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Healthcare Experiences of Transgender Mississippians: A Qualitative Study

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Healthcare experiences of transgender Mississippians: A qualitative study

By

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For this study, in-depth, semi-structured interviews were conducted with 16 transgender adults who lived, or had previously lived, in Mississippi and sought healthcare services in the state. The questions asked focused on identifying the barriers to care that these individuals faced as well as the strategies for navigating the barriers they employed. Recommendations for providers were also considered.

DEDICATION

This thesis is dedicated to the transgender Mississippians who made this project possible. Your willingness to share deeply personal, often painful experiences with incredible honesty, openness, and vulnerability is the reason this data exists. Your candor and willingness to help will hopefully help someone else who may be experiencing what you experienced suffer less from lack of access to healthcare than they would have without your insights and recommendations. I cannot thank you all enough.

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Thank you to my mom, without whose unwavering support and unconditional love I could not have made it this far. Love you mama! And to my best friends, Kristie Holler, Melanie Walsh, Amanda (Snarly) Ready, and Lindsey Shaw – without you guys, I couldn't have done any of this. Your support during what was the most trying time in my life is the only reason this got done. When I think back on this time, all the best memories I have will include one or all of you. I love you guys so much! Finally, to my academic advisor Dr. Rachel Allison, whose expert advice, patience, and support have made this project a reality. Thank you Dr. Allison!

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

This thesis project is motivated by literature showing that transgender individuals and individuals living in rural areas frequently experience difficulty accessing health care providers and receiving competent, quality care. Recent research estimates the United States' transgender population at 0.6% of adults, or about 1.4 million people (Flores et al., 2016) and indicates that transgender individuals are more likely than cisgender individuals to live in rural areas (Crissman et al., 2017). Transgender individuals experience discrimination due to their gender identities in a wide variety of settings, and healthcare is no exception. As a result, data reveal that transgender individuals have poorer health outcomes compared to cisgender (please see appendix for definitions) individuals. There is a significant amount of literature that consistently shows these patterns of discrimination and poorer health. What does not currently exist in the literature is research on the experiences of transgender individuals seeking healthcare in the American South, specifically Mississippi. This project seeks to understand the challenges that transgender people experience in accessing and receiving healthcare in Mississippi, as well as the strategies employed to access and receive quality care in a largely rural state.

CHAPTER II

LITERATURE REVIEW

State of Trans Health: Mental Health

The mental health of transgender individuals is a consistent subject of intrigue in medical and social science research. Significant psychological and psychiatric research has been devoted to comparing trans individuals to cisgender people, with results indicating substantial mental health disparities. In particular, transgender people report higher rates of depression, anxiety, and a host of other mental health conditions. People with gender dysphoria score lower on scales measuring satisfaction with life and psychological well-being than do non-dysphoric individuals (Rabito-Alcon 2016). Results from the largest survey of transgender Americans to date revealed that an astonishing 41% of transgender people report at least one suicide attempt in their lifetime, compared to 1.6% of the general American population. Additionally, 26% of trans people surveyed reported abusing alcohol and/or drugs *specifically* to cope with stress related to the discrimination experienced due to their gender identity and expression (Grant et al. 2011). Poor mental health is linked to and can indeed lead to poorer physical health, and vice versa (Ohrnberger et al. 2017). Despite a lack of data on the physical health of trans individuals, it is not unlikely that trans persons may experience poorer physical health than do cisgender individuals, as it correlates with poorer mental health.

State of Trans Health: Sexual Health

Trans individuals, particularly trans women of color, are at a higher-than-average risk for contracting HIV and AIDS (Garofalo et al. 2006, Nuttbrock et al. 2009), often due to engagement in sex-for-work, illicit drug use, and needle-sharing behaviors, tying into their higher experienced rates of poverty, homelessness, poorer mental health, lack of social support, unemployment and underemployment. Through a systematic review of behavioral literature, Herbst et al. (2008) found that HIV infection estimates for trans women ranged from 11% to 28%. Black trans women had higher rates of HIV infection than did Latina or White trans women.

Though less information on trans men's sexual health and HIV rates exists, Herbst et al. found low prevalence rates of HIV infection within the population. However, trans men are more likely than trans women to engage in risky sexual behavior (Kenagy and Hsieh 2005) and report having significantly less protected sex than trans women (Clements-Nolle et al. 2001). Trans men who have sex with men are at an increased risk because, coupled with less protected sex, they also have more kinds of sex than do trans women (Bockting et al. 2005). Further troubling the factor of trans men's increased risk, trans men are less likely than cisgender women and other individuals with cervixes to receive routine cervical cancer screenings (Peitzmeier et al. 2014). Trans men who only had sex with women were even less likely to receive screenings than bisexual or gay trans men.

Barriers to Care: General

Reliable access to quality health care is important for the physical and mental well-being of all individuals. Social, economic, and legal barriers often complicate the

path to receiving and maintaining access to quality medical care. There are many such obstacles, including lack of affordable insurance, geographic barriers, financial barriers, racial discrimination, and learned distrust of medical professionals (Tajeu et al. 2015, Rondini 2015). These and other factors play into one's ability to access competent, quality health care and to be treated respectfully by providers. Accessing knowledgeable, respectful care may be difficult for individuals for any number of reasons but it is often particularly difficult for transgender people.

Barriers to Care: Unique

Coupled with the barriers to accessing quality health care that often affect cisgender people, transgender individuals often encounter significant amounts of stigma and discrimination due to their heavily politicized, and frequently misunderstood, gender identities. This is unfortunate because healthcare is uniquely important for many individuals in the transgender community who must seek care to assist in their medical transitions. Transgender individuals often must seek healthcare that is specific to their trans identities to receive diagnoses of Gender Dysphoria, which is typically a precursor to accessing hormone replacement therapy and receiving gender-confirming surgical procedures (Coleman et al., 2012). Trans individuals often enter these points of contact with medical providers unsure if care will be provided to them and, if it is, what the quality of the care will be. Frequently, transgender individuals are refused care directly due to their gender identity (Grant et al., 2010).

Barriers to Care: Discrimination & Refusal of Care

The National Transgender Discrimination Survey (NTDS) (2011) found that 19% of the individuals in a sample of 6450 were refused medical care because they were transgender, with even higher percentages for some people of color. The percentages of service denial were lower for whites and Asians at 17% and 15%, respectively. For non-Asian trans patients of color, these rates are consistently higher, with American Indians and multi-racial respondents reporting the highest rate of care refusal at 36% and 27% (Grant et al., 2010). There are several high-profile cases of transgender people dying due to lack of medical treatment. One such case was Robert Eads, who died of ovarian cancer in 1999 after being refused to be seen by over 20 doctors, one of whom said that having ovarian cancer would make Eads "deal with the fact that he is not a real man."

Unfortunately, cases in which transgender people are denied medical care are not anecdotal or few and far between – data collected in a San Francisco study revealed that 39% of FTM participants and 13% of MTF participants experienced significant difficulties or were denied medical services due to their gender identity (Clements-Noelle et al. 2001). In Philadelphia, PA, 26% of respondents reported being denied health care and 52% reported significant difficultly obtaining care in the last year (Kenagy 2005). In Virginia, a study showed that 41% of the 350 respondents reported discrimination related to their gender identity in at least one of the following areas: housing, employment, and health care; health care discrimination was the most common at 27% (Bradford et al. 2013). Reflecting broader trends in society, trans individuals who have less income and are persons of color are subject to an increase in more types of discrimination experienced (Bockting 2013). While exact percentages of trans people who are refused

care vary across studies and by demographic variables, existing data consistently show a troubling trend in the health care industry's treatment of these individuals.

Barriers to Care: Institutional Considerations

Bauer et al. (2009) conducted focus groups with 85 trans individuals in Ontario. These data revealed familiar patterns in participants' concerns about health care including financial barriers, difficulty accessing trans-inclusive health care, experiences with transphobia, among others. In addition to these concerns, this study contributes to knowledge surrounding the forms of erasure trans individuals encounter. Bauer et al. focus their analysis on trans individuals' experiences of informational and institutional erasure. Informational erasure included concerns about lack of widely accessible health care information about trans people due to the presumption that is does not exist or is not needed. Institutional erasure included concerns about the absence of policies and procedures to accommodate trans people in health care settings. The most basic example of institutional erasure this is the format of the form one fills out upon arriving at a new doctor's office, with the "gender" options being either "male" or "female." Either box a trans person checks, when it comes to coding for insurance, neither is necessarily appropriate for the specific health care needs they may have.

Dewey (2008) conducted interviews with 22 trans individuals as well as engaged in participant observation with three trans organizations over the course of one year. Her analysis identifies ways in which participants identified and internalized societal views about people like themselves through interactions with medical providers, as well as reflexive adjustments to the way in which they presented their medical needs in future encounters. Dewey contributes to the research by identifying the ways in which trans

patients both challenge and support conventional medical knowledge. They challenge it because they exist outside of the gender binary and require certain related care but support it because they must work with people and rationalize within a system that currently does not have a place for them. Citing a diagnosis of Gender Identity Disorder to encourage a hesitant doctor to prescribe cross-sex hormones is an example of a way in which a trans individual may support conventional medical knowledge in their search for health care.

Barriers to Care: Provider Knowledge

Even when trans persons are able to locate health care providers who are open to working with them, those providers may not be knowledgeable about trans-specific health care. This lack of knowledge is largely attributed to a complete lack of required medical training on transgender health (Vance 2015, Snelgrove 2012, Vanderleest & Galper 2009). Qualitative analysis of responses from trans patients revealed that even if they were not denied treatment, they were still at risk for mistreatment in the form of gender insensitivity, or providers acting uncomfortable with them, substandard care, verbal abuse, and forced care (Kosenko et al. 2013). Additionally, providers may unwillingly create an uncomfortable environment for their trans patients if they are uninformed about important interactive behaviors such as sensitivity to preferred names and pronouns. Due to the apparent state of healthcare access for many transgender individuals, it is unsurprising that there would be increased apprehension and feelings of concern when considering accessing care.

Barriers to Care: Anticipating Discrimination

Because of the known potential for experiencing discrimination in healthcare settings, transgender individuals frequently anticipate mistreatment, leading to heightened perceptions of stigma in medical encounters, and may even avoid accessing care altogether. Indeed, 28% of respondents to the NTDS reported postponing seeking medical care due to fear of encountering discrimination. This anticipation of discrimination leading to hypervigilance and emotional exhaustion, identified as *paranoid cognition* by psychologists, has been shown to be negatively related to transgender employees' job satisfaction and is positively associated with emotional exhaustion and turnover intentions in the workplace (Throughgood et al. 2017). It is plausible that such perceptions affect healthcare experiences for this population as well.

Educational & Physicians' Barriers

Of those trans individuals who responded to the NTDS, 50% of those who did seek and receive healthcare reported that they had to teach their doctors about transgender healthcare needs (Grant et al. 2011). While direct discrimination against transgender patients is certainly a concern, the glaring lack of trans-specific healthcare training and education puts even the healthcare providers who want to help in a bind. One study using survey data that polled pediatric endocrinologists found that 47% of providers felt confident providing care to trans youth, despite 66% reporting that they had provided care to trans youth during their careers. A lack of training ranked as providers' primary concern and hindrance when feeling confident about treating trans clients. Exposure to trans patients, availability of mental health providers for referral, and issues with insurance reimbursement were also identified as barriers (Vance 2015).

