TRANSGENDER BODIES, IDENTITIES, AND HEALTHCARE: EFFECTS OF PERCEIVED AND ACTUAL VIOLENCE AND ABUSE

AU :1

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ABSTRACT

''Disparity'' implies the existence of a ''markedly distinct in quality or character,'' difference between one group and another. Some groups, due to elevated stigma associated with group membership, are invisible as a disparate minority and therefore, while there may be a great inequity in healthcare between that group and the normative population, the invisible minority is ignored. This chapter addresses the issue of healthcare for the transgender-identified population. We address how the normative viewpoint of mental illness and unacceptable religious status, along with lifelong perceived and actual abuse and violence, creates a socially sanctioned inequality in healthcare for this population.

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INTRODUCTION

Invisibility, Minority, and Disparity

The issue of healthcare disparity has become a central research focus in recent years (Victoria, 2006; Irwin et al., 2006; Alliance for Health Reform, 2006). Reports from various federal agencies, as well as private think tanks (Smedley, Stith, & Nelson, 2003) carefully document disparities in healthcare delivery, health status, and treatment outcome for various "US racial and ethnic minority groups" (Atdjian & Vega, 2005; Sheikh, 2006). Atdjian and Vega (2005) further point out that all such research articles and reports "urge immediate action to overcome these disparities."

Central to this discussion are two words: "minority" and "disparity." The term "minority" recognizes the existence of a socially sanctioned "out-group" or "group/sub-population differing from others in some characteristics and often subjected to differential treatment" (Merriam-Webster Online, 2006), yet now deemed important enough to study. The term "disparity" implies the existence of a "markedly distinct in quality or character" (Merriam-Webster Online, 2006), difference between one group and another. Both definitions (1) imply that a unique sub-group of individuals exists and that (2) there is/are inequity/inequities between that group and the "normative" or "in-group" population.

However, some "out-groups," due to the elevated stigma associated with membership in that group, are invisible with respect to being defined as a disparate minority (Witten & Eyler, 1999) and therefore, while there may be a great disparity in healthcare between that group and the normative population (U.S. Department of Health and Human Services, 2000), the invisible minority is not sanctioned as "studyable" (GLMA, 2000). This may be due to the fact that the in-group finds the existence of a particular minority identity to be intolerable for religious, moral, or other psycho-socio-economic-political reasons, thereby causing it to be invisible with respect to healthcare research and delivery (Witten, 2004).

OVERVIEW OF GENDER MINORITY IDENTITIES

Traditional Western Biomedical Perspective of Sex/Gender

The traditional Western biomedical construction of identity routinely conflates sexuality, gender, and birth body or "birth sex/reproductive sex" AU :2

(Basu, 2000; Doyal, 2001; Greenberg, 1998; Grant, 2001; Pesquera, 1999; Pryzgoda & Chrisler, 2000; Witten, 2004, 2005; Witten & Eyler, 1999). A trivial example is the conflation of sex and gender on numerous medical forms worldwide that routinely ask for "gender" when they obviously mean "birth sex/birth body," as suggested in Witten (2005). This is best illustrated when examining the National Institutes of Health PHS398 personal investigator information form. This form is required of all researchers who submit a grant proposal to the NIH. As part of the information collected, the NIH asks for the investigator's "sex/gender." Furthermore, even if a survey asks for birth sex, it provides only the two choices of male and female, thereby ignoring the existence of the worldwide intersex population. This lack of attention to the intersex population is particularly important as intersex birth incidence is estimated between 1/1200-1/200 (ISNA, 2007). AU :3 AU :4

Multi-Cultural Minority Gender Identities

Gender minority persons include transsexuals, transgenders, cross-dressers, and others with gender self-perceptions other than the traditional Western dichotomous gender world-view (i.e. identifying only masculine and feminine) such as members of some Native American and other indigenous groups (Langevin, 1983; Satterfeld, 1988; Godlewski, 1988; Hoenig & Kenna, 1974; Kröhn, Bertermann, Wand, & Wille, 1981; Kockott & Fahrner, 1988; Sigusch, 1991; Tsoi, 1988; van Kesteren, Gooren, & Megens, 1996; Walinder, 1971, 1972; Weitze & Osburg, 1996; Witten et al., 2003). Breadth of cultural competence is important in transgender (HBIGDA, 2007) and intersex (ISNA, 2007) healthcare, as many indigenous peoples also recognize genders other than male and female. For example, adult members of the Tewa tribal culture identify as women, men, or members of the third gender, "*kwido*," although their American birth records and other government documents recognize only females and males (Jacobs & Cromwell, 1992). The Chukchi, in early 20th century North America, recognized seven genders in addition to female and male. The traditional cultures of Tonga and Samoa identify Fa'afafine and Fa'afatama as additional genders (Witten et al., 2003; Schmidt, 2003). Recently the Hijra (India, Pakistan, and Bangladesh) have been acknowledged as a third gender by the Indian government, thereby paving the way for their passports to indicate this status. Japanese culture contains a number of "folk categories" that are considered to be transgendered, for example "*okama*, *gei bli*, *bur^bli* and *ny^h#fu*" (McLelland, 2004). The Mak Nyah AU :5 AU :6

