/appearance
- Race/ethnicity
- Religion/spirituality
- Sexual orientation
- None of the above

  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

17.10

[This question is only for respondents who selected either "Trans status/gender identity" or "gender expression/appearance" in **17.9**]

In the past year, did strangers physically attack you in public because of your trans status, gender identity, or gender expression?

- No
- Yes

Section 18

These are questions about unwanted sexual contact. Some people get sexual attention that they don't want and don't ask for. It could come from someone they know well - a romantic or sexual partner, a friend, a teacher, a coworker, a supervisor, or a family member. These questions are based on national surveys that we will use to compare with the U.S. population. If you experience any difficult emotions because of these questions we encourage you to get help from someone you trust or call one of the anonymous helplines listed at the end of the section.

18.1

Have you ever experienced unwanted sexual contact (such as oral, genital, or anal contact or penetration, forced fondling, rape)?

- ○ No [Skip to **19.1**]
- ○ Yes

18.2

Who did this to you? **(Mark all that apply).**

- ○ A partner/ex-partner
- ○ A relative
- ○ A friend/acquaintance
- ○ A law enforcement officer
- ○ A health care provider/doctor
- ○ A stranger
- ○ A boss or supervisor
- ○ A co-worker
- ○ A teacher or school staff member
- ○ A person not listed above

18.3

Now just thinking about **the past year**, have you experienced unwanted sexual contact (such as oral, genital, or anal contact or penetration, forced fondling, rape)?

- ○ No
- ○ Yes

If you are experiencing any difficult emotions after answering these questions and would like to talk to someone, please contact one of the anonymous resources below:

Veterans Crisis Line (for veterans, military personnel, and their families)
1-800-273-8255 and Press 1
http://veteranscrisisline.net/

FORGE Transgender Sexual Violence Project
414-559-2123
http://forge-forward.org/anti-violence/for-survivors/ to list of resources

National Sexual Assault Hotline
800-656-HOPE (4673)
https://ohl.rainn.org/online/

Section 19

These are questions about any harm caused by a current or former romantic or sexual partner. This could include physical, emotional, or financial harm.

19.1

Have you ever had a romantic or sexual partner?

- ○ No [Skip to **20.1**]
- ○ Yes

19.2

Have any of your romantic or sexual partners ever...? (**Please provide an answer in each row.**)

	No	**Yes**
Tried to keep you from seeing or talking to your family or friends	O	O
Kept you from having money for your own use	O	O
Kept you from leaving the house when you wanted to go	O	O
Hurt someone you love	O	O
Threatened to hurt a pet or threatened to take a pet away from you	O	O
Wouldn't let you have your hormones	O	O
Wouldn't let you have other medications	O	O
Threatened to call the police on you	O	O
Threatened to "out" you	O	O
Told you that you weren't a "real" woman or man	O	O
Stalked you	O	O
Threatened to use your immigration status against you	O	O

19.3

Have any of your romantic or sexual partners ever...? (**Please provide an answer in each row.**)

	No	**Yes**
Made threats to physically harm you	O	O
Slapped you	O	O
Pushed or shoved you	O	O
Hit you with a fist or something hard	O	O
Kicked you	O	O
Hurt you by pulling your hair	O	O
Slammed you against something	O	O
Forced you to engage in sexual activity	O	O
Tried to hurt you by choking or suffocating you	O	O
Beaten you	O	O
Burned you on purpose	O	O
Used a knife or gun on you	O	O

Section 20

These are questions about your experiences with bathrooms while in public places, at work, or at school.

20.1
In the past year, did anyone tell or ask you if you were using the wrong bathroom?

- No
- Yes

20.2
In the past year, did anyone stop you from entering or deny you access to a bathroom?

- No
- Yes

20.3
In the past year, were you verbally harassed, physically attacked, or experience unwanted sexual contact when accessing or while using a bathroom? **(Mark all that apply).**

- No [Skip to **20.7]**
  [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- Yes, verbally harassed [Respondent will receive **20.4**]
- Yes, physically attacked [Respondent will receive **20.5**]
- Yes, experienced unwanted sexual contact [Respondent will receive **20.6**]

20.4
You said that you were **verbally harassed** in a bathroom in the past year. Where did this happen? **(Mark all that apply).**

- A bathroom in a public place (such as a restaurant, shopping mall, movie theater, etc.)
- A bathroom at my workplace
- A bathroom at my school
- A bathroom at another location (please specify) _____

20.5
You said that you were **physically attacked** in a bathroom in the past year. Where did this happen? **(Mark all that apply).**

- A bathroom in a public place (such as a restaurant, shopping mall, movie theater, etc.)
- A bathroom at my workplace
- A bathroom at my school
- A bathroom at another location (please specify) _____

20.6

You said that you **experienced unwanted sexual contact** in a bathroom in the past year. Where did this happen? **(Mark all that apply).**

- A bathroom in a public place (such as a restaurant, shopping mall, movie theater, etc.)
- A bathroom at my workplace
- A bathroom at my school
- A bathroom at another location (please specify) _____

20.7

In the past year, did you avoid going to the bathroom because you were afraid of having problems using them? This would include bathrooms in public, at work, or at school.