Trans healthcare has largely been left out of medical training, though an evaluative study conducted in Arizona indicated that medical professionals felt significantly more comfortable and knowledgeable about treating transgender patients even after brief trainings on trans health. By showing the effectiveness of brief training interventions, which raise medical professionals' confidence regarding trans medicine and appear to dispel some negative attitudes about trans people, the authors make a case for inclusion of trans health data in undergraduate medical training curricula (Vanderleest and Galper 2009).

While trans patients obviously face challenges accessing quality care, physicians also face barriers to medically providing for trans patients at multiple levels. A qualitative study investigating physicians' barriers to providing healthcare to these patients identified barriers at informational and institutional levels (Snelgrove 2012). The authors identify transphobia as the starting place for discrepancies in health care access and provision to trans patients. A general lack of knowledge and training about trans care in the medical community furthers this ability to be ignorant. Additionally, policies at the structural level that allow for the inclusion of trans patients are typically absent. Insurance coding and sex-segregated medical spaces are two primary sources of stress or trans patients and their providers. This lack of knowledge coupled with little room for trans patients in a binary sex coding system leads to a general pattern of erasure within medical contexts. Treating patients whose legally listed sex categories may not conventionally align with certain procedures (e.g. androgen therapy, hysterectomy, prostate exam) also creates a bind for providers, who lament about working within the context of "two-gender medicine." Providers who participated in the Snelgrove study relied on 4 strategies to

circumvent the lack of trans health knowledge: physician support networks, explorative interest (in trans medicine), clinical guidelines, and listening to the trans patient for care advice.

Physicians working with transgender patients within a system of "two-gender medicine," as Snelgrove (2012) discusses, face challenges when billing for insurance purposes. Insurance companies code certain procedures as "male" and "female" procedures and, in an attempt to eliminate fraud and coding errors, will reject claims that do not "match." Additionally, if a patient is legally listed as one sex and their doctor writes down that they are a different sex (even if this is more in line with their identity), this can cause billing errors and reimbursement rejections (Snelgrove 2012). In these cases, communication between doctors and their patients is critical. Interview participants in preliminary research reported that doctors they trusted would code "creatively." For example, one transgender man who is listed as legally male saw a urologist to adjust his hormone replacement therapy. In order for his insurance to cover the laboratory testing and visit, the doctor coded his visit as being for "hypogonadism." Another example is when an older trans woman, who is legally listed as female, saw a doctor to receive prostate cancer screening. She discussed the complications she had with billing in the past and her doctor agreed to code the procedure as a general wellness check.

As briefly mentioned above, trans individuals who wish to physically transition must, by necessity, seek assistance from medical providers to begin any step of a medically assisted transition process. Trans individuals are typically required to obtain a letter from a licensed mental health provider before being granted access to hormone replacement therapy or accessing gender-confirming surgeries (Coleman et al., 2012).

This is not a legal requirement, but a practice that serves to protect health care providers who prescribe hormone replacement therapy from the possibility of legal ramifications – anyone who has the authority to write prescriptions and deems it medically necessary could legally do so. Some clinics that specialize in trans health care provide an "informed consent" option where the patient is briefed on any risks and signs a waiver before beginning HRT. Not all persons on the trans spectrum seek hormone replacement therapy or gender-affirming surgeries, but for many these medical interventions are considered necessary for their well-being.

Barriers to Care: Rurality

Depending on where you live, finding a mental health provider to write a letter recommending hormone replacement therapy can be a costly, time-consuming process that may require traveling great distances. While large cities often have clinics specifically for the transgender population, individuals in many areas of the United States are geographically distant from any such resource. Because Mississippi is a largely rural state, the effect of rurality in addition to gender identity-based discrimination must be considered. Details specific to Mississippi, such as demographics of individuals living in rural areas, will be addressed in the section entitled "Mississippi," see also the section entitled "Health Outcomes: Community Context Effects."

Some survey data indicate that mental health care disparities, particularly heightened levels of anxiety, do exist between urban and rural trans persons, with the effect of rurality being particularly negative for trans men (Horvath 2014). Survey data that analyzed primary health care utilization among LGBT rural populations found that transgender and non-binary individuals are more likely to anticipate stigma in medical

encounters. The anticipation of stigma within these groups is associated with reduced PCP utilization compared to cisgender LGBQ individuals (Whitehead et al. 2016). Transgender and non-binary individuals were also found to be nearly three times more likely than cisgender respondents to report traveling an hour or more to see a primary care provider (Whitehead et al., 2016, p. 8).

Accessing healthcare in rural areas is not a challenge specific only to trans individuals. Individuals living in rural areas are more likely than their urban-living counterparts to be uninsured, uneducated, and have lower incomes – all factors which are associated with low utilization of healthcare services (Casey et al. 2001, Shur & Franco, 1999). Probst et al. (2004) report that 65% of rural counties experience healthcare professional shortages, with that percentage increasing to 83% when those counties are majority African-American. Because of these healthcare professional shortages, residents of rural areas are significantly less likely than residents of urban areas to access preventative health care (Casey et al. 2001). In addition to provider shortages, residents of rural areas report challenges accessing preventative care due to factors including lack of insurance coverage, cost of care, and travel distances (Casey et al., 2001).

Barriers to Care: Gatekeeping

Even when individuals have the resources to travel to gender clinics, their options for treatment are at the discretion of the mental health provider. Mental health providers are often the gatekeepers for hormone access. Reasons for denial may be arbitrary and not linked to patients' gender identity at all but rather a provider's personal "ethic of body modification," an ethic specific to trans health decisions that rests on the various biases of the provider. These ethics, subjective by provider, may rest on the perceived

quality and social appropriateness of the gender performance by the individual seeking care (Whitehead and Thomas 2013). Guidelines for treatment of trans people are irregularly enforced. However, care guidelines for transgender patients do exist and are easily accessible, the foremost of these being the World Professional Association for Transgender Health (WPATH), but it is up to providers to seek out and implement them.

Finding a provider to write a prescription for cross-sex hormones even after obtaining a letter from a mental health provider is not guaranteed to be an easy process. A recurring experience of trans clients identified early on in this research project was provider hesitation to write prescriptions for hormones, even if the client had been successfully taking them for many years. The conceptualization of medical professionals as "gender gatekeepers" with the power to arbitrarily allow or deny individuals' personal trans-specific health care choices is prevalent in literature concerning interactions between trans patients and their health care providers (Davis et al. 2016, Speer and Parsons 2006, Whitehead and Thomas 2013). This practice of gatekeeping may or may not be rooted in provider stigma.

Poteat et al. (2013) conducted a qualitative study with trans patients (N = 55) and providers who serve trans clients (N = 12), focusing their inquiry on the ways in which stigma functions in healthcare encounters. They found that providers may consciously or subconsciously use stigma to manage uncertainty's threat to their medical authority. Providers may feel threatened when they do not understand terminology related to their trans clients' medical needs and may position the trans patient as inherently problematic. In contrast, some providers may attempt to guard trans patients from stigma and discrimination. Providers who are members of the LGBT community and those who felt

personally connected to trans people were more likely to engage in protective behaviors and resistance to stigma (p. 27).

Establishment of authority, structural and institutional stigma, as well as uncertainty and ambivalence were considered in this study. When considering the establishment of authority, the researchers found that a provider's medical authority is typically anticipated by both parties in the health care encounter. However, due to the lack of medical literature and training about trans health, providers are often unsure about providing care to trans patients. Trans patients also anticipate the likelihood of this lack of competence and know they may have to supplement provider knowledge. Considering structural and institutional stigma, researchers found that providers perceive trans patients as having been "pushed around," which leads to increased maladaptive behaviors and mental illness. These factors often lead providers to understand trans patients as "difficult to deal with" (p. 26)

Looking at uncertainty and ambivalence, Poteat et al. found trans clients often anticipate that providers may not only be ignorant to how to medically assist them but also may be uncomfortable with them as individuals who violate social norms. Within the medical encounter, there is a lot of room for awkwardness, substandard care, and unhelpful approaches to addressing the needs of a trans patient. Trans patients express exasperation about having to train their providers about care, making the argument that they should already know how to care for them. Most (all but one) of the medical providers in the study expressed uncertainty and feelings of unpreparedness when treating trans patients. Some providers struggled to accept their patients transitioning all together (p. 27).

Positive Health Outcomes

Though the evidence for poorer health due to trans-related stigma and discrimination is staggering, there are also data which indicate that there are many beneficial and ameliorating factors which lead to increased resilience, leading to more positive mental and physical health outcomes for transgender individuals (Stieglitz 2010). In a study concerning prepubescent transgender children who have parental support and have been allowed to transition, researchers discovered no significant elevation in levels of depression or anxiety compared to cisgender children (Olson et al. 2016). Even two decades ago, studies showed that beginning the physical transition process prior to adulthood results in more favorable post-operative physical and mental health outcomes (Cohen-Kettenis & van Goozen 1997, de Vries et al. 2011). Even when transitioning later in life, having access to a provider who practices transgender-inclusive healthcare is associated with decreased levels of depression and suicidality (Kattari et al. 2016).

Existing qualitative studies with transgender individuals focusing on health care give important insights. Roller et al. (2015) conducted interviews with 25 trans individuals and identified ways in which they navigate the health care system. Results were heartening in regard to trans patients' agency and emergent themes included 1) moving forward: finding a health care provider that is knowledgeable about trans issues and makes the patient comfortable 2) doing due diligence: going the extra mile to find good providers even when they are quite difficult to find, 3) finding loopholes: finding pathways to successful treatment and insurance billing in a system that is built with expectations of gender/sex alignment (e.g. coding a transwoman's annual prostate exam as a general physical so insurance will cover it), and, relatedly, 4) making it work: the

ways in which these individuals persisted over time so that their health care needs were met.

Research considering the link between openness about one's sexual and/or gender minority status and well-being indicates that LGBT youth who are "out" to others about their identities have increased levels of self-esteem and lower levels of depression. Despite this increased sense of well-being, greater levels of 'outness' are also associated with more experiences of victimization, including verbal harassment and physical assault (Kosciw et al. 2015, Stieglitz 2010).

Health Outcomes: Community Context Effects

Community context plays a role in the experiences of outness for LGBT youth. Community size is negatively associated with psychological distress for trans individuals (Bockting 2013). While rural LGBT youth are as likely as urban and suburban youth to be out, they experience a significantly greater risk of victimization and severity of victimization due to their outness than do LGBT youth living in other community contexts. Despite this increased risk, data indicate that the mental health benefits of being out moderate the negative effect of increased victimization experiences for rural youth (Kosciw et. al 2015). Due to a lower population density and decreased social diversity in rural areas, it is likely that LGBT youth living in rural contexts may find fewer LGBT peers with whom to associate. Youth in these community contexts may also experience difficulty organizing and finding resources locally, constraining them to finding connection with other sexual and gender minorities through means such as the Internet (Gray, 2009). This may be an unfortunate side-effect of rurality, as increased contact with other LGBT individuals has been shown to increase well-being for transgender

individuals.