are Malaysian male transsexuals (Teh, 2001; Zucker & Blanchard, 2003; Poasa & Blanchard, 2004). Identity and Thai transgender is discussed in the work of Winter (2005, 2006), while Turkish transsexual status is covered in Atamer (2005). Similar non-traditional gender identities exist in indigenous New Zealand peoples (Maori). A more detailed discussion of worldwide gendered identities may be found in Witten and Eyler (2007, forthcoming). Roughgarden (2004) provides a particularly comprehensive discussion of transgender organisms across the animal kingdom.

Aging and Transgender Identities

Estimates of US and worldwide transgender population sizes are discussed in Witten (2003). Based upon these estimates, Witten finds that the worldwide population of non-normative (non-Western) gender identities may exceed 20 million individuals and therefore constitutes a non-trivial minority population that remains excluded from international healthcare research efforts.

Physicians and other healthcare/caregiving professionals should remain aware of the possibility of culturally normative gender variance when discussing gender identity with their patients, particularly as elderly persons are more likely to have retained traditional cultural beliefs and practices than are their younger peers. Multicultural aspects of gender identity are especially important in countries where the rates of aging are high, such as Malaysia, Bangladesh, India, Pakistan, and Thailand. We will momentarily see why the intersection of aging and trans-identities/bodies is a topic of importance.

VIOLENCE, ABUSE, HATE SPEECH, AND HATE CRIMES AGAINST TRANSGENDERED IDENTITIES

Transgender Hate Violence and Abuse

Hate crimes against a lesbian, gay, bisexual, or transgender (LGBT) person result in both short-term and long-term psychological effects for the victim(s) as well as for society as a whole. The fear and/or trauma engendered by a hate crime can impede an individual's ability to carry out normal day-to-day activities (Bradford, Ryan, & Rothblum, 1994). Moreover, it can have longer term life effects (Witten, 2004).

Hate crimes, violence, and abuse are also a fact of life for a great number of transgender-identified individuals. Witten and Eyler (1999) state that, in the TranScience Longitudinal Aging Research Study (TLAR) survey; a sample of snowball sample of 213 transgender-identified individuals, 91% of the respondents stated that they had suffered perceived and actual violence and abuse. Sadly, much of this abuse and violence is suffered prior to the age of 18 years old and falls into multiple categories and is multiple occurrence. 69.76% of the TLAR respondents stated that they had suffered some sort of violence or abuse (multiple choices of form of violence/abuse could be checked) prior to age 18. The top perpetrators of this violence/abuse were – in order of importance – the father, another adult, a relative, the mother, and a peer. Consider the following quotations from both the TLAR and the FTM survey:[1]

> The abuse was exploitation by a brother. I was defrauded of money (approx. $2000) and though I would not have taken action to recover it, he assured my silence by threatening to present a letter to my employer and "outing" me. I would call it extortion. It was several yrs ago. Not reported to authorities. Family members voiced their disapproval.

> Stabbed in eighth grade by schoolmate mugged by a group in 1973. While crossdressed verbally abused 1995, 1990.

> My early experiences in cross-dressing were discovered … and reported to my father. He caus[ed] me great embarrassment in front of the whole family. The second [time] I was caught resulted in a private consultation where I was issued the ultimatum: Stop dressing or be sent to a psychiatric institution …

These violence and abuse results are supported by the more recent work of Lombardi, Wilchins, Priestling, and Malouf (2001) and the Washington Transgender Needs Assessment Survey (WTNAS) (Xavier & Simmons, 2001, personal communication). More recent results from the Virginia Transgender Health Initiative Study (VTHIS, 2007) add additional support with 40% of the VTHIS respondents reported being physically attacked since the time they were 13 years old, including 45% of the female-to-male and 36% of the male-to-female respondents. Similar results have been reported by Kenagy (2005) for Philadelphia and for Los Angeles (LACCHR, 2006). Dang and Vianney (2007) in a sample of GLBT Asian and Pacific Islanders state that 98% of the respondents report at least one form of harassment or discrimination.