- I have never avoided them [Skip to **21.1**]
- I have sometimes avoided them
- I have always avoided them
- Not listed above (please specify) _____

20.8

Did you experience any of the following because you avoided using bathrooms in public places, at work, or at school? **(Mark all that apply).**

- Not going when needed ("holding it")
- I avoided drinking or eating
- Urinary tract infection
- Kidney infection
- Other kidney-related problems
- I have never had physical problems from avoiding bathrooms
- Not listed above (please specify) _____

Section 21

These are questions about things that might have happened to you at your job or business, or while you were looking for work.

21.1
Have you ever worked at a job or business? Do not include sex work, selling drugs, or other work that is currently considered illegal.

- No [Skip to **21.6**]
- Yes

21.2
Have you ever lost a job or been laid off?

- No [Skip to **21.4**]
- Yes

21.3
Do you believe that you were ever laid off or lost a job because of your… **(Mark all that apply).**

- Age
- Disability
- Income level or education
- Trans status/gender identity
- Gender expression/appearance
- Race/ethnicity
- Religion/spirituality
- Sexual orientation
- None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

21.4

Have you ever been fired or forced to resign from a job?

- No [Skip to **21.6**]
- Yes

21.5

Do you believe that you were ever fired or forced to resign because of your… **(Mark all that apply).**

- Age
- Disability
- Income level or education
- Trans status/gender identity
- Gender expression/appearance
- Race/ethnicity
- Religion/spirituality
- Sexual orientation
- None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

21.6

Now just thinking about the past year, did you apply for a job and/or work at a job or business? Do not include sex work, selling drugs, or other work that is currently considered illegal. **(Mark all that apply).**

- No [Skip to **23.1**]
  [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- Yes, I applied for a job
- Yes, I worked at job or business

21.7

In the past year, how many times have you been… (**Please provide an answer in each row.**)

In the past year…	0 times	1 time	2 times	3 times	4 times	5 or more times
Denied a promotion at a job	O	O	O	O	O	O
Not hired for a job you applied for	O	O	O	O	O	O
Fired or forced to resign from a job	O	O	O	O	O	O

21.8_1 [*PROGRAMMING NOTE: This question is only for respondents who selected 1 or more times for "Denied a promotion at a job"* ***21.7***]
Do you believe that any of the times that you were **denied a promotion at a job** in the past year were because of your… **(Mark all that apply).**

- ○ Age
- ○ Disability
- ○ Income level or education
- ○ Trans status/gender identity
- ○ Gender expression/appearance
- ○ Race/ethnicity
- ○ Religion/spirituality
- ○ Sexual orientation
- ○ None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

21.8_2 [*PROGRAMMING NOTE: This question is only for respondents who selected 1 or more times for "Not hired for a job you applied for"* ***21.7***]
Do you believe that any of the times that you were **not hired for a job you applied for** in the past year were because of your… **(Mark all that apply).**

- ○ Age
- ○ Disability
- ○ Income level or education
- ○ Trans status/gender identity
- ○ Gender expression/appearance
- ○ Race/ethnicity
- ○ Religion/spirituality
- ○ Sexual orientation
- ○ None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

21.8_3 [*PROGRAMMING NOTE: This question is only for respondents who selected 1 or more times for "Fired or forced to resign from a job"* ***21.7***]
Do you believe that any of the times that you were **fired or forced to resign from a job** in the past year were because of your… **(Mark all that apply).**

- ○ Age
- ○ Disability
- ○ Income level or education
- ○ Trans status/gender identity
- ○ Gender expression/appearance
- ○ Race/ethnicity
- ○ Religion/spirituality
- ○ Sexual orientation
- ○ None of the above

[*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

21.9
[*PROGRAMMING NOTE:* This question is only for respondents who selected either "Trans status/gender identity" or "gender expression/appearance" in **21.8_3**]
Now just thinking about when you were **fired or forced to resign from a job** because of your gender identity, trans status, and/or gender expression in the past year, please describe your response. **(Mark all that apply).**