Survey research from Bockting (2013) indicates that having social support and trans identity pride helps to ameliorate negative mental health outcomes. Budge et al. (2013) find that increased social support reduces levels of anxiety, which are particularly prevalent in the transgender population. While internalized transphobia is significantly linked to mental distress and decreased self-esteem (Austin & Goodman 2017), regular interaction with other LGBT individuals is associated with less anxiety and decreased suicidality, particularly when the interaction is with others who are transgender or otherwise gender nonconforming (Testa, Jimenez, and Rankin 2014, Bariola et al. 2015). One qualitative study focusing on trans youth identifies 5 "themes of resilience:" 1) ability to self-define and theorize one's gender, 2) proactive agency and access to supportive educational systems, 3) connection to a trans-affirming community, 4) the reframing of mental health challenges, and 5) navigation of relationships with friends and family (Singh, Meng, & Hansen 2014).

Having higher income, being White, and identifying as heterosexual are also factors associated with increased resilience (Bariola et al. 2015, Bockting 2013). These factors are unsurprising, as higher income, whiteness, and heterosexuality provide considerable social privilege in a capitalist, racist, and heterosexist society such as the one that exists in the United States. Relatedly, having a physical appearance that is visually congruent with one's expressed gender identity is associated with increased mental health (de Grift et al. 2016). In addition to the differential physical effects of hormone replacement therapy and natural variances in appearance, having higher income can directly determine the level of visible gender congruence a trans person may be able

to realize through financial access to gender-affirming surgeries such as FFS (facial feminization surgery) and "top surgery" (the masculinization or feminization of the chest).

It is worth mentioning that the gendered physical characteristics most associated with distress in trans individuals are those that are readily apparent to others (e.g. Adam's apple for trans women, breasts for trans men), and less associated with, as one might assume, one's genitals (de Grift et al. 2016). This indicates that social and physical markers of masculinity and femininity are of great importance due to their ability to allow or disallow trans individuals to maneuver through their daily lives with less visual stigma. Indeed, a study in which cisgender, heterosexual college students evaluated the faces of hypothetical transgender individuals found that the more gender-congruent faces received significantly more positive evaluations (Gerharstein and Anderson 2010). Gender nonconforming trans people have also been shown to experience significantly more discrimination than do individuals with gender-congruent presentations, leading to increased rates of engagement in "health-harming" behaviors such as suicidality and substance abuse (Miller and Grollman 2015).

CHAPTER III

THEORETICAL CONSIDERATIONS

Gender is imbedded not only in individuals, but in virtually every aspect of social life. Gender, and our ways of thinking about it, are so deeply embedded in our consciousness that it can be disturbing to challenge what largely has remained unquestioned. What has largely remained unquestioned is that biological sex determines gender, a social "fact" that trans individuals contest. When these social facts are challenged in settings such as the medical industry, there are implications at multiple levels. A helpful way of considering unpacking the complexity of gender, and all its implications, is to view gender as a social structure. Risman (2004) argues for a conceptualization of gender as a social structure that operates, and is embedded in our society, at three levels: the individual, interactional, and institutional.

While gender is a powerful structure that coerces individuals into often divergent social roles, Risman notes that these roles are also chosen by individuals with agency, perhaps not always in the same direction that the institutions which effect their lives are pushing them. Those who go against structure are not immune to its effects – indeed, social expectations and censure at interactional levels punish those who violate norms. Trans individuals are perfect examples of agenic actors going against many institutional pressures through the process of confirming their identities. At this site, Risman argues we must pay attention to the decisions of the actors in society. She urges researchers to

pay attention to the complexity with which gender operates, asking for attention to the ways in which people do gender, unintentionally do gender, or refuse to do gender, and all the implications of those choices. This attention to agency cannot be separated from structure and, though it may influence it or be influenced by it, the critical point is to identify and consider the consequences. Risman calls for the identification of processes that explain gendered outcomes. This would then allow for detrimental processes to be changed and positive processes to be emulated. Cognitive bias is a social factor that she urges us not to forget as a factor that shapes lived experiences, but may be moderated through exposure and programs. The cognitive bias against trans individuals is also moderated by trans individuals' ability and/or desire to have a visual and performative gendered embodiment that is socially acceptable.

As discussed in the section on positive health outcomes, having a gender presentation that is congruent with one's gender identity has been shown to reduce negative mental health outcomes and experiences of discrimination in daily life. The goal of embodying one's gender in a socially acceptable and successful way, or "passing" as cisgender is a significant goal for many transgender individuals. Not only does it provide congruence between one's internal and external experience, it provides social privilege to be identified as cisgender, or to be *cis-passing*.

Raewyn Connell (2009) explores trans women's social accountability to their gender performance and presentation of femininity by reasserting the core argument of West and Zimmerman's (1987) "doing gender:" that the gender dichotomy is the *effect* of doing gender, not the foundation of it. Connell argues that trans individuals do not have a gender identity problem, rather the problem is getting others to recognize that gender. To

get people to acknowledge this identity, trans people have to perform it for them. They also, by necessity, must interact with the medical industry. This accomplishment of gendered embodiment, or "passing," is much more the priority of doctors in her treatment than the trans women. Having a "cure" for gender identity that allowed trans women to socially disappear and integrate into society with a cisnormative appearance was a powerful answer to the social pressures doctors were facing for treating them.

Trans people, Connell argues, make visible what culture has made invisible: the social accomplishment of gender. The "site" of transformation, the trans body, therefore threatens what has been constructed as natural difference between males and females, a construction which informs much of how our society operates. With "passing" often situated as the ultimate goal, we only further make invisible the nature of gender performativity. Recognition is currently based on one's embodiment of gender, which indicates biological sex in a cissexist society. Therefore, the problem is not anyone's gender identity but rather the ability of that identity to gain recognition from others through dominant embodied ways of doing gender. Connell argues that through solidarity in educational and political efforts, trans women can change the conditions of individual accountability, the process that currently produces an appearance of "naturalness" in gendered interactions. Instead of reifying the binary performances of gender through normative embodied transitions, it could be the very site that assists with its deconstruction.

Because gender orders are formed and reformed over time, Connell situates trans as a site of renegotiated gender configurations (2012). At this site, through social practice, trans people are bringing a new social reality into being over time. Connell

discusses how, in the neoliberal economic climate of the 1980s, trans medicine in the form of physical transition shifted from being a tightly-controlled publicly-supplied service to the global private medical sector. Thus, trans medicine, and those who receive it, became informed by class and global inequality rather than just patriarchal gatekeeping practices. Connell argues that transition is inherently traumatic – an otherwise healthy body is not made healthier by these procedures, though medical ethics justify the procedures as they relate to gains in mental health. The real goal of these procedures, she argues, is to allow life, primarily social life, to continue in a society that demands an embodiment that "matches" identity.

The ontoformative character of gender, Connell argues, is crucial for understanding trans women's lives. Connell points to the long list of contradictory gendered embodiments that anyone can face (e.g. femininity and disabled women). Trans women, she argues, are a hot topic because their lives involve the "most severe" of contradictions of social embodiment. While there are multiple narratives of trans women's embodiment (the most common "being stuck in the wrong body"), in all cases, the experience of contradictory embodiment is central: knowing one is a woman despite having a male body. Embodiment, and the recognition that precedes and proceeds it, is central. First, a trans woman recognizes herself, then she must do something to have others recognize her. This contradiction of recognition and embodiment must then be "handled." For trans women, this contradiction often creates significant terror and ambivalence about what to do – moving towards transition is an attempt to end the ambivalence and achieve a "settled" embodiment. Connell argues that feminist social science is indeed the most vital resource for an understanding of transsexuality and a

rethinking of the politics that surround it. Trans women are more than identity projects: they are social actors who must engage with social institutions, including the patriarchal state, the economy, the family, and the medical industry.

CHAPTER IV

MISSISSIPPI

With an estimated transgender population of 13,650 (Flores et al., 2016), Mississippi is a unique and important site for research as it relates to transgender individuals and their health. This research assumes that Mississippi exists in a culturally distinct (though not monolithic) region; one which has the potential to influence the knowledge, biases, and lived experiences of both health care providers and their transgender patients. This research seeks to understand the experiences of persons marginalized by their gender identity in a conservative social climate in a largely rural state that has health care outcomes recognized as subpar and disparate by race and class (El-sadek et al., 2015).

At 83%, the vast majority of adults in Mississippi identify as Christian, and 41% of those identify as Evangelical Christians (Street et al. 2015). Of white evangelicals surveyed, 84% believe that whether a person is a man or a woman is determined at birth and 61% believe that society is too accepting of transgender individuals (Smith, 2017). Unsurprisingly, previous studies have indicated that individuals' negative attitudes towards transgender people increase with higher levels of political conservativism (Norton & Herek 2012) and religious fundamentalism (Nagoshi et al. 2008). Political conservativism and religious fundamentalism are frequently defining features of social life in Mississippi. Due to these patterns of religious affiliation, being transgender in the

South creates a unique juxtaposition of a relatively small, marginalized, and controversial population seeking health care that requires treatment which may go against the political and religious convictions of those providers from whom they seek the necessary care. While the social and political landscapes relevant to transgender people are beginning to change in more progressive areas of the United States, with some states offering employment and housing protections based on gender identity and 17 states offering at least some protections regarding health insurance, the state of Mississippi offers no such legal securities. Just one city, the capitol city of Jackson, has an ordinance prohibiting private employment discrimination based on gender identity – the only currently existing legal protection for transgender people in the state.

Mississippi is a state infamous for being resistant to social change and where discrimination is characterized, at least by much of the rest of the country, as its most defining feature. In April of 2016, Republican Governor Phil Bryant passed House Bill 1523, otherwise known as the "Religious Liberty Accommodations Act," which legally protects individuals who hold various religious beliefs, including that marriage should be between one man and one woman as well as the idea that "male (man) or female (woman) refer to an individual's immutable biological sex as objectively determined by anatomy and genetics at time of birth," H.B. 1523 (2016). The bill's language has been critiqued as vaguely written and has been widely interpreted as the legalization of state-sanctioned discrimination against LGBT individuals.

Drawing from the work of Foucault (1975), sociologist Bernadette Barton conceptualizes the Bible Belt as a panopticon, where conservative Christian beliefs and values are an ever-present figure of power and control, consistently present in popular

symbolism and shaping much of social life (Barton 2012). This ever-present ideology permeates through many social interactions and often compels sexual and gender minorities to police their expression and behavior so that it is 'suitable' to their environment. Simply existing as a transgender person goes against the expectations of this environment. This "Bible Belt Panopticon" effect may have a particularly negative influence on trans Mississippians that could lead to increased rates of postponing seeking medical care and poorer mental health due to feelings of social isolation and stigmatization from the dominant ideology. Research has shown that the risk of trans individuals postponing or refusing to seek medical care increases by four times when they must teach their providers trans-specific information (Jaffee, Shires, and Stroumsa 2016); it is reasonable to anticipate that the likelihood of having such fears and/or experiences would be increased in a low-population, rural, conservative region such as Mississippi that has few resources for gender variant individuals. Additionally, the state's legal climate, which lacks protections based on gender identity while protecting individuals who discriminate against LGBT persons based on religious beliefs, may exacerbate the risk of trans patients' rejection and/or mistreatment by providers.