Reporting of Transgender Violence and Abuse

Respondents of the TLAR survey were also asked to identify whether or not they had ever told another individual about the violence, abuse, or mistreatment that they had received, and to whom these events had been reported. Of the participants who answered this question, 23% indicated that they had not told others of their abuse experiences. With respect to reasons for non-reporting, 21% indicated that they were afraid to report for fear of reprisal by the perpetrator, 11% feared abuse by the medical/legal system, 4% were unable to report, 29% felt that it would not make a difference if they had reported the incident or incidents, 8% wanted to protect the perpetrator, and 17% indicated that there had been reasons other than those listed. For the VTHIS (2007) study, over 70% of the respondents who were attacked did not report any assault to the police. The published results do not provide a breakdown of the reasons for not reporting. Fear of reprisal and fear of abuse from the systems that are supposed to protect people was frequently mentioned in both the TLAR and the FTM survey respondents:

> Arrested a few yrs ago for possession of cocaine – I was verbally harassed by police (''you mean you have a pussy and not a dick?'' and forced to pull my pants down in front of 4–5 cops to prove my gender status. 4 yrs ago at a demonstration cops began beating on me with clubs.

> Police verbal: paraded around police station for amusement – ''This guy is really a woman.'' Police also informed my employer of my transsexualism. I had been stopped and asked for ID – There had been no crime nor suspicion of crime, just a request for I.D. I had a female drivers license, so I was taken into custody for proof of identity. Released without charges.

The more recent study of Lombardi et al. (2001) reported that 59.5% of the sample experienced either violence or harassment (26.6% experienced a violent incident, 14% reported rape or attempted rape, 19.4% reported assault without a weapon, 17.4% reported having items thrown at them, and 10.2% reported assault with a weapon) and 37.1% reported some form of economic discrimination. The National Coalition of Anti-Violence Programs (2005) found that 10% of the crimes tracked by the organization in 2004 were transgender victims. While this number represents a 3% decline from the 2003 report, the researchers noted that the decline may actually be a result of many transgender people attempting to remain undetected (go stealth) rather than an actual decrease in anti-transgender attitudes. This conclusion is not surprising, given the perceptions and experiences

illustrated in the following cross-sectional sample of quotations from both the longitudinal TLAR survey and from this FTM survey:

> Mugged in NYC by a gang of black people who took all my cash. Brutally sexually mutilated in what the police said was a "drug related" hit on the wrong person. Police didn't consider it serious enough to follow up on even though my penis was bisected several centimeters with a knife or razorblade. Numerous assaults while growing up.

> Was sexually harassed at work place, employer and employees found out that I was a transsexual, and co-workers tried to find out if I was really a man or woman by grabbing at my chest and hair and other body parts.

Gender Education and Advocacy (2005) report that, "Over the last decade, more than one person per month has died due to transgender-based hate or prejudice, regardless of any other factors in their lives." Given the significant degree of perceived and actual violence and abuse against the transgender-identified population, how does this affect healthcare utilization and healthcare delivery?

HEALTHCARE-GENDERED BODIES AND GENDERED IDENTITIES

Healthcare Perceptions of Non-Western Normatively Gendered Person/Identities

The institution of healthcare is not immune from participation in transgender abuse and violence. In fact, as the GLMA (2000) document clearly points out, the federal government routinely marginalizes the GLBT population and in doing so silently sanctions anti-GLBT behaviors (Witten, 2002; Belongia & Witten, 2006). Many transgender-identified individuals have experienced a variety of both subtle and overt abuse and violence at the hands of healthcare workers.

Witten and Eyler (1999) demonstrate that hate crimes involving transgender people are similar in many ways to hate crimes involving lesbian, gay, and bisexual victims. This similarity is rooted in the commonality of the two groups' transgression of traditional gender norms; whether this takes the form of sexual intimacy with a person of the "non-opposite" gender or if one's own gender identity is more closely associated with another gender. Despite these similarities, Witten and Eyler (1999) concluded, from both anecdotal and survey evidence, that transgender

people were simultaneously more likely to be victimized and less likely to have access to medical care and legal services.