- ○ I did nothing [Skip to **22.1**]
- ○ I contacted a lawyer.
- ○ I contacted a trans, LGBT, or other non-profit group. [Skip to **22.1**]
- ○ I contacted my union representative. [Skip to **22.1**]
- ○ I made an official complaint.
- ○ Not listed above (please specify)_____[Skip to **22.1**]

21.10
[*PROGRAMMING NOTE: This question is only for respondents who selected either "Trans status/gender identity" or "gender expression/appearance" in* ***21.8_3*** *and "I contacted a lawyer" in* ***21.9***]
You said that you contacted a lawyer in response to being **fired or forced to resign from a job** in the past year. What did the lawyer do to help you?

- ○ I was not able to hire the lawyer.
- ○ The lawyer called or wrote a letter to my employer.
- ○ The lawyer helped me file an official complaint.
- ○ The lawyer filed a lawsuit for me.
- ○ Not listed above (please specify) _____

21.11

[*PROGRAMMING NOTE: This question is only for respondents who selected either "Trans status/gender identity" or "gender expression/appearance" in **21.8_3** and "I made an official complaint" in **21.9***]

You said that you made an official complaint in response to being **fired or forced to resign from a job** in the past year. Where did you make the official complaint? (**Mark all that apply**).

- ○ EEOC (Equal Employment Opportunity Commission)
- ○ Local/State Human Rights Commission
- ○ The Human Resources or Personnel department of the employer
- ○ Equal Employment Opportunity (EEO) office of the employer
- ○ Not listed above (please specify) _____

Section 22

22.1

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes, I worked at a job or business" in **21.6***]

In the past year, to **avoid** trans discrimination at work… **(Please provide an answer in each row.)**

	No	Yes
I asked for a transfer to a different position/department at my job in the past year	O	O
I stayed in a job I'd prefer to leave in the past year	O	O
I didn't seek a promotion or a raise in the past year	O	O
I quit my job in the past year	O	O
I had/have a job for which I am over-qualified (in the past year)	O	O
I had to be in the closet about my gender identity in the past year	O	O
I delayed my gender transition in the past year	O	O
I did not ask my employer to use the pronouns I prefer in the past year (such as he, she, or they)	O	O
I hid the fact that I have transitioned gender already in the past year	O	O

22.2

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes, I worked at a job or business" in **21.6***]

In the past year, did any of these things happen to you because of trans discrimination at work? **(Please provide an answer in each row.)**

	No	Yes
My employer/boss forced me to resign in the past year.	O	O
My employer/boss forced me to transfer to a different position/department at my job in the past year.	O	O
My employer/boss removed me from direct contact with clients, customers or patients in the past year.	O	O
My employer/boss told me to present in the wrong gender in order to keep my job in the past year.	O	O
My employer/boss gave me a negative job review in the past year.	O	O
My employer/boss and I could not work out an acceptable bathroom situation in the past year.	O	O
My employer/boss did not let me use the bathroom I should be using based on my gender identity in the past year.	O	O
My employer/boss or coworkers shared information about me that they should not have in the past year.	O	O

22.3

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes, I worked at a job or business" in **21.6***]

In the past year, did any of these things happen to you at work because you are trans? **(Mark all that apply).**

- I was verbally harassed
- I was physically attacked
- I experienced unwanted sexual contact (such as fondling, sexual assault, or rape)
- None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

Section 23

These are questions about experiences you may have had with housing.

23.1

Have you ever experienced homelessness? Experiencing homelessness includes such things as staying in a shelter, living on the street, living out of a car, or staying temporarily with family or friends because you can't afford housing.

- No
- Yes

23.2

Now just thinking about the past year, have you had any of these housing situations **because you are trans? (Please provide an answer in each row.)**

Please choose "Does not apply to me" if you could not have had that housing situation in the past year. For example, if you didn't rent a home in the past year, you would answer "Does not apply to me" to the first question because you could not have been evicted.

In the past year...	Yes	No	Does not apply to me
I was evicted from my home/apartment.	O	O	O
I was denied a home/apartment.	O	O	O
I experienced **homelessness***.	O	O	O
I had to move back in with family members or friends.	O	O	O
I had to move into a less expensive home/apartment.	O	O	O
I slept in different places for short periods of time, such as on a friend's couch.	O	O	O

Hyperlinked text for "homelessness": Experiencing homelessness includes such things as staying in a shelter, living on the street, living out of a car, or staying temporarily with family or friends because you can't afford housing.