CHAPTER V

METHODS

Contribution

In the current political, social context, trans bodies are becoming more visible sites for both progressive and regressive political agendas. Recent examples of anti-trans legislation include the Trump/DeVos-era Department of Education's reformed stance on the interpretation of non-discrimination by sex under Title IX, which, under the Obama administration, included the gender identity of transgender students. The Department of Education has also made the decision to stop taking cases in which transgender students allege discrimination regarding bathroom use. Relatedly, several states have implemented anti-trans "bathroom bills," making it illegal for individuals to use the restroom that does not align with the sex designated on their original birth certificate. The most well-known of these bills is the "Public Facilities Privacy & Security Act" or House Bill 2 in North Carolina, which was eventually rescinded due to its negative impact on the state's reputation and economy. Additionally, President Trump has directly called for the United States military, thought to be the single largest employer of transgender Americans (Gates & Herman, 2014), to no longer allow transgender members to serve in any capacity. Directly tied to health research, staff at the Center for Disease Control and Prevention were told not to use the word "transgender" in official documents, along with other words including "vulnerable," "fetus," and "science-based." Particularly concerning

to trans individuals seeking healthcare is the Department of Health and Human Services' recently-opened "Conscience and Religious Freedom Division," housed under their Office of Civil Rights, which will advocate for discrimination by health care providers who choose to deny care by citing religious or moral reasons. In light of these developments, making contributions to the study of trans health though social science with a progressive, feminist orientation is a critical and particularly timely pursuit. By reviewing existing data on trans health, it is clear that there is significant room for additional knowledge creation in this area.

Much of the existing data on transgender individuals comes from public health initiatives and academic health research that employs survey data. Existing qualitative data frequently focuses on the perspectives of the providers of care rather than its recipients (Carabez et al. 2016, Speer and Parsons 2006, Whitehead and Thomas 2013). While these data are beneficial for understanding the broader scope of the state of transgender health care and the perceptions of trans patients by health care providers, the individual voices of trans people are at risk of being lost and reduced to a generalized, disheartening picture of everything that is going negatively for them. Qualitative excerpts from a study on trans women's HIV risk behaviors indicates that these women experience frustration about health researchers heavy, often exclusive focus on HIV/AIDS. These women cited other problems, such as joblessness, homelessness, and fear of gender-based violence as critically important to improving health outcomes for the population (Garofalo 2006). In response to the overwhelmingly negative focus in trans health care research, researchers have called for a shift in focus to ameliorating factors and resiliency in trans populations (Stieglitz 2010, Bockting 2013).

This research project, while acknowledging the disparities that exist for trans people, looks not to just document experiences of discrimination but also to uncover the individual stories of resilience that can only be properly represented when individuals' experiences and insights are heard. Qualitative sociological studies concerning the health care experiences of transgender individuals are currently few in numbers – with much of the existing data on the experiences of transgender patients coming from disciplines such as nursing, public health and psychology. With this research, though a sociological lens, I look to uncover the unique challenges and triumphs transgender Mississippians experience in their search for quality healthcare in the Deep South and identify ways to improve provider knowledge, accessibility, and quality of care for transgender Mississippians in the future. To do so, this project addresses the following research questions: "What challenges do transgender Mississippians face in accessing and receiving healthcare?" "How do transgender Mississippians navigate these challenges?" and "What strategies do transgender Mississippians use to access quality care?"

Ontological & Epistemological Considerations

Ontology is the study of existence and focuses on the discovery of *what* there is to be known (Burr, 2003). Epistemology, as defined by Burr (2003), is 'the study of the nature of knowledge and the methods of obtaining it,' in other words, *how* we create knowledge through various research methods. This research design was developed based on an interpretivist epistemology with a feminist orientation (Harding 2004). The knowledge generated from the interviews and interview analysis will be situated representations of the trans Mississippians' understandings of their interactions and experiences with health care. It will also include the generation of my own

representations of their responses – Are there topics they avoid? Are there particular conversations or topics that seem to make them uncomfortable? The importance of being critical and sensitive to the relationship between saying and doing cannot be overstated (Khan and Jerolmack 2013). Consistent reflexivity during the entire data collection and analysis process will be paramount to the generation of rigorously developed themes.

The ontological assumptions underlying my conceptualization of gender are largely in line with West and Zimmerman's doing gender theory, which posits that gender is "produced" during interactions. I understand gendered social traits and understandings of self to be imperfectly distributed, along a spectrum, and highly exaggerated in the process of "doing gender" in socially acceptable ways. In the same way that all males are not taller than all females, any "natural" gendered traits may *tend* to occur, but are not necessary to be a man, woman, or nonbinary. To summarize, my ontological assumption of gender is that neither socialization nor biology may fully explain why someone is a certain gender and no one gender category can fully describe any individual within it. Like Lane (2016), I call for a "biopsychosocial" approach to understanding and researching transgender individuals – one that blends biological and psychological understandings of gender with socialization research, allowing for the conceptualization of trans persons' "gender development as an intertwined biological and social process of transformation" (189).

As a feminist researcher, I will also include considerations of my own situatedness as it relates to the data production at the interview site. Because I am a white transgender man doing academic research, I must be aware that the trans individuals I interview may speak to me differently than they might to others. Initial interviews

indicate that white trans men are likely to simplify complex discussions through assertions that I "already know how it is." Because I have racial and educational privileges, I must remain cognizant of how those may affect my interactions with differently intersectioned trans persons. During this the research effort, I have been what fellow transmasculine sociologist Sonny Nordmarken (2014) would call "queerly between" – that is, I am perceived as male in some casual social interactions, but those who have more experience interacting with gender non-conforming people may identify me as transgender or be confused by my gender identity. It will be critical to remain sensitive to how my own changing gender presentation influences interactions during the interview process.

It is important to note that any social "achievement" of passing status is largely in relation to the rural, socially conservative area within which I live – a regional consideration that may play into increased invisibly and erasure of the trans population. As previously mentioned, it will be important to consider my whiteness, masculinity, and educational privilege in these encounters – how might these interactions be different if I was a trans woman or trans man of color? What if I had less education? Are they saying gendered or racially coded things about interactions with providers or other trans people? Will trans people of color feel comfortable talking to me about their potentially negative perceptions of white transgender people and/or white providers? I cannot answer all of these questions but it is imperative that I remain sensitive to and reflect upon them throughout the research process.

Recruitment

Semi-structured, in-depth interviews with 16 transgender Mississippians will be the specific method for generating the data for this project. This limited sample size is due to the small size of the population and difficulty of accessing members. In addition to being a numerically small population, individuals may be hesitant to talk to a researcher about their experiences. For these reasons, advertising on regional transgender support social media pages and snowball sampling are the best ways to get a sample of this small, vulnerable, frequently "invisible" population. A graphic including information on the study and my contact information was posted in social media groups specific to transgender Mississippians and those individuals who expressed interest in participating were interviewed. Personal social networks were also be tapped in the recruitment process. Following interviews, participants were be asked if they knew of any other individuals who may be interested in participating in the study. Because I recruited through social media groups for transgender Mississippians, snowball sampling, and personal social networks, this means the individuals accessed are connected to the LGBT community. Those who are not connected are unlikely to be in the sample.

Participants

The participants interviewed for this research included 16 self-identified transgender adults who currently or formerly lived in Mississippi for 2 or more years. At the time of the interviews, 14 individuals lived in Mississippi and 2 had moved out of the state. 13 of the 16 participants were born in Mississippi and spent the majority of their lives in the state. Of the individuals interviewed, 8 were white, binary trans men, 6 were white, binary trans women, one was a binary Black trans woman, and one was a white

non-binary individual who was assigned female at birth. All of the individuals aside from one transgender man had accessed HRT at the time of the study. All individuals aside from one trans woman were currently presenting as their gender in their daily lives. Participants ranged in age from 21 to 56 and held a diverse range of educational attainment and occupational status.

Table 1 Participant descriptions

Name	Age	Gender	Sexuality	Occupation	Education level
Levi	29	Male	Heterosexual	Engineer	Bachelor's
Eric	30	Male	Heterosexual	Doctor	MD
April	24	Female	Heterosexual	Entertainer	< High school
Lisa	31	Female	Lesbian	Student	Some college
Jensen	29	Male	Heterosexual	Manager	GED
Mike	47	Male	Heterosexual	Mental Health Provider	Master's
Kate	21	Transfemale	Gynosexual	Retail worker	Associate's
Robert	37	Male	Heterosexual	Healthcare worker	Associate's
James	56	Male	Heterosexual	Librarian	Master's
Brad	26	Trans, male	Straight	Transportation worker	High school
Caleb	25	Male	Bisexual	Food service	Some college
Juno	22	Non-binary	Bisexual	Student	Some college
Angie	28	Transfemale	Pansexual	Customer service	Bachelor's
Stacy	46	Female	Fluid	Upper management	Master's

Table 1 (continued)

Tamera	53	Female	Bisexual	Unemployed due to disability	Bachelor's
Chris	37	Male	Heterosexual	Healthcare worker	Associate's

Interviews

Interviews were conducted in person and over the phone. In-person interviews were conducted as travel funding and personal schedules allowed. The interview questions consisted of demographic, social, and medical background information about the individuals followed by discussions of specific health care experiences that stand out to them – in particular, experiences in which their (trans)gender identities were important factors. I explored how, if at all, they felt regional factors influenced their own perceptions of and experiences seeking health care.

Interview Schedule

The interview schedule for this project was organized to identify patterns of experiences transgender Mississippians may commonly have when seeking and receiving healthcare. Questions about how patients locate providers for trans-specific healthcare services helped identify how these individuals navigated the healthcare system and what resources were critical to locating appropriate care. Including questions about the effect of their residence in Mississippi on their healthcare experiences and perceptions helped answer the question of regional influence on the transition process. Asking about specific, memorable patient/provider interactions helped identify the ways in which trans patients

talk to their doctors about their care, as well as how providers interact with them as a gender minority. All interviews were transcribed verbatim from audio recordings of the interviews and reviewed for accuracy. Please see appendix for the full interview schedule.

Thematic Analysis and Coding Processes

Following interview transcription, the resulting data was analyzed with qualitative analysis software MAXQDA, using thematic analysis as detailed by Braun and Clarke (2006). To begin, I immersed myself in the data by quickly reviewing all existing transcripts in bulk – jotting down first impressions, ideas about what information is standing out, any initial patterns noticed, marking ideas for coding to revisit in subsequent phases of the process, and noting any connections to previous literature that are immediately apparent. Literature did not drive the coding process, as I used an inductive, data-driven approach to begin, but made notes of the connections during memo-writing to revist in subsequent phases of analysis. Next, I reviewed each transcript individually several times, making notes about what seemed to be important without a focus on the bulk of data or connections across interviews.

After this initial familiarization with the data, the more formal coding process began. An appropriate alignment between my research questions and the coding method employed was critical. The three research questions I have proposed, "What challenges do trans Mississippians face in accessing and receiving healthcare?," "How do trans Mississippians navigate these challenges?," and "What strategies do trans Mississippians use to access quality care?" are epistemological in nature. That is, they "address theories of knowing and an understanding of the phenomenon of interest" and "suggest the

exploration of participant actions/processes and perceptions found within the data" (Saldana, 2016, p. 70). Taking this into consideration, an appropriate coding method is Process Coding, upon which I relied heavily. Process Coding uses action words or "gerunds ("-ing" words) exclusively to connote action in the data (p. 111)." This action may be directly observable (e.g. "confronting doctor") as well as conceptual (e.g. "negotiating expectations"). The analysis of Process codes was a site to "reflect on what slows, impedes, or accelerates the process, and under which conditions the process changes" (p. 114). Process Coding is a good fit for exploring the effects of participants' actions and internal processes as they navigate healthcare systems. It is ideal for examining the results of actions and interactions trans individuals undertake in their process of searching for and accessing healthcare, with the goal of accessing quality care while often navigating challenging social and material conditions. In addition to relying heavily on process coding, I also used In Vivo and Descriptive coding.