Among the numerous types of healthcare response, TLAR respondents indicated that 5.2% were placed in a psychiatric hospital, 15.7% were forced to see a counselor or therapist who tried to change them, and 2.4% were forced to have surgery (intersex identification, Greenberg, 1998; ISNA, 2007). Consider the following comment from "B" (an FTM-identified respondent in the TLAR study):

> It is always important to realize that, within the trans-population, different sub-populations will have different healthcare related problems. For example, female-to-male transsexuals who have had mastectomy will always have the problem of secrecy … Either his chest scars are obvious, or his genitals give him away. Thus, accessing normatively sexed and gendered healthcare services is nearly impossible. Add to this the difficulty of FTMs who have taken only hormones but could not afford or do not want surgeries. Billy Tipton comes to mind as one who never accessed healthcare in his lifetime and probably died prematurely because of it. There are scads of FTMs who suffer in isolation because they refuse to subject themselves to medical scrutiny, possible mistreatment and ridicule. Also, there is Robert Eades who recently died of medical neglect, after seeking help from at least 20 doctors who refused to treat him for ovarian cancer.

TLAR and FTM respondents detail a diverse distribution of abuse types ranging from non-inclusion to outright abuse and violence to denial of services (as in the case of Robert Eades). The following examples from the TLAR and FTM surveys illustrate these experiences:

> Went to counseling – and was taken out of the home at age 15 to mental hospital – Went back home for 5 months – went back to the hospital and then to foster parents.

> They [my therapists] would try to convince me to remain a man (biological sex) as it would be the most healthful and totally discourage any cross dressing.

Among the most famous healthcare abuse stories is that of Tyra Hunter, a Washington, DC hit and run victim, who was allowed to bleed to death by an EMT team when they discovered that she was a pre-operative male-to-female transsexual. The EMT team argued that they thought she was gay and had AIDS (Fernandez, 1998).

Transgender Elder Healthcare Abuse and Violence

Elderly transgender people were also noted as victims of abuse and/or violence, as their access to healthcare and caregiving services is often

reduced because of their transgender status as well as their elder status (Bradley, 1996; Cahill, South, & Spade, 2000; Cooke-Daniels, 1995; Witten, 2002, 2003; Witten & Whittle, 2004). AU :8

More recently, Belongia and Witten (2006) reported that transgender elders are invisible with respect to eldercare facilities (see also Shankle, Maxwell, Katzman, & Landers, 2003; Watt, 2001; Witten, 2003; Witten, Eyler, & Weigel, 2000). In their study of 29 regional eldercare facilities, Belongia and Witten reported that 80% of the facilities contacted stated that participation in a one-hour lunchtime training in transgender eldercare was not relevant to their patient population and/or staff. One facility Director of Nursing had the misperception that transgender was "a homosexual thing." Her disapproval of the topic was quite evident, and she refused to reconsider her position that "these people" are not part of her patient population. In fact, the nursing director stated that, "we don't have that kind of client here." The common institutional response seems to be a firm belief that "these people" are not ever patients in nursing homes or other eldercare facilities. It is important to understand that violence and abuse against trans-persons and against elderly transgender-identified persons is not just a US problem. Rather, it is a worldwide problem (Witten & Whittle, 2004).

This process of making a population invisible results in the in-group's failure to allow the out-group to be sanctioned as a minority, for example the Gay/Lesbian/Bisexual-identified population (GLMA, 2000). It then follows that, by not sanctioning the existence of such minorities, the healthcare system, as well as other macro-level institutions further condemn these groups to a future of healthcare disparity and healthcare disenfranchisement. Such a dynamic clearly flies in the face of Atdjian and Vega's (2005) call to "immediate action to overcome disparities."

Institutionalized Bias, Terminology Conflation, and Marginalization in Healthcare Systems

The problem of institutionalized bias and terminology conflation with respect to gender identity and sex (Basu, 2000; Doyal, 2001; Gannon, Luchetta, Rhodes, Pardee, & Segrist, 1992; Grant, 2001; Pryzgoda & Chrisler, 2000; Velkoff & Kinsella, 1998; Witten, 2003, 2005, 2007) can be demonstrated early on in healthcare students. Witten (2004) describes a recent study in which over 2000 anonymous response surveys were sent out to all the students in the five colleges (Medicine, Nursing, Dentistry, Allied Health Professions, and Biomedical Sciences) of a major southwestern

university medical center. Among other questions, survey respondents were asked to rate their perception of their gender using the Eyler-Wright gender continuum measurement instrument (Eyler & Wright, 1997). Qualitative comments were also collected from the individuals who responded to the survey. Of those that responded, a number of them expressed vehement emotions concerning the concepts of gender and sexuality. One self-identified 24 year-old biological female medical student stated that:

> I feel that this survey is very sad, because the world as a whole does not understand that God in the book of Genesis made "Adam and Eve" not "Adam and Steve"! I hope that you turn from your immoral ways and know that God loves you and can deliver your from this evil immoral way of thinking. There is no way to survey people on what is wrong and ungodly! Turn away from your evil ways and submit yourself to the Lord before it is too late! God bless you! God is coming SOON!!