Section 24

[PROGRAMMING NOTE: Section 24 questions are only for respondents who selected "I experienced homelessness" in 23.2]

24.1

When you experienced homelessness **this past year**, did you seek shelter in a homeless shelter? **(Mark all that apply).**

[*PROGRAMMING NOTE: Respondents cannot select a "yes" option AND a "no" option.*]

- Yes, and I stayed at one or more shelters.
- Yes, but I was denied access to one or more shelters.
- No, because I feared I would be mistreated as a trans person [Skip to **25.1**]
- No, for other reasons [Skip to **25.1**]

24.2

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes, but I was denied access to one or more shelters" in **24.1***]

Do you believe that you were denied access to a homeless shelter in the past year because of your … **(Mark all that apply).**

- Age
- Disability
- Income level or education
- Trans status/gender identity
- Gender expression/appearance
- Race/ethnicity
- Religion/spirituality
- Sexual orientation
- None of the above

  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

24.3

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes, and I stayed at one or more shelters" in **24.1***]

In the past year, did any of these things happen to you in the homeless shelter? (**Please provide an answer in each row.**)

	No	Yes
I was thrown out after they learned I was trans.	O	O
I decided to dress/present as the wrong gender to feel safe in a shelter.	O	O
They required me to dress/present as the wrong gender in the shelter.	O	O
I decided to leave a shelter because of poor treatment or unsafe conditions, even though I had no place to go.	O	O

24.4

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes, and I stayed at one or more shelters" in **24.1***]

In the past year, did any of these things happen to you in a homeless shelter because you are trans? **(Mark all that apply).**

- I was verbally harassed
- I was physically attacked
- I experienced unwanted sexual contact (such as fondling, sexual assault, or rape)
- None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

Section 25

These are questions about your experiences in places of public accommodations, such as hotels, restaurants, or government agencies.

25.1

In the past year, have you visited or used services in any of these places? **(Mark all that apply).**

- ○ Domestic violence shelter/DV program/ Rape crisis center
- ○ Drug/alcohol treatment program
- ○ DMV or RMV (Department or Registry of Motor Vehicles)
- ○ Social Security office (such as for name or gender change, Social Security card, public benefits)
- ○ Public assistance/ government benefits office (such as SNAP, WIC)
- ○ Gym/health club
- ○ Legal services from an attorney, clinic, or legal professional
- ○ Court/court house
- ○ Nursing home/extended care facility
- ○ Public transportation (such as bus, train, subway, taxi)
- ○ Retail store, restaurant, hotel, theater
- ○ I have not visited or used services in any of these places.
  [*PROGRAMMING NOTE: Respondent cannot select this last answer option and any other response option*]

25.2

In the past year, did you **NOT** visit or use services at these places because you thought you would be mistreated as a trans person? **(Please give an answer for each place.)**
[*PROGRAMMING NOTE: The locations that are listed in this question are those locations that were NOT SELECTED in **25.1***]

	No	Yes (I did NOT visit because I thought I would be mistreated)
Location #1	O	O
Location #2	O	O
Location #3	O	O
Location #4	O	O
Location #5	O	O
Location #6	O	O
Location #7	O	O
Location #8	O	O
Location #9	O	O
Location #10	O	O
Location #11	O	O

25.3

In the past year, when you visited or used services at these places, do you think the staff or employees knew or thought you were trans? **(Please give an answer for each place.)**
[*PROGRAMMING NOTE: The locations that are listed in this question are those locations that were SELECTED in **25.1***]

	No	Yes
Location #1	O	O
Location #2	O	O
Location #3	O	O
Location #4	O	O
Location #5	O	O
Location #6	O	O
Location #7	O	O
Location #8	O	O
Location #9	O	O
Location #10	O	O
Location #11	O	O

25.4

In the past year, when you visited or used services at these places, did any of these things happen to you because you are trans? **(Please provide an answer for each location.)**
[*PROGRAMMING NOTE: The locations that are listed in this question are those locations that were SELECTED in **25.1***]

	Denied equal treatment or service	Verbally harassed	Physically attacked	None of these things happened to me at this place
Location #1	O	O	O	O
Location #2	O	O	O	O
Location #3	O	O	O	O
Location #4	O	O	O	O
Location #5	O	O	O	O
Location #6	O	O	O	O
Location #7	O	O	O	O
Location #8	O	O	O	O
Location #9	O	O	O	O
Location #10	O	O	O	O
Location #11	O	O	O	O

Section 26

These are questions about experiences you may have had in school.