In tandem with employing different forms of coding, memo-writing during the coding process was of critical importance. Writing is thinking made tangible, and memo-writing allowed me to document and develop my processes of thought during analysis, removing the ambiguity of unarticulated half-thoughts that would likely, if not documented, be forgotten. Memos served as a bank of thoughts and reflections that were later incorporated into the write-up of the findings. Birks et al. (2008) use the clever mnemonic MEMO to identify the functional role of memos in the research process: "Mapping research activities; Extracting meaning from the data; Maintaining momentum; Opening communication" (p. 70). Memos showed the evolution of the process of analysis, how ideas developed and what the catalyst for that development was. They

allowed for more space than several-word codes to dive further into analysis and develop meaning. Memos also encouraged remaining deeply, actively engaged with data and maintaining a schedule of consistent writing. My memos contained a wide variety of reflections but focused specifically on using them as a reflection on my coding choices, what led me to them as well as their potential for development, connections to literature, and ideas about refinement, noting similar codes that were later merged, and any contradictions that may arose among the data.

Considerations of my own situatedness respective to the data and topic were included in my analysis and the final write up. Because my approach is interpretive, I will acknowledge the situated truths of the data generated in my methodological considerations. The final write up is my best effort to represent the various understandings held by transgender Mississippians regarding their perspectives and experiences seeking medical care as residents of Mississippi.

CHAPTER VI

RESULTS

Theme 1: Barriers to Care

Limited representation: To first access trans-specific healthcare such as hormone replacement therapy and gender-confirming surgeries, trans individuals must first understand themselves to be a gender not assigned to them at birth. If they have never met another transgender person, heard of transgender people, or seen representation of themselves in the media, they may not understand where their feelings of gender dysphoria come from, what they mean, or that treatment exists to align their bodies with their identities. If they do not have this representation, their transition is likely to be delayed. Beginning transitional care at a younger age has been shown to increase mental health outcomes and general well-being (Olson et al. 2016).

About two-thirds of the participants, like Levi, explicitly described how they have always been aware of their identity. Levi said, "It was just always something I kinda knew. Yeah, you know, I would tell my family that 'You know, I'm not a girl I'm a guy' and they would just pass it off as like a passing phase." Like Levi, Lisa, a white trans woman in her early 30s, recognized her identity at a young age. When I asked how she understood her identity as a child, she told me about an event in childhood where she expressed her gender and received negative, abusive reactions from others that were emotionally traumatic, leading to a long-term repression of her identity: "Textbook story.

7 years old. It was…The whole story is pretty unpleasant. But, uh, basically got caught crossdressing in kindergarten class by a teacher and 30 jeering classmates, one of whom got the teacher her camcorder while I was hiding inside a closet, crying. Uhm, literally dragged out and into the principal's office. I buried it for a long time after that. So…that's not a pleasant memory." When I asked how he understood his gender as a child, Jensen recalled understanding himself "as a boy in [his] own head" beginning around the age of 5 and emulating masculine behaviors he saw in popular media. He said,

> I'm like a little shrimp right? A little kid. And I remember pullin' my pants down, sagging my pants, and I remember feeling super cool. I thought it made me like one of the guys, right? To do this, like, limp walk. So I'm like 7 or 8 years old and I'm like trying to wear baggy clothing and sag my pants and do this limp walk, and like spit on the ground or something [laughs]. So, this is my mentality as a child.

Brandon, a white, middle to upper middle class transgender man, recalled growing up feeling different, understanding that he was attracted to girls, but without a way to describe how he felt about his gender – both topics that he understood, even at the age of 7, would not be well-received from his family if he tried to discuss it with them. He described his understanding of self in childhood this way:

> Even as a little kid, I knew there was something about me that was different. I really didn't have a label for it, uh, and that probably started when I was 7, 8 years old. Sat behind a little brown-headed, brown-eyed girl who was just as cute as she could be. And I was 7, I was in the 2nd grade, I didn't know any different ... I always wanted to be a boy. But I never – I never talked to anyone about it. I didn't discuss it. There were certain things that you just didn't bring up in my household.

While many participants reported knowing their gender from a young age, even without the terminology to describe it, for other participants, knowing their gender identity was less an ever-present, innate understanding of self and more a process of self-discovery. Two individuals explicitly reported that understanding their identity was a

process over time. Juno, a nonbinary individual who takes testosterone for their gender dysphoria, told me how they started becoming more comfortable in their gender presentation after experimenting with androgyny as a teenager, and even more comfortable presenting as nonbinary, mixing in femininity, after starting testosterone. They described going on to identify with various identities under the gender nonbinary umbrella at different points during their self-discovery process. They said,

> I probably started thinking about things when I was around 15. Like I cut my hair short and I was heavily – like my only really source of interaction with people, because I was so isolated and just like a weird kid that no one liked, is like the Internet. And like me and my friends – like my Internet friends, would tell me I looked androgynous, which I didn't know what that meant, but I looked into it and I really liked that ... I'd been wearing baggy clothes just because I was really uncomfortable with my body. And you know, I just didn't know why, and the more I explored, the more, you know – eventually with testosterone I was more comfortable wearing makeup again and dressing femininely but um, and I've kind of evolved from like – I've used like tons of different labels, like it was androgynous, and then I liked genderqueer, and like nonbinary is becoming a more popular word – genderfluid. You know, I called myself agender for a while, so I've – I've used a whole bunch.

Similarly to Juno, Angie described her understanding of self to be a process of discovery over time. She said,

> I've been through different identities – kind of, I guess, trying different things on, living different ways to see what fit better before sorta coming to terms with myself. Like I don't have the typical 'I've known since I was 5' thing – like I always – not I guess always, but like a lot of times I did think I should've been born female, like that would have been better for like me as a person, but until later I didn't think I actually was, if that makes sense. Like a lot of people just know, but for me it was more of a process of discovering how I was more comfortable, in a way.

She explained that her process was shaped less by gender dysphoria, which has historically been a criterion for accessing trans-specific care, and more by gender

euphoria, or the feeling of being much more comfortable in a gender presentation than the one previously prescribed to her. She said,

> [while in college] I was saying I was genderfluid. So in my daily life I'd usually dress male, I'd go by my birth name, but then there was this part of me that was always more comfortable as a female, dressing up, makeup, and especially – I think especially when I'd hear my friends like, when I was dressed female, like when they would refer to me as 'she' and 'Angie' it always felt more like me, it was almost like – so you obviously know the term gender dysphoria, you've probably heard of gender euphoria right?
> Interviewer: Yeah, I've heard the term.
> Well when I was my female self, I did definitely feel that, the gender euphoria, but it was just a lot easier to just go through my daily life with the option to dress as my male self.

Discovering other trans people exist: While individuals' processes of understanding their identities differed, participants frequently recalled vivid memories and 'ah-ha' moments of discovering the existence of other transgender people, often after years of thinking that no one else had ever experienced what they felt. Others saw representations of trans people and, because those representations were negative, rejected that identity and internalized negative views of that population. Ashley, a black trans woman in her early 20s, told me how she felt after seeing other trans people represented in the media for the first time. She said,

> So when the Tyra Show used to come on, like back in the early 2000s, I was watching and she was just interviewing all these little boys and girls, and come to find out, all the little boys and girls were trans. And I said then – I said wait a minute, 'I feel like how they feel, like something's not right. Something's not connecting.' Cause I was only – like gay's the only word I knew, so I was like, I guess that's what it's gotta be. ... It opened it up. It opened up doors for like self-expression, explained like why – like it's this way. We just don't really like see ourselves on TV.

Stacy, a trans woman in her mid 40s, told me about seeing transgender English actress and model Caroline Cossey on television in the 1980s and feeling hopeful about

her future ability to transition: "I remember seeing her interviewed on something like Donahue or whatever way back when. And I was just stuck to the television like, 'Oh my gosh, she is so beautiful. So feminine,' I would've never, ever, ever guessed that she were transgender. I mean, I can't believe that – and it was just another thing that was just like, there's hope - there's hope, I can potentially do this." While there have always been limited portrayals of transgender individuals in the media, those that do exist have historically been unflattering. Internalizing these negative representations can lead to postponing transition, which can lead to more difficulty in the future. Continuing her thoughts after her 'ah ha' moment while watching the Tyra Show, Ashley described the majority of trans representation as negative. She said,

> We just don't really like see ourselves on TV. Like except for Orange is the New Black, escorts, murder victims – it's never anything really positive except for Janet Mock.

As previously discussed, seeing almost nothing but negative representations of transgender people in the media can cause internalized transphobia and fear, leading to the rejection of one's identity and/or the postponement of transition. Caleb remembered hearing about one of the few transgender men who has some celebrity, Chaz Bono, who is the son of pop icon, Cher. He recalled hearing Chaz mocked on the radio and fearing that, if he did transition, he would still not be able to achieve the life he had envisioned of living as any other man. He said,

> I do remember years after [speaking with a therapist] hearing about Chaz Bono on the radio in the car with my mom. It was like a conservative talk show kind of thing and they were making fun of him ... But I looked him up one day when it was just me at home and I don't know – it freaked me out. Like all the things people said about him, even like – and I know, this is kinda shitty on my part, but even like the way he looked then, I guess. I didn't want to look like that. I just wanted to be a normal looking guy if I was going to

have to go through all of that. It just felt like there was no way to be just a normal person and be trans. Like I'd always be seen as weird or be weird looking or both, I guess. So after that I just kinda decided it wasn't something that would ever be worth it to me. Like the thought of like – even if I had all of those surgeries and going through having to come out to people and maybe looking like – not like – just like not how I wanted to look.

Stacy, who grew up in Mississippi and has lived there her entire life, told me about the damaging effect of hearing the disparagement of transgender people from her peers and in the media. She said,

> As I started growing in my knowledge, a little bit of transgender people, I mean, it became for the most part, especially back then in the early 80s – it uh, transsexual – transgender people were the laughing stock, and so it was those kind of things that just kept eating at me internally and really stayed with me most of my life.

While there are increasing numbers of positive trans figures in the media, like Janet Mock, who Ashley mentioned, other figures, specifically Caitlyn Jenner, have been fraught with controversy and have received heavy criticism from the LGBT community as well as society in general. Brandon, who identifies as politically independent and voted for Donald Trump in the 2016 Presidential election, expressed exasperation over the portrayal of transgender people that he feels American audiences are receiving – portrayals that he says reflect poorly on the community and appear very different from the average transgender person. He said,

> We're not what you think we are. We're your neighbor. We go to church with you. We run into you at Wal-Mart. Maybe we went to high school with you. It's not what you think it is. When [healthcare providers] don't have that first-hand knowledge of what it means to be around a transgender person, all they know is what they hear about on TV, what they see on social media, reality shows. Being transgender is not the life that Caitlyn Jenner is portraying ... being affiliated with the Kardashians and all that crap – social media and the news has pushed it down America's throat, but they're doing it in

such a way that people are putting their hands up. When the reality is, that is not what we're really like.