Observe the command to "submit" to the Judeo-Christian-Islamic proscription of sexuality as defined within the construct of the proscribed genital sex dyad (Witten, 2005). One 19-year old, self-identified male nursing student wrote:

> If you were born a woman, you're a woman, If you were born a man your a man That's that.

Here we see the inability of the "normative" type to function within a conflicted reality in which the new proscription is based upon norms that are in conflict with the accepted norms of the larger cultural institution. A 22-year old, self-identified biological male medical student wrote:

> Biology teaches us that men are XY and women are XX. There are no other possibilities, anything else is sick!

It is important to understand that this type of response is frequently the normative response experienced by members of the transgender-identified communities (Witten, 2004; Witten & Eyler, 1999). However, this type of viewpoint is not exclusive to transgender-identified individuals. Intersex-identified individuals frequently experience similar types of pejorative remarks as well. Cheryl Chase (2002, personal communication; ISNA, 2007) tells the following story about a young intersex-identified college student and her visit to her university clinic:

> A college student visited the university clinic for back pain problems. When the doctor discovered that she had been treated for the intersex condition he wrote, in capital letters on her chart, "Ambiguous Genitalia." The student stopped attending the clinic because of the reasonable expectation that she would be treated as a freak.

Atdjian and Vega (2005) further point out that the "discourse on disparities is not an academic exercise but rather a matter of life and death … it is our responsibility to our patients, to our communities and to the pursuit of social justice." This is consistent with the call to arms seen in the work of Witten and Eyler (1999), who point out that transgender violence is a public health problem. These results are further supported by the work of Lombardi et al. (2001) and in a more recent publication by Patton (2006). At the writing of this chapter, transgender-identified persons continue to be murdered for their transgender identification and intersex babies continue to be surgically sexed (ISNA, 2007; see also McGhee, 2003). Given this environment, how can the healthcare system have discourse about a group that is being made invisible by that very system?

This type of dynamic begs the question, "What do members of an invisible minority" (Shankle et al., 2003) do when the very systems of healthcare professionals who profess such a "life & death" viewpoint, simultaneously refuse to recognize/treat these out-group members? Or, if and when they do treat these transgender/intersex-identified individuals, the healthcare experience is perceived by the client as strongly negative, from the care recipient's perspective (Greenberg, 1998; Goodnow, 2000; Witten & Eyler, 1999; Fernandez, 1998; Willigig, 2006a, 2006b). For example, a male-to-female transsexual TLARS survey respondent stated that,

> I obtained an inappropriate surgery because I lied to my M.D. about being a TS. I did this because the last time I told a medical professional (University student mental health counselor) the truth they wanted to institutionalize me.

while a female-to-male transsexual TLAR survey respondent stated that:

> I have experienced a wide variety of abuse. From being beaten and sexually assaulted by a police officer to being gawked at by doctors, dismissed by mental health professionals

Another female-to-male transsexual responded:

> Previously stated at gynecological exams as requirement for testosterone shots – also laughed at by emergency staff – treated unnecessarily roughly and ignored during hospitalization.

Finally, another TLARS respondent reported that,

> Notations re: gender are always disclosed in medical records. Whenever insurance applications are filled out, an authorization for release of all medical records is included. Once the info is disseminated to the insurance carrier, all hope of confidentiality is lost ... providers are not TG friendly.