26.1

Were you out as trans in school at any time between Kindergarten and 12th grade?

- No
- Yes [Skip to **26.3**]

26.2

Do you believe that any of your classmates, teachers, or school staff in Kindergarten through 12th grade (K-12) **thought** you were trans?

- No
- Yes

26.3

Do you believe that any of your classmates, teachers or school staff in K-12 thought or knew you were lesbian, gay, bisexual, or queer (LGBQ)?

- No [*PROGRAMMING NOTE: If respondent selects "No" to 26.1, 26.2, and 26.3, then skip to **26.6 or 27.1 depending on educational level***]
- Yes

26.4

[*PROGRAMMING NOTE: This question is only for respondents who selected "Yes" in **26.1** or "Yes" to **26.2***]

Did any of these happen to you while in K-12? (If any of these things were done to you in K-12 by classmates, teachers, or school staff, please answer "yes.") (**Please provide an answer in each row.**)

	NO	YES
I was verbally harassed because people thought I was trans.	O	O
I was physically attacked because people thought I was trans.	O	O
I experienced unwanted sexual contact because people thought I was trans	O	O
I wasn't allowed to dress in the way that fit my gender identity/expression.	O	O
I was disciplined for fighting back against bullies.	O	O
I believe I was disciplined more harshly because teachers/staff thought I was trans.	O	O
I left a school because the mistreatment was so bad.	O	O
I was expelled from school.	O	O

26.5

[*PROGRAMMING NOTE: This question is only for respondents who selected "No" in **26.1** and "No" to **26.2** and "Yes" to **26.3***]

Did any of these happen to you while in K-12? (If any of these things were done to you in K-12 by classmates, teachers, or school staff, please answer "yes.") (**Please provide an answer in each row.**)

	YES	NO
I was verbally harassed because people thought I was LGBQ.	O	O
I was physically attacked because people thought I was LGBQ.	O	O
I experienced unwanted sexual contact because people thought I was LGBQ.	O	O
I wasn't allowed to dress in a way that fit my gender identity/expression.	O	O
I was disciplined for fighting back against bullies.	O	O
I left a school because the mistreatment was so bad.	O	O
I was expelled from school.	O	O

[*PROGRAMMING NOTE: Questions **26.6 through 26.9** are only for respondents who selected "Some college" or higher educational attainment in **2.22***]

26.6

Now just thinking about classmates, professors, or staff at your college or vocational school, did they think or know you were trans?

- No [Skip to **26.9**]
- Yes

26.7

Were you harassed (verbally, physically, or sexually) at college or vocational school because people thought or knew you were trans?

- No [Skip to **26.9]**
- Yes

26.8

Did you have to leave your college or vocational school because the harassment was so bad?

- No
- Yes

26.9

Did you leave or were you forced to leave a college or vocational school because you are trans? **(Mark all that apply).**

- No
  [*PROGRAMMING NOTE: Respondents cannot select "no" and any other option.*]
- Yes, I left school because the mistreatment was so bad.
- Yes, I was expelled or forced out.
- Yes, I left for other trans-related reasons.

Section 27

These are questions about things that may have happened to you when going through airport security.

27.1

In the past year, have you gone through airport security in the United States?

- No [Skip to **28.1**]
- Yes

27.2

When you went through airport security in the past year, did a TSA officer do any of these things to you? **(Mark all that apply).**

[*PROGRAMMING NOTE: Randomize answer options for each respondent, but "None of the above" will remain as last response option.*]

- They questioned the name or gender on my ID.
- They used the wrong pronouns with me (he/him or she/her) or wrong title (Mr. or Ms.)
- They patted me down due to gender-related clothing or items (such as a binder, packer).
- I was patted down by a TSA officer of the wrong gender.
- They searched my bag due to a gender-related item (such as binder, packer).
- They asked me to remove or lift clothing to show a binder, undergarment, or other sensitive area.
- They took me to a separate room for questioning/examination.
- They announced or questioned loudly my gender, body parts, or sensitive items (such as a binder, packer).
- They called the police about me.
- I missed my flight due to screening.
- I was not allowed to fly.
- They detained me for over an hour.
- They verbally harassed me.
- They physically attacked me.
- I experienced unwanted sexual contact (beyond a typical pat down by a TSA officer)
- None of the above
  [*PROGRAMMING NOTE: Respondent cannot select "None of the above" AND any other response option*]

Section 28

These are questions about things that happened to you with police, in jail, in prison, or in a juvenile detention center.

28.1

If you needed help from the police, how comfortable would you feel asking them for help?