James, a white trans man in his mid 50s who has a graduate degree, recalls infrequently seeing trans women represented in media, but never seeing trans men. After asking him what led to his decision to pursue medical transition, James detailed the effect of this limited representation on his process of understanding his identity. He said,

> It wasn't so much deciding as much as it was discovering. Cause I didn't know the answer to that question. I didn't – okay, so I am old enough that [sighs], yes, I had seen 'The World According to Garp' and I damn well knew who Renée Richards is. Okay? That's what I knew. That's it. It's a very one-sided portrayal of life. But that was all that was ever shown. That was all that was ever discussed. So it's like, well that's – that's not me. I knew that wasn't me.

Brandon, who is in his mid 30s, described to me the limited, highly sexualized view of transgender people that was presented to him in society and popular media: "Uh, I didn't know anything about transgender people. The only thing I knew was there was guys out there that liked to wear their wives underwear, or, you know, transsexuals or crossdressers. Guys that were – that got some sort of charge by wearing women's clothing or dressing up as women. I didn't know anything about gender identity disorder."

Multiple participants reported delaying efforts to transition by making attempts to conform to the gender roles prescribed to them at birth, rejecting their felt gender and hoping to make those identities go away by investing themselves in socially anticipated gendered behaviors. To reiterate, this delay can create health problems for trans people. Jensen remembered, after a childhood of understanding himself as a boy, his thought process in regard to transition and his desire to be successful – a goal he felt being

transgender would inhibit. He described his decision to conform to women's gender roles this way:

> I thought 'it is what it is, and if you want to live a successful, you're gonna roll with the fact that you're a female and you're just gonna do it.' That's all I thought I had for options. Um, so what did I do? I completely transformed and said 'If I'm gonna be female, I'm gonna be the best damn female there is. I'm gonna go ahead and be the most attractive. I'm gonna primp myself up, I'm gonna look good, I'm gonna make friends and everybody's gonna know me and I'm gonna be the best at whatever it is I do.'

Lisa, a military veteran who served in combat, also discussed the lengths transgender people often go to attempt to accept and conform to the sex assigned to them at birth, as well as the negative effects on their mental health. She said,

> We're a small percentage of the population, but within the military that number shoots waaaay up. It's like a hiding place for many of us, either direction you're going on the gender spectrum – eventually, you know, eventually – MtF [male-to-female] folks, it's the last stage of denial for a lot of us. There's – like it's a pretty common story. As über-masculine a role as you can possibly take, then there's a nervous breakdown and usually a discharge – I got lucky and kept honorable. Uhhh, it's like 'Know what? Fuck it, this isn't working. Time to deal with it.'

Brandon, who grew up in Mississippi and later lived in the Midwest before returning to Mississippi, described to me the influence of living in the South on his decision to reject his identity and try to conform and live as a woman: "Growin' up in the South, you learn real quick that there's certain stereotypes and certain generalizations that – that you can either choose to buck the trend or – I was one that chose to be a conformist." He later described his attempts to invest in a life where he was perceived as an average heterosexual woman: "Uh, so, I did – I went the way a normal preteen, teenage girl was supposed to be. I got married early, uh, right after I turned 17, graduated early. Had a child by the time I was 18 and a half. I was married to a really good guy, I

mean there was nothing wrong with him, he was fine. He was just – there was something about me." Angie, who at one point identified as genderfluid before identifying as a transfemale, recalls her hesitation about transition due to fears discrimination and losing her 'normal' life of a person who had the ability to be perceived as a white cisgender man. She said,

> It was just a lot easier to just go through my daily life with the option to dress as my male self. It made school a lot easier – working, you know, just all the day-to-day things where being seen as a white male helps, which is most things [laughs]. I didn't have to deal with the possibility of putting myself – not like, *putting* myself in that situation, but you know, like having to deal with being misgendered if I was presenting female, having to go through all of the legal name change ordeal, worrying about not being hired if all my paperwork wasn't up to date. Like even if I had been able to afford to get my name and gender marker all legally done back then, being in Mississippi, you know – it just isn't easy, especially at the beginning. I'm three years in and I probably still get clocked all the time, so like just trying to just have like a normal life was something I was scared of losing.

As with understanding identity and interpretations of representations of transgender people, the process of deciding to move forward with medically-assisted transition looks different for each individual, with unique combinations of barriers to accessing that medical process for each. Increased barriers, coupled with longer transition delays are more likely to result in negative mental and possibly physical health outcomes. Several participants describe reaching a breaking point at which they were so gender dysphoric and unhappy that their mental health was suffering significantly.

Lisa told me about the emotional anguish that led up to her pursuit of transition: "It had to come down – it had to get so bad that I was about to swallow a hollow point before I actually did something about it." Like Lisa, Tamera made every effort to deny and change her understanding of herself as a woman for decades, even choosing to go

through seminary to become a preacher in an effort to 'fix' herself. After researching various proposed biological explanations for transgender variation, she came to the conclusion that her feelings were unlikely to ever change and imagined a bleak future for herself if she did not transition. She said,

> I came to the conclusion that there wasn't a day in the future when this would end, and, of course, there's always the lifelong, lingering depression of not being right – anybody who's trans can relate to that, even when people think you're doing fine, inside you think 'when will this ever end?' It's like having a headache that never goes away or something, and uh, once that illusion that it would end was stripped away, then that spiraled and I came to the conclusion that I would either kill myself or transition or become such a miserable person that I might as well have killed myself because I would be a cancer to anybody around me. And once your eyes have been opened, you can't un-see what you have seen.

Tamera, who began her supervised medical transition in her early 50s, went on to explain that, since she knew she would have to eventually have to transition for the sake of her own health, she wanted to do it before reaching older age: "My situation was never so much, 'I can't do this today, I can't continue to wear the mask this week' my conclusion was, 'I can't do this for the next 30 years, and if I'm going to take the mask off at all, why be 70 years old when I do it?'" For others, this breaking point was reached at an earlier age. April, a white, trans woman in her early 20s who is married to a cisgender man, recalls the effect of experiencing consistent homophobic and transphobic peer bullying during junior high school. She said,

[The other students] always like singled me out. Always made me feel like I was weird. And I just like..it was a struggle *every* day [sighs]. I.. I basically tried to make myself sick *every* day so I didn't have to go to school. *Every* day. It was that tough. But [clears throat], but then I turned 15 and I was like – I – I couldn't. I couldn't live my life

as a boy anymore. I could not do it. And I wasn't going to do it.

Primary barriers to healthcare access: Four primary themes related to accessing care were described by each of the 16 participants in the study, in varying detail, as they related to their ability to access healthcare: Financial barriers, insurance-related barriers, barriers related to documentation, and employment discrimination. These four barriers were often mentioned by participants in relation to each other, as they inform each other in multiple, often complex ways. The first factor of financial barriers, which was identified by most participants as the leading barrier to care access, relates directly to employment discrimination, which affects the transgender population at a disproportionate rate (Bradford et al. 2013, Grant et al. 2011). If an individual is discriminated against based on their gender identity and has difficulty finding employment, or is employed at a level lower than that which they are qualified for, this directly limits their ability to accrue the financial means to access healthcare services. Also, it affects their ability to purchase health insurance, or access an insurance plan provided by an employer.

Financial barriers also influence the ability of transgender individuals to access the legal processes necessary to update documentation to reflect their correct gender and name, if it is changed from the name given at birth. Filing fees for changing name and gender marker run upwards of $100, with some variation by county, not including potential lost wages from taking time off of work during the week to appear in court. While filing to legally change one's name is a relatively straightforward process, changing one's gender marker on identification such as driver's license and birth

certificate can be a complicated process, with rules for doing so varying widely by state – some states will not amend a birth certificate to reflect an individual's current gender at all. Other states will only update a birth certificate after an individual has undergone sexual reassignment surgery, which is often rendered inaccessible due to financial limitations in tandem with lack of insurance or transgender care exclusions in insurance policies. In Mississippi, gender markers on state-issued identification such as driver's license can only be changed if the individual's birth certificate has been amended. Almost always, amending a birth certificate requires the assistance of a lawyer, making it even more costly and inaccessible for resource-limited individuals.

While documentation is influenced by financial barriers, it also influences financial barriers. Even when a transgender person is not visually stigmatized and has passing privilege, if they have been unable to update their documentation, they may be identified as transgender when seeking employment and subsequently discriminated against. This process of needing financial means to update documentation, but needing updated documentation to access employment opportunities, and thereby financial means, has the potential to create a frustrating conundrum for trans people who need care.

Issues surrounding documentation also influence insurance barriers. For example, Brandon has his gender marker updated to reflect that he is male. Brandon has insurance through his employer and he and his wife have good jobs. However, when Brandon urgently needed a hysterectomy, he experienced concerns about insurance billing. When insurance companies monitor for fraud, they look at sex-linked procedures and if the reported sex of the patient does not match in ways they would anticipate, they may reject the claim. Also, if the service provider reports the patient's sex as something other than

what is listed on their insurance plan, it may be rejected. These fraud screening policies can create billing issues for trans patients and providers alike. Brandon described to me how this can play out in interactions with medical providers. He said,

> When I had the hysterectomy, going down to the clinic, you know, they immediately said "Mrs." and used my last name. My wife was the one who initially stood up, just so it wouldn't cause any issues in the waiting room. And, uh, they were telling her to get up on the scale, but actually I'm the patient. And they quickly, like, reviewed their chart. They were like "Oh I'm so sorry" and you could tell it had caught them off guard. But they handled it really, really well. They showed an extreme level of professionalism at that office. And when I went in for surgery, you go in for pre-admission early in the morning and they wanted to put me as female on my chart. And I said, you know, 'my insurance is going to pay for this, but my insurance has me listed as male, so if there's any sort of issues, I'm just telling you right now, I'm not putting up with this.' And you could tell that the admission person was not very comfortable with talking to me.

Financial barriers: As stated previously, financial barriers were identified by most participants as the primary barrier to accessing care. Because each of these barriers can affect the others, it creates a complex system of, as Stacy put it, encountering "headache after headache." While all of these factors are important, financial barriers held the most power. Brandon described the gravity of the financial barriers the transgender community faces, and mentioned the role of family support and employment as they relate: "The number one concern we've always had is 'How can I afford this? How can I afford to do these things? How can I afford the medication? How can I afford the surgeries?' Especially when you can't get a job or your family doesn't help you. Imagine you're living on the streets." When asked what, if any, barriers had kept her from accessing the gender-confirming surgeries she wanted, Kate replied simply: "Money. Just… money." Like Brandon, Eric mentioned the role of financial support from family that can play into

accessing care, especially at a younger age. He described the reason he had to delay his transition for years after coming out to his family: "I wasn't financially independent and uhm, they basically weren't going to pay for anything. So I waited until I was financially independent and by then they were kind of accepting of it – or, I guess more accepting, so uhm. But that's why it took so long." Levi described the frustration and dysphoria he felt while saving money for top surgery, for which he paid $6000 out-of-pocket, not including the cost of time off of work, medications, lodging for a week, and traveling to a provider who was located over 500 miles away

> Initially it was defeating. You know, I'd saved up all my money for surgery, you know. I was really worried – I had to worry about my chest all the time. Like every waking moment of my life, I had to worry about that. So that was my main concern. It was kinda like a defeat, you know, to say – well the most I could save up was a couple thousand dollars and then something major would happen like my car would break down.