Transgender Identities and Multiple Marginalizations: Emergent Complexities

We have already established that transgender-identified persons frequently suffer a broad spectrum of life course abuse and violence (ISNA, 2007; Witten & Eyler, 1999; Lombardi et al., 2001; Witten, 2003, 2005). Further, we have seen how these individuals are further marginalized by the healthcare system as they age (Yagoda, 2005; Velkoff & Kinsella, 1998; Witten, 2002; Witten & Whittle, 2004; Cahill et al., 2000). However, these effects can be further exacerbated and confounded by additional life factors. An excellent overview of some of the relevant issues can be found in Cahill et al. (2000). Important factors to consider include such items as *race* (Chadiha, Proctor, Morrow-Howell, Darkwa, & Dore, 1996; Lombardi et al., 2001; Witten & Eyler, 1999), *socio-economic status* (Turrell, Lynch, & Kaplan, 2002; Witten, 2004; Witten & Eyler, 1999), *frailty and functional limitation status* (Burbank, 2006; Kelley-Moore & Ferraro, 2001), *HIV/AIDS status* (Bockting et al., 1999; Earth, 2006; Manfredi, 2002; Melendex et al., 2006; Whipple & Scoura, 1989; Witten & Eyler, 1999), *developmental and physical disability status* (Allen, 2003; Sobsey, 1994), *non-Western cultural status* (Connor & Sparks, 2004; Earle, Bradigan, & Morgenbesser, 2001; Jacobs, Thomas, & Lang, 1997; Kleinman & Sung, 1979; Kulick, 1998a, 1998b; Lancaster, 1998; Teh, 2001; Wikan, 1991; Wilhelm, 2004; Winter, 2006; Witten & Eyler, 2007b), *military status* (Settersten, 2006; AU :9
Witten, 2007b), *physical location* (Butler & Hope, 1999; Goins & Krout, 2006; Willging, Salvador, & Kano, 2006a; Willging, Salvador, & Kano, 2006b), *social network structure and social status* (Everard, Lach, Fisher, & Baum, 2000; Fiori, Antonucci, & Cortina, 2006; Grossman, D'Augelli, & Hershberger, 2000; Holtzman et al., 2004; Kubzansky, Berkman, & Seeman, 2000; Pinquart & Sorenson, 2000; Rautio, Heikkinen, & Heikkinen, 2001; Seeman, Kaplan, Knudsen, Cohen, & Guralnik, 1987), *substance abuse status* (Abrams & Alexopoulos, 1988; Earth, 2006; Ettrich & Fischer-Cyrulies, AU :10
2005; Fixon, 2002; Kausch, 2002; Lawson, 1989; Elason, 2000; Witten & Eyler, 2007a, 2007b), and *prison status* (Earle et al., 2001; Witten, 2007b). One excellent example of the complexities of the multiply marginalized trans-person (Nemoto, Operario, Keatley, & Villegas, 2004; Oggins & Eichenbaum, 2002) is illustrated in the following quotation from the TLAR survey:

> Report from the war zone I was an outreach worker on a volunteer basis with the High Risk Project Society. … Few transgendered women would go into drug rehab programs

> because they were housed with the males. … Sex trade workers are regularly attacked and beaten and a number have died in the last year. More have died of HIV infections than were murdered.

As evidenced by the preceding discussion, successful aging is strongly affected by numerous factors that are negatively mediated by both perceived and actual violence and abuse. Moreover, it is clear, from the presented data that transgender-identified individuals experience a significant amount of perceived and actual violence and abuse throughout their life course.

TRANSGENDER PERCEPTIONS OF HEALTHCARE

Part 2 of the TLAR Study (Witten & Eyler, 2007, forthcoming) asked questions about healthcare needs, utilization, insurance, and problems. It also gave the respondents the opportunity to write in options that were not specified and to provide written supplemental commentary on all questions. Lastly, it asked for a summary comment addressing anything that the respondent felt had not been covered either adequately or at all in the survey.

Primary Struggles with the Healthcare System

The primary respondent issues fell into five distinct areas. It is easy to see why these areas are critical to a population that falls outside of the traditional Western biblical models of sex and gender and why these areas would not necessarily come up for those who fall within the traditional definitions.

Confidentiality

Respondents fear that by going to the medical provider, their "secret" would be out and they would suffer serious ramifications (loss of job, for example). TLAR survey results show that 80% of the FTM respondents express serious concerns regarding medical confidentiality while 48% of the MTF respondents express serious concerns. The more recent VTHIS (2007) results show that 20% of the respondents felt that they were denied their job because of their transgender status or gender expression and 13% reported being fired from a job due to the employer's reaction to their transgender status or gender expression. Thus, the need for confidentiality is central to the transgender life course.