- o Very comfortable
- o Somewhat comfortable
- o Neutral
- o Somewhat uncomfortable
- o Very uncomfortable

28.2

In the past year, did you interact with the police or other law enforcement officers?

- o No [Skip to **28.8**]
- o Yes

28.3

In the past year, do you believe the police or other law enforcement officers you interacted with thought or knew you were trans?

- o None of the officers thought or knew I was trans. [Skip to **28.6**]
- o Some officers thought or knew I was trans, some did not.
- o All officers thought or knew I was trans.

28.4

In the past year, when you interacted with police or other law enforcement officers, were you treated with respect?

- o I was never treated with respect.
- o I was sometimes treated with respect.
- o I was always treated with respect.

28.5

In the past year, when you interacted with police or other law enforcement officers, did any of these things happen to you? **(Please give an answer in each row)**

In the past year…	**No**	**Yes**
Officers kept called me by the wrong gender pronouns (such as he/him or she/her) or wrong title (Mr. or Ms.)	O	O
Officers asked me questions about my gender transition (such as hormones and surgical status).	O	O
Officers assumed I was a sex worker.	O	O
Officers verbally harassed me.	O	O
Officers physically attacked me.	O	O
Officers forced me to engage in sexual activity to avoid arrest	O	O
I experienced unwanted sexual contact from an officer (such as fondling, sexual assault, or rape)	O	O

28.6

In the past year, were you arrested for any reason?

- ○ No [Skip to **28.8**]
- ○ Yes

28.7

In the past year, do you believe that you were arrested because you were trans?

- ○ No
- ○ Yes

28.8

In the past year, at any time were you held in jail, prison or juvenile detention?

- o No [Skip to **29.1**]
- o Yes

28.9

In the past year, what types of jail, prison, or juvenile detention facility were you in? **(Mark all that apply).**

- o Federal prison
- o State prison
- o Local jail
- o Holding cell
- o State juvenile system
- o Locally or privately-operated juvenile facilities
- o Other correctional facility (please specify) _____

28.10

In the past year, during your time in jail, prison or juvenile detention facility were you physically forced, pressured, or made to feel that you had to have sex or sexual contact with any **facility staff**?

o No [Skip to **28.12**]
o Yes

28.11

In the past year, how many times did this happen to you?

[Drop down list of number of times from "1" to "11 or more"]

28.12

In the past year, during your time in jail, prison or juvenile detention facility, were you physically forced, pressured, or made to feel that you had to have sex or sexual contact with **another inmate**?

o No [Skip to **28.14**]
o Yes

28.13

In the past year, how many times did this happen to you?

[Drop down list of number of times from "1" to "11 or more"]

28.14

In the past year, during your time in jail, prison or juvenile detention facility were you **physically** assaulted or attacked by **facility staff**?

o No [Skip to **28.16]**
o Yes

28.15

In the past year, how many times did this happen to you?

[Drop down list of number of times from "1" to "11 or more"]

28.16

In the past year, during your time in jail, prison or juvenile detention facility were you **physically** assaulted or attacked by **another inmate**?

o No [Skip to **28.18**]
o Yes

28.17

In the past year, how many times did this happen to you?

[Drop down list of number of times from "1" to "11 or more"]

28.18

Before your time in jail, prison, or juvenile detention, were you taking hormones?

- No [Skip to **29.1**]
- Yes

28.19

Did you have a prescription for the hormones you were taking?

- No
- Yes

28.20

In the past year, during your time in jail, prison, or juvenile detention, were you not allowed to take your hormones?

- No
- Yes

Section 29

Now we have some questions about voting and registration.

29.1

In any election, some people are not able to vote because they are sick or busy or have some other reason, and others do not want to vote. Did you vote in the election held on **Tuesday, November 4, 2014***?

- No
- Yes [Skip to **30.1**]

****Hyperlinked text for "Tuesday, November 4, 2014"**: This was the election in November 2014 to elect members of the U.S. Congress and state-level offices.*

29.2

Were you registered to vote in the **November 4, 2014 election***?