Insurance barriers: Though this is not necessarily exclusive to transgender Americans, insurance factors created some of the more complex barriers to accessing care. These factors add unique complications related to exclusions and billing that cisgender people do not face. Tamera related the financial barriers to care with the added complications that accompany insurance factors: "Very few insurance plans that can be purchased in the state of Mississippi cover transition related expenses. And therefore, anybody living off of a marginal income is probably shut out of that process. Even if you find a doctor that'll do it, if you can't afford to pay out of pocket, you still can't." James, who works for the state and has good health insurance, also describes the challenges of accessing care as they relate to transgender-specific exclusions in insurance coverage. He

shared this insight after I asked him if he has ever traveled out of the state for trans-specific care: "You have to understand that, being a state employee, that if you go out of the state, you have really limited healthcare unless it's an emergency. Cause getting preapproval is almost non-existent. And they're not gonna cover anything that they even *think* is trans-related. It specifically says they're not. So, I'm kinda stuck. You know. That's bad." Tamera, who is white and in her early 50s, sustained a life-threatening injury at work that left her disabled and unable to work. She is now eligible for and receives Medicaid and Medicare. Though she came out and began living as a woman over a decade ago, until very recently she was unable to access supervised hormone treatment for her dysphoria. She attributes this to significant financial barriers and resource limitations in her area. Tamera described how, in tandem with changes to transgender-specific insurance exclusions prohibited by the Affordable Healthcare Act, her life-threatening injury and subsequent disability are, ironically, the only way she has been able to access supervised HRT. She said,

> At some point in time I tracked down a provider that would bill Medicare for [trans-specific healthcare]. And that was after – this also all involved national-level decision for Medicare to cover transition-related costs, which wasn't really in place when I initially got on Medicare. So the point at which I'm now able to actually go see Dr. O and get an actual medically supervised program – still it goes back to the fact of, because of my life-threatening injury, I find myself on Medicare over a decade early and therefore have insurance coverage that enables me to do that. Cause otherwise I still wouldn't be able to do that.

Documentation: Having documentation that does not match a person's gender presentation can create a situation where a trans person is unnecessarily outed to their provider, even if they are able to 'blend' and not be immediately visually identified as

transgender. Ashley has been in transition for 4 years and now appears to others as a cisgender woman. She described how her documentation, which still reflects her name given at birth and sex assigned at birth, made what would have been a routine emergency room visit an incredibly awkward encounter. She said,

> Me and my best friend were in a car accident, we were hit from behind and so we went to the hospital and we got there – so my appearance didn't match my name – so after that happened, like once they checked me into the back, I could kinda hear the doctor talking saying 'well is it a boy, is it a girl? Should I ask the last time when her cycle was on?' and I was like 'I'm here because I was in a car accident, not to play 21 questions with y'all.' And when the doctor came in there, he was just looking at me and he said 'well are you okay?' but I could tell that he was uncomfortable because he couldn't tell whether I'd be mad – like he didn't feel comfortable enough to say 'ma'am.' He didn't ask me any really personal questions. He was just like 'well, I mean, from where I'm standing, everything looks alright' and I was like – he acted like he was afraid to touch me, and I was just like 'I'm sure you see more horrible things than a minor car accident on a daily basis.'

Angie described how, because of her then out-of-date documentation, fear of discrimination, and previous interactions with her provider while presenting as a man, she made the difficult and uncomfortable decision to dress in men's clothing to avoid the risk of confrontation or mistreatment at the dentist. She said,

> One time I had to go to the dentist because I knew I had a cavity and luckily I was on my family's dental plan back then – but like, this was just at the beginning after I had gone full-time and started HRT, maybe only like 3 or 4 months, but I got really stressed out about it because I had seen her before and like – like she was always really nice and probably knew I was queer in some way – but yeah, like I had never gone in there dressed female – and I just remembered there being like Bibles and like Christian magazines in the waiting room and like all these little kids running around while Fox News is playing on the TV. So then like I probably – like I still got called 'ma'am' a lot but I also got a lot of stares – definitely got clocked [visually identified by others as transgender] more then. [pause] So I was kinda stressed about how she would react – and that's really – like anyone who knows me knows I really don't give a fuck what anyone

thinks, so I don't know - but I remember that morning I was like dressed and halfway through getting my makeup on and I just took it all off and grabbed some of my old male clothes, like put my hair up and everything [pause]. It did suck but I just wanted my fucking filling and to not have to worry about anything. So it was fine but I do wonder what it would have been like, cause I hadn't legally gotten my name changed or anything and my old name was on the insurance policy.

Employment discrimination: We know these four primary factors are highly intertwined and moderated by even more factors; it can be difficult to piece apart where one barrier and/or influence ends and another begins. Brandon talked about the connections between employment discrimination, insurance, and fear of discrimination and how they work together: "You know, I'm not sure if it's an insurance thing because, come on, there's a lot of people that are transgender that – they're – they can't get a job because they're transgender. So therefore, they're not gonna have insurance. If you don't have insurance, you're not gonna go to the doctor. So why would you go to the doctor if they're gonna be judgmental towards you and treat you like crap?" Also related to employment discrimination is documentation, which has the potential to 'out' applying individuals as transgender to employers. Ashley describes the reactions she has received during her employment search, while still legally having to report her name given at birth. She said,

I'm currently looking for employment but um, a lot of places that I go apply, once they see that – cause I haven't gotten my name changed yet – so when they look at my paperwork a lot of the times, I think they expect a young male coming, and it's not. And so I always get this – I'm not gonna say it's a dirty look, but they're trying to be like 'well, you look like a woman to me, but your name doesn't match what I see, and I'm like highly confused, what's going on?'

To clarify, I asked her directly if she feels her out-of-date documents have hindered her employment opportunities. She replied that it has, and related it back to the

financial barriers that accompany the legal process of updating documentation: "Yes. Very much. It's seriously such a hassle to get all that changed and it's so expensive. The ACLU has provided me like, a lot of documentation about the things I'd have to do and where I'd have to go to get my named changed – because I see now that it is kinda pricey."

Visual stigma: One factor that works to affect access to care in many, sometimes subtle ways, is visual stigma. The effect of visual stigma may be direct – if someone is visually identifiable as transgender, they may be discriminated against immediately and have a more difficult time finding employment, particularly in roles where they frequently interact with clientele. Studies have shown that persons have more favorable opinions of transgender persons whose gendered appearances are more conventionally aligned with their gender identity (Norton et al., 2004). Visual stigma may also work as a factor that promotes transition delay and/or care-avoiding behaviors due to fear of discrimination and/or internalized transphobia. Jensen, who transitioned while working as a manager in a retail location that serves hundreds to thousands of people each day, told me how he navigated the brief period of time at the beginning of his medical transition in which his appearance was sometimes interpreted by others as ambiguous, or as a masculine-presenting female. He said,

> I had to prove myself a little bit more so than ever that, 'Hey, I'm gonna take care of you. You came in here for a reason, I'm gonna get to know you, uh, as best I can. We're gonna, you know, find some sorta way to connect here, I'm gonna help you find whatever it is you came in for and then some. You're gonna have a great overall experience and you're gonna be so happy by the time you leave here that it didn't matter what your initial perception of me was'…essentially. So, I mean, I've really had to – I really had to

fight harder during those few months – to, like I said, kind of prove myself, uhm, so that way I was not mistreated."

While Jensen was able to keep his job through transition and worked hard to go above and beyond to ensure customers were not focused on his gender, other participants faced employment discrimination and lost job opportunities directly due to visual stigma. Tamera, who has a Bachelor's degree, told me about an experience she had after leaving an application at a local business, later hearing from a family member a conversation they overheard after she left the establishment. She said,

> I'm aware of one location, another business, where I dropped off an application and an acquaintance, an in-law, as it were, was in the store shopping. And when I left, this person overheard a couple of the other customers say to the manager taking my application 'If you hire that thing in here, you will never see us again.' ... And I presume there was a lot of that attitude in other places, even if it wasn't vocalized in public, or, you know, the manager of a given grocery store is just going to assume that they would get a lot of complaints, and why bother with that kind of grief?

Ashley recalled a similar experience of being visually stigmatized early in her transition, when she worked at a clothing retailer. After receiving customer complaints, her manager assured her she would be protected, until customers started going to corporate, at which point her job security was jeopardized and she preemptively left the position. She said,

> So it was like, going to work and having an employee that was trans, they would get complaints from some of the customers, saying that 'I don't want to come shop in here if that freak works in here. You got that thing working here around these kids' and it just became very malicious and I just decided to – because the customers had just gotten so nasty – and my manager was like 'you know, Ashley, it's gonna be okay, we're gonna ignore them.' But then when they started going to corporate, they were like 'Oh, well, Ashley we gotta let you go.' ... I quit and then corporate wrote me like a letter, but I had already filed like, paperwork against them anyway, as like a fighting case against them because I felt like, even though the customers were complaining and calling corporate, I

felt like my job could've fought for me a little bit harder. It's just like having a bunch of white folks to come in and complain if there's a black employee, it's just not right.

Fear of discrimination: In addition to the intersecting material barriers that face transgender individuals seeking access to care, including discrimination in employment and the subsequent financial barriers, fears of potential maltreatment based on gender identity in medical interactions can create a barrier to care access. This fear can delay beginning transition and other care-seeking behaviors, as well as create anxiety when considering accessing those services. Brandon, who works in the healthcare sector, described his fears of being in an emergency situation as a transgender man with passing privilege. He said,

> The problem with going into the ER, especially in an emergency situation, of like chest pains? Just let me die. I don't even wanna deal with it. The humility of it. You ought to see what I hear on a daily basis going into the clinical lab. Our mannequins, you can move their genitalia around. You ought to hear all the Caitlyn-Bruce Jenner jokes I hear. I mean, these people are gonna be nurses and doctors.

In response to a subsequent question, Brandon again asserted that he would rather die than receive potentially discriminatory or subpar emergency care for his heart condition, specifically if his wife, a nurse, was not there to provide him support or make a 911 call herself. He expressed his distress at potentially being identified as transgender by paramedics in an emergency situation and speculated that their reaction to identifying him as transgender could endanger his life. He said,

> I have a heart condition. And I told my wife 'Unless you go with me, I am not going to the ER for an emergency if I can avoid it. You're gonna have to call the paramedics on your own. I mean, let me die.' Especially before I had chest surgery. Now, I'm like, they're gonna cut my shirt open to do, you know, to shock me, and see these scars and they're still gonna hesitate and I'm still gonna die. It is – it is scary.

April, a trans woman who began transitioning at the age of 15 and does not visually appear different than a cisgender woman, described how she would be comfortable with a doctor examining her if they knew she was a trans woman and accepted her as a patient, but would be concerned if the provider did not know, and she was unsure what their reaction to a transgender patient would be. She alluded to the lack of legal protections and the fear of religious discrimination for transgender Mississippians. She said,

> Like if they knew I was trans, I wouldn't have a problem with them, like, checkin' my prostate or whatever. But you also gotta think about it, like, if they did not know, I would not want them…you know, going down…in the front of me, checkin' my crotch area. That's just like…a big no. You just don't do that. If I say no, that should mean no. Not, 'whatever.' Cause if they *do* look at your crotch and find out that you do have the genitalia of the other sex, then basically [claps hands] they can just deny you service just like that. *Just like that*. And – and –…it sucks. You know, I mean…[sighs] I mean, healthcare…even for trans – trans people, like I said, we have it hard. Especially livin' here in the South. You have to be a certain way and live your life a certain way. If you don't, then you get judged. That's just how it is.