Experience/Qualifications of Healthcare Providers

Most medical practitioners have no idea how to treat the healthcare needs of minority communities in general, and have little to no experience or training in dealing with the needs of the gender community. Some of the survey comments in this area were illustrative of the transgender-identified person's experience with healthcare deliverers:

> Most physicians are clueless

> … I think the physician who prescribes my testosterone knows less than I do about relevant care issues, blood tests, etc.

Need to Educate Provider

It follows as a consequence of the previous item that it is up to the trans-person to train the provider, assuming the provider is willing to treat the client and is willing to be trained by a "non-professional." TLAR survey results showed that 74% of the FTM respondents and 35% of the MTF respondents report having had to "educate" a physician about transgender healthcare in order to receive appropriate services.

Safe Environment

Most medical environments are not safe in that the trans-person risks being "outed" and, as a consequence of that, risks confidentiality and therefore all of the subsequent ramifications of privacy violation:

> I spent about 10 years lying to doctors and getting inappropriate treatment … I was convinced I would be institutionalized if I told the truth. I believe this fear was reasonable and based in real experience. However, since coming out as a TS, I have met several responsible and sympathetic health care professionals. I believe now that if I had told the physician who did my endometrial resection the truth, it might have been helpful, to say the least. I honestly do not know how to reconcile this conflict. I believe my experience is not unique.

Cost/Economics

Since being outed is a significant risk, most trans-persons will not use their medical insurance, even if they have medical coverage. Unfortunately, because trans-related items are typically not covered under insurance, these are considered out of pocket expenses. The large number of low-income respondents support the hypothesis that many members of the gendered population are most likely not on medical insurance and probably cannot afford either the insurance or the out of pocket expenses to obtain their

healthcare needs, much less the added needs of being a member of the trans-population.

> My insurance specifically excludes TS care, so I'm having trouble with money for medical care. Oregon Health plan excludes mental health, so I can't afford therapy, which I need for surgery. I obtained an innapropriate surgery because I lied to my M.D. about being a TS. I did this because the last time I told a medical professional (University student mental health counselor) the truth they wanted to institutionalize me. I had serious complications from the surgery, possibly because I was on birth control pills because I could not get testosterone.

Respondent Healthcare Stories

Some of the most poignant commentary concerning the experience of transgender-identified persons with the healthcare system comes from the respondents themselves.

> There needs to be sensitivity training for hospital personnel in particular re: transgender issues. The greatest fear I have is receiving substandard care in the event of trauma. A list of care providers sensitive to TG patients … would be helpful.

A female-to-male transsexual wrote

> If they have questions, they should ask and not assume knowledge they don't have – they should know that FTMs get yeast infections, etc.

Confidentiality and the consequences of its violation are of major concern to all members of the gender community. Because being transgender-identified is not socially acceptable, the need for invisibility becomes crucial, especially during the early stages of the transition period. As we saw earlier, fear of reprisal and its economic consequences is weighed heavily when seeking out healthcare.

> In considering using health insurance to cover the cost of my surgery I feared I'd lose my job if word got back to my employer.

It is clear that the consequences of viewing the constructs of sex and gender from a Western biomedical model, coupled with the biblical models of sex and gender, gives rise to a total failure of the healthcare community in assessing the needs of both the intersex and transgender communities.

DISCUSSION

As one of the TLAR survey respondents stated:

> Condoned social institutions that foster hate and intolerance should be looked at. They cause much psychological damage as anything. Prevailing attitudes by society need to be changed so that all people can fit in without fear of violence, loss of job/family etc. There is room enough for everybody to live peaceable lives as they see fit.

From a macro-sociological perspective, it is well documented that "health" is intimately tied to position in the power hierarchy. That is, top people live longer than bottom people. Thus, in the scheme of the power hierarchy of all social institutions, including healthcare, transgender-identified individuals are invisible and therefore would be equally invisible in the health hierarchy.

Tightly integrated with this status in the hierarchy or "socio-ecological embedding" is the critical role of early experience in influencing health and well-being over the course of the life cycle. Our research, and the research of others has demonstrated that the transgender community exists in a socio-cultural-political environment that carries with it implicit daily struggles surrounding the issues of perceived and actual violence and abuse. We have demonstrated that the impact of psychosocial, biomedical, temporal-cultural issues all have an impact on the life course of a transgender and/or intersex individual. Moreover, we have shown that these factors impact the generative processes of both health and aging as a human being.