- No
- Yes [Skip to **29.4**]

****Hyperlinked text for "November 4, 2014 election"**: This was the election in November 2014 to elect members of the U.S. Congress and state-level offices.*

29.3

[*PROGRAMMING NOTE: This question is only for respondents who selected "No" in **29.1** and "No" to **29.2***]

Which of the following was the MAIN reason you were not registered to vote? **(Please choose only one response.)**

- Not eligible to vote because I am not a U.S. citizen.
- I wanted to avoid being harassed by election officials because I am trans.
- My current name does not match social security card.
- I thought my state's voter ID law could stop me from voting.
- I don't have ID and thought I would need one to register.
- Did not meet registration deadlines.
- Did not know where or how to register.
- Did not live here long enough/did not meet residency requirements.
- Permanent illness or disability
- Difficulty with English
- Not interested in the election or not involved in politics.
- My vote would not make a difference.
- Not eligible to vote because of a criminal/felony conviction.
- Not eligible to vote for a reason other than a criminal/felony conviction.
- A reason not listed above (please specify) _____

29.4

[*PROGRAMMING NOTE: This question is only for respondents who selected "No" in **29.1** and "Yes" to **29.2***]

What was the MAIN reason you did not vote?

(Please choose only one response.)

- ○ I wanted to avoid being harassed by election officials because I am trans.
- ○ Illness or disability (own or family's)
- ○ Out of town or away from home
- ○ Forgot to vote (or send in absentee ballot)
- ○ Not interested, felt my vote wouldn't make a difference
- ○ Too busy, conflicting work or school schedule
- ○ Transportation problems
- ○ Didn't like candidates or campaign issues.
- ○ Registration problems (for example, I didn't receive an absentee ballot or wasn't registered in current location)
- ○ Bad weather conditions
- ○ Inconvenient hours, polling place, or hours or lines too long
- ○ I didn't have the identification documents (ID) I needed to vote.
- ○ My identification documents (ID) do not match my current name, gender, or have an old photo.
- ○ My gender/name on my identification document (ID) does not match my voter registration.
- ○ I was not allowed to vote by a poll worker or election official because I am trans.
- ○ A reason not listed above (please specify) _____

Section 30

These are questions about civic and political activities.

30.1
Do you agree or disagree with the following statement about political affairs in this country?

Someone like me can't really influence government decisions.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

30.2
People may be involved in civic and political activities. In the last **Presidential election in 2012*** did you…(**Please provide an answer in each row.**)
[*PROGRAMMING NOTE: Randomize response options, keeping #1 and # 2 response options and #3 and Number #4 response options grouped together in the order offered.*]

In the last Presidential election in 2012 did you …	**No**	**Yes**
Volunteer or work for a Presidential campaign		
Volunteer or work for another political candidate, issue, or cause		
Give money to a Presidential campaign		
Give money to another political candidate, issue, or cause		

****Hyperlinked text for "Presidential election in 2012"**: *This was the presidential election in 2012 between Mitt Romney and Barack Obama.*

30.3
In the past 12 months have you…(**Please provide an answer in each row.**)
[*PROGRAMMING NOTE: Randomize response options.*]

In the past 12 months, have you…	**No**	**Yes**
Attended a political protest or rally		
Contacted a government official		
Worked with others in your community to solve a problem		
Served on a community board		
Written a "letter to the editor"		
Commented about politics on a message board or Internet site		
Held a publicly elected office		

30.4

In politics, as of today, do you consider yourself a Republican, a Democrat, or an Independent?

- ○ Republican [Skip to **30.6**]
- ○ Democrat [Skip to **30.6**]
- ○ Independent
- ○ Other party (please specify) _____

30.5

As of today, do you lean more to the Democratic Party or the Republican Party?

- ○ Democratic
- ○ Republican
- ○ Neither/Other

30.6

How would you describe your political views?

- ○ Very conservative
- ○ Conservative
- ○ Moderate
- ○ Liberal
- ○ Very liberal

Section 31

This question asks for your opinion on the most important policy priorities for trans people in the United States.

This is a two-part question:

31.1

For each issue below that affects trans people in the U.S., please mark how important it is. (**Please provide an answer in each row.**)

[*PROGRAMMING NOTE: Randomize list of issues.*]

	Very important	Important	Not very important
HIV/AIDS	O	O	O
Identity documents (ID) (updating name and gender)	O	O	O
Bullying/discrimination in schools	O	O	O
Police mistreatment of trans people	O	O	O
Mistreatment in prisons/jails	O	O	O
Immigration reform	O	O	O
Military (ability to be openly trans)	O	O	O
Training health care providers about trans health	O	O	O
Insurance coverage for trans-related health care	O	O	O
Employment	O	O	O
Housing and homelessness	O	O	O
Violence against trans people	O	O	O
Parenting and adoption rights	O	O	O
Marriage recognition	O	O	O
Conversion Therapy	O	O	O
Racism	O	O	O
Poverty	O	O	O

31.2

Of these issues, please select your top 3 most important issues.