The impact of our previous discussion is not localized only to the current cohort of transgender and intersex persons. It extends into the future generations to come. For example, in 1999, in the United States, the size of the age 65 years and older population was 34.7 million individuals. This sub-population represents approximately 13% of the total population of the United States. There were 4.2 million people who were over age 85 years. The age 65 years and older population is projected to reach over 70 million individuals over the next three decades. Centenarians, individuals 100 years old or more, represent a special component of the aging population. They are the fastest growing segment of the aging population; the second fastest being the 85 plus year old population segment. For centenarians, the current estimate is 50,000–75,000 individuals. This group is expected to reach 834,000 by the year 2050. Moreover, 90% of the centenarians are women and 10% are men. This prevalence rate is approximately the same or a little higher than that of other industrialized countries. Based upon estimates of the demographics of the US population as a whole and of the demographics

of the transgender and intersex populations it is possible to construct a reasonable demographic of the aging transgender and intersex populations. Back of the envelope calculations demonstrates that the numbers of potentially older transgender and intersex persons is not negligible (Witten, 2002, 2003). Furthermore, if we allow for the more broad interpretation of transgender as including cross-dressing, non-surgical, gender queer, and non-Western gender, then these estimates would increase substantially.

Moreover, given the demonstrated preponderance of the lack of medical coverage in all three studies, the VTHIS, the WTNAS and the TLARS surveys, given the large proportions of the population with marginal to no income, given the perceived and actual abuse, violence and marginalization experienced at the hands of the healthcare institution, and given the stigma associated with being transgendered, it is not unreasonable to project that the long-term quality of life and the success at meeting the HP2010 goals will be marginal to non-existent given the current federal policies with respect to the transgender population in general and the elders of that population in particular.

CONCLUSIONS

In this chapter we have presented a study of the impact of invisibility, violence, and abuse, coupled with aging, and healthcare disparity issues for the transgender-identified community. Using the sociological argument of lifespan health effects as mediated by power inequality in the socio-economic/political hierarchy of society, coupled with the inherent violence and abuse suffered by the transgender/intersex community, we have demonstrated that these populations are at risk for significant healthcare-related problems, in a variety of areas; risks that may well exceed those of the "normative" control populations. We have seen how the stigma and social isolation of being transgender-identified leads to significant social isolation and that this isolation, coupled with the generative processes of aging, the concomitant risks associated with the transgender/intersex lifestyle, and the fiscal insecurity associated with these lifestyles are profound covariates with respect to what would be expected life cycle issues for a normative control individual. There are little to no data on international populations, with respect to mid-to-late life aging issues in the transgender and intersex communities (Witten et al., 2003).

Transgender and intersex persons must go through a great deal to survive. Those that manage to live long lives as transgender-identified must have

developed coping and survival strategies that were highly effective in the face of all that is against them. Understanding these coping and survival strategies can potentially benefit the normative population, particularly if these strategies can be extended to any individual in the mid-to-later stages of the life cycle. Understanding how members of the community manage to live fulfilling lives can also help us to better understand the abilities of the human being to deal with complex difficult situations and to resolve them in a fashion that can allow the person to not just simply survive, but to also have a satisfactory quality of life.

The findings from this chapter and the studies therein contained clearly have important and wide-ranging implications for the US and worldwide research community. The non-traditional gender-identity population is a worldwide, non-negligible population and represents an invisible and highly stigmatized and disenfranchised minority that needs to be included in future research efforts. Healthcare institutions must understand that the costs of dealing with such an effort are not as overwhelming as might be perceived (Horton, 2005). Funders must, for example appreciate that research into healthcare minorities, must include populations that are non-traditional and may therefore not fit into preconceived socio-cultural mores. Moreover, these populations can teach us much about what is traditionally seen as the ''normative'' gendered populations.

What is now needed is a deeper understanding of latent assumptions of the healthcare research system and a focus on inclusion rather than exclusion in order to address the marginalization of this worldwide population. Those with the power to change the way in which research is performed should include the implications of what is discussed in this chapter in their efforts to extend to all invisible minorities the inclusion and participation rights that they deserve as human beings.

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Harry Benjamin International Gender Dysphoria Association. (2006); Herek (1989); Herek et al. (2002); ISNA-Intersex Society of North America. (2006); Rubenstein (2004);.

NOTE

1. For all survey quotations, spelling and grammar has been preserved as written.

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AU :11

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To find out more about the TranScience Research Institute, the research being sponsored, conducted, and/or to participate in any of its projects, you may visit the TSRI website at http://www.transcience.org/ or you may reach Dr. Tarynn M. Witten at any of the following email addresses: transcience@earthlink.net or transcience@transcience.org.

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