Issue#1 [Drop down list of issues listed in **31.1**]

Issue#2 [Drop down list of issues listed in **31.1**]

Issue#3 [Drop down list of issues listed in **31.1**]

Final Question

32.1

Is there anything else that you would like to tell us about your experiences of acceptance or discrimination so we can better understand your experiences?

- No [*PROGRAMMING NOTE: If respondent selects "No," their survey response is submitted and the respondent is directed to the "Thank You Page" hosted by NCTE.*]
- Yes [Proceed to **32.2**]

32.2

Please tell us anything else that you would like to tell us about your experiences of acceptance or discrimination so we can better understand your experiences. Please do not provide any information that could be used to identify you, such as your name or contact information. Your response will be anonymous.

[Text Box]

Please enter your survey responses by clicking on the submit button below:

SUBMIT

[*PROGRAMMING NOTE: Once respondent selects "SUBMIT" their survey response is submitted and the respondent is directed to the "Thank You Page" hosted by NCTE.*]

Thank You Page

THANK YOU FOR MAKING YOUR VOICE HEARD

YOUR SURVEY HAS BEEN SUBMITTED [This text added 8/19]

You are almost done! [This text deleted 8/20]

Want to be one of the first to get the survey results?
Want to win one of the cash prizes?
Give us your info here.
This information will not be connected to your survey responses.

Preferred name _____
Email address _____
Zip Code (required) _____
Phone (optional) _____

[ ] Send me the results of the survey when you release them!

[ ] Enter me in the drawing for one of three cash prizes: one prize of $500 and two prizes of $250!

SUBMIT

****

RESOURCES

We recognize that answering some of the questions on this survey may have been hard. If you are experiencing any difficult emotions after answering the questions and would like to talk to someone, please contact one of the anonymous resources below:

National Suicide Prevention Helpline
1-800-273-8255
http://www.suicidepreventionlifeline.org/

FORGE Transgender Sexual Violence Project
414-559-2123
http://forge-forward.org/anti-violence/for-survivors/ to list of resources

Veterans Crisis Line (for veterans, military personnel, and their families)
1-800-273-8255 and Press 1
http://veteranscrisisline.net/

The Trevor Project
The Trevor Project is a phone and internet chat hotline for LGBTQ people. For those participating in this survey, The Trevor Project will speak or chat with people of all ages.
1-866-488-7386
http://www.thetrevorproject.org/section/get-help

National Sexual Assault Hotline
800-656-HOPE (4673)
https://ohl.rainn.org/online/

NCTE Story Collection Page

We need your story. You submitted your survey responses, but those were anonymous. Your stories can help us change the hearts and minds of policymakers in a way that data can't. We need stories from all parts of life and from all types of people. We need stories of mistreatment and discrimination as well as of overcoming challenges and being accepted.

We will never use your name or any identifying details unless we contact you and you give us permission first. Your survey responses will remain in the study, even if you do not provide your story.

Please take a few more moments and share with us! Your story could really be used to change policies, laws and society to make it better for trans people.

First Name _____ Last Name _____ Email address _____ Zip Code (required) ____ Phone (optional) _____

What type of experience of acceptance or discrimination will you be telling us about **(Check all that apply)**?

- School
- Job
- Family
- Police/Jail
- Health Care
- ID documents
- Violence
- Other experience

If you had to choose only one of the following terms, which best describes your current gender identity?

- Cross-dresser
- Woman
- Man
- Trans woman (MTF)
- Trans man (FTM)
- Non-binary/Genderqueer
- Other

Please select the choice that most accurately describes your racial/ethnic identity. **(Check all that apply)**

[] Alaska Native
[] American Indian
[] Asian/Asian American
[] Biracial/Multiracial
[] Black/African American
[] Latino/a/Hispanic
[] Middle Eastern/North African
[] Native Hawaiian/Pacific Islander
[] White/European American
[] Other

What is your age?

[Drop down list of ages]

Please share your story below [Text box]

Thank you for sharing.
Note that we are unable to be in touch with everyone who submits a story.

Disqualification Page #1

Thank you for your survey responses. We're interested to learn more about your identity and experiences. If you would like to tell us more, please respond to the following questions. Please **do not** provide any information that could be used to identify you, such as your name or contact information.

1. Tell us about your gender identity or expression.
   [Text box]

2. Tell us about your experiences related to your gender identity or expression.
   [Text box]

Disqualification Page #2

Based on your answers, you are not eligible to complete this survey.

Thank you for your interest in participating in this study.

For more information about this project please visit the NCTE website: http://www.ustranssurvey.org.

Vita Auctoris

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