Access to care, specifically HRT and gender-confirming surgeries, can also influence health-seeking behaviors in *positive* ways. Levi, a white, cis-passing transgender man with a college education and a lucrative career, described the positive effect that being seen as any other man has on his health-seeking behaviors. He said,

> I don't think I avoid going to the doctor because I'm trans anymore. I mean, now I know where I need to go when I need something. Like, there's a couple different doctors I go to now. Like, if I'm getting sick, I'm gonna go ahead and get some antibiotics and take care of it before I get real bad so I don't miss work. Um, now if I did go to a doctor I don't normally go to, they're not gonna know about me anyway. It's just like anyone else going now, so I don't really avoid it anymore, I'd rather get well quick than suffer with it.

Role of religiosity: As mentioned previously in the chapter entitled "Mississippi," the cultural context of Mississippi is heavily religious and very conservative, most frequently leaning towards socially and fiscally conservative political preferences coupled with evangelical Christian identity. Both evangelical Christian identity and political conservativism are associated with increased prejudice against transgender people (Norton & Herek, 2012, Nagoshi et al. 2008). Even though 7 of the 16 participants personally identified as Christians, transitioning in an environment where you can safely assume that the majority of your friends, neighbors, and community leaders fundamentality disagree with who you are, and that they may even think you are damned to Hell, can be an incredibly emotionally damaging environment. Though certainly not exclusive to Mississippi, the role of religiosity played heavily into participants' understandings of self and decisions to transition, or not. Tamera recalled the effects of living this culture on her understanding of self and how she heavily invested herself in religion in attempt to make her gender change to conventionally align with her sex assigned at birth. She said,

> My indoctrination was that I was broken and flawed and sinful and perverted and God would fix me if I believed hard enough, and that's really what led to being a preacher, was I bought into the notion that if I would just double down and was the best Christian ever, that God would recognize my repentance and heal me and take it away from me and I wouldn't have to ever have to let anybody else know about my shameful secret. That was all like in the late 80s, that process – and so after almost 20 years it began to occur to me that God wasn't doing anything and maybe all these assholes have been lying to me [laughs].

Stacy, like Tamera, has lived in Mississippi her entire life. She also recalled investing herself in religion and church attendance in an effort to rid herself of what she perceived to be sinful feelings. She said,

> And go back to when I was eleven years old, when I made a profession of faith in the Baptist church. I did that because, number one, I was terrified of Hell. But number two, I thought I was going to hell because of the way I felt inside - because I felt like I was a girl on the inside. Again, I didn't know what transgender was back then. And I just kept thinking, 'okay, if I pray this prayer, if I ask Jesus into my heart, this is going to go away. And this is what they're talking about, having all the sins washed away, you know, and this will go away.' And of course it didn't.

The default understanding of everyone around you likely being someone who disapproves of you often leads to fear when seeking healthcare, even when someone is able to move past the internalized transphobia they gained from growing up in an explicitly unsupportive cultural climate. Levi, who regularly attends a Baptist church, described the challenges he faced when deciding which mental health professional to see when seeking to access a therapist's letter that would allow him to access hormone replacement therapy. He said, "The first step was to get a letter from a therapist so that I could later take that to the doctor for what I needed. So the challenge was to find a therapist that was – that was uh, not really associated with the church, so to say. And it's hard to look in the phonebook and know which counselors are, uhm, I guess more religious counselors versus, like, just general therapy type counselors." Later, after describing a discriminatory encounter with a healthcare provider located at a university health center when seeking care for a sinus infection, Levi, who is a Christian, describes what he later learned about the doctor he went to see – contrasting him with another

Christian doctor who had previously provided Levi with his testosterone prescription. He said,

> Apparently Dr. S is known for being very like, religious in a way that, uh, he doesn't believe in gay stuff. I don't know how to word it. But like he thinks homosexuality is wrong and therefore trans people are an abomination and therefore he wouldn't prescribe that kind of thing [hormones] to anybody. He's kinda known for being that kind of religious. So uhm.. when Dr. C retired, you know, I said 'I'm really thankful for a good Christian doctor like Dr. C, you know.' Because he's a completely different kind of Christian, you know. He's more like my type, you know. He really made a really big difference in my life, doing the whole hormone thing.

Even when providers may have positive or neutral positions towards assisting transgender clients in their medical transitions, Mississippi's cultural climate may have an effect on their choices to prescribe hormones to trans patients. Tamera, who lives in a very small town, with a population of about 6000, told me about her interactions with local providers and her perceptions of why those practicing in her area refuse to provide trans-specific healthcare. She said,

> Any time that I had been to any local provider, like a family physician or whatever, none of them wanted to involve themselves in transition-related prescriptions. I did convince one to prescribe Spiro, but he wouldn't touch hormones. Said he didn't know anything about that, didn't want to be involved or whatever. I think that a lot of them think that if anybody ever discovered that they were doing so, that they would end up with a lot of patients like that and then they would end up with a lot of with a lot of reputation issues with the church folks, and they'd just rather not go anywhere near that.

Cultural climate: Religiosity, coupled with an overwhelming trend towards fiscal and social conservativism, play a significant role in stoking the fears of discrimination that transgender Mississippians experience when seeking healthcare. Jensen, who has lived in many different areas of the United States, told me his reaction to the cultural climate after moving to Mississippi for the first time. He said,

Mississippi is far behind. Far behind. I thought it was a joke when I moved here. I don't know – I'm not making fun. I really thought there was some sort of prank that was being pulled on me personally when I moved here. I feel like I jumped back at least a good 100 years in time. Uhm, there are so many issues besides trans awareness, or LGBT equality and rights and healthcare and services – there's so many other issues here that are just so far, to me, back in time. Like I just jumped backwards to a different century. Um, there's race issues here. There's education issues here, in general. Starkville, Hattiesburg, Jackson-metro area are a little bit more advanced than the sticks of Mississippi where there's not a whole lot going on, right? Cause Mississippi's quite large. And Mississippi's quite different in these areas I mentioned compared to the rest of Mississippi, right? It's almost like two different states. But even the city part or these big college towns – the education. It's not where it's at, compared to where I come from, which is the Northeast. Nowhere close. The race issues here are just unbelievable. I thought that was a joke. Like, y'all are kidding me! I say y'all now, I've conformed a little bit.

Later, when I asked why he chose telemedicine over a local provider, Jensen described the effect of Mississippi's cultural reputation on his interest in seeking face-to-face care with a local provider: "I was new to Mississippi and I was not – and I didn't necessarily know of or trust any therapists in the area. All I had known was what I had heard. And what I had heard was that Mississippi is not very supportive – or does not have many resources in that department."

1.5.2.1: Delaying transition: One recurring effect of the cultural climate in Mississippi was delaying transition. Research shows that accessing medically supervised HRT at a younger age is associated with positive mental health outcomes and greater ability to realize a correct gendered appearance (Olson et al., 2016). When asked if she felt living in Mississippi had affected her, Stacy, who recently accessed medically-supervised HRT but is only out to close friends and family, and presents as a man in her daily life, replied that living in Mississippi had a major impact on her transition process as it related to fears of visual stigmatization. She said,

Absolutely. Absolutely. Probably internally, more than anything, it's affected me and my decisions of whether or not I should come out. ... I think the conservative nature of Mississippi, I don't know – I haven't really put all this to the test though Micah, so I don't know. I haven't been ostracized publicly or in any way, except maybe with one on one relationships. So I think it's more in my head, which it might be accurate, but I'm afraid in this state. I don't want to be the laughingstock. I have mentioned many, many times to different people, I don't to be perceived as a linebacker in a dress. I want to pass and until I'm able to get to that place, I don't know if I'm ready to go full-time.

Lisa also described how the effect of living within Mississippi's cultural climate led her to delay transition, as well the anxiety she experienced after witnessing the visual stigma another trans woman was received. When asked how she thinks it would have been different if she had transitioned elsewhere, Lisa replied,

I would've liked to have started a looot younger. Ideally? 12. That would've been great. The correct puberty, military enlistment bonus would've gone to medical things. Umm…but living here? [shakes head no]. It had to come down – it had to get so bad that I was about to swallow a hollow point before I actually did something about it. Cause I knew, going into it – and my therapist, before she wrote the HRT letter and everything, 'where you live, it's going to suck. A lot.' [long pause] 'Ma'am you don't need to tell me that.' I have seen how other – what I now knew was a trans person – she did not pass very well. I think somebody probably should've told her that shaving one's legs might've helped. But I saw the way she was treated and I thought 'that's gonna be me in like 6 months…fuck.'

Like Lisa, Angie, who recently moved from Mississippi to a large, left-leaning city on the West Coast, reported that a primary effect of living in Mississippi is the delay of transition – which is informed by not just cultural climate but also the political and legal landscape. She said,

I probably would've started sooner, so I'd be farther along and maybe my dose [of hormones] would've always been right, so there's no telling how I could have looked [laughs]. It would've just been a lot more – like a more comfortable step to take knowing that there's actually places I could go that would have experience and I probably

wouldn't be just like kicked out of anywhere just for being trans. But I guess that's the main thing that would be different just like starting sooner.

Levi, who grew up in Mississippi and has lived there his entire life, recalled a traumatic experience of seeing a pediatrician around the age of 11 or 12. His mother had enlisted the pediatrician to speak to him about his persistent insistence that he was a boy, an experience that he reported made him deeply uncomfortable and permanently impacted his life in a negative way. He expressed how, if that provider had been knowledgeable about transgender people, it could have positively changed his entire life. He said,

When I visited my parents for the summer, they took me to a pediatrician for like a checkup. And uhm..it was just a bad experience. It was just really bad.. I kinda don't want to talk about it.. [long pause] It was kinda like, my mom had the pediatrician talk to me about being a girl.. and, uhh, it could've gone so much differently. Like, if that pediatrician had came to me and said 'look, there are trans people in the world and it's okay, and maybe hormone blockers would be an option,' that would have completely changed my whole life. But instead, she told me I was a girl and I just had to get over it, and she just went into graphic details about things. Uhh.. I don't know.. when I left I just felt so molested. So violated. I really did hate doctors after that, I guess.

As discussed previously, having no other transgender people to relate to, be it in the media or in face-to-face relationships, can create a barrier to accessing care because, without the terminology to describe your feelings, you probably cannot do anything about them. Coupling that limited visibility with fears of discrimination creates an environment where transgender people attempt to distance themselves from the transgender community, blending into society and limiting the number of people to whom they reveal their sex assigned at birth. Jensen, who moved to Mississippi for the first time in his mid 20s, lamented the missed opportunities due to the limited visibility of Mississippi's

transgender population, despite personally knowing many transgender people who reside in the state. He said,

> I think that's part of our miss here, too – the miss here is that trans, period, in the state of Mississippi is almost like a hidden subject, or a hidden topic, or a hidden style of living, and um, it's due to fear. It's due to fear, and it's about time we create this as normalcy. Because it is normalcy, more than you would know. I mean, I've only lived in the state of Mississippi for a little over two years, and within the first 6 months of living here, I met 5 trans guys that lived within a 5 mile radius of where I lived, because of people I decided to associate with. And they decided they were comfortable enough sharing with me. But they don't share on social media, they don't share with *friends*, they don't share with their employers, the only people that might know are their direct blood relatives. And that's it. Because it's – it's been so hush. It's had to be hush.

Tamera described how she was the only transgender person she knew of in not just her friend group, but in her town in general, despite believing there had to be other individuals around her who just were not out. She said,

> I have friends, not necessarily the same ones I used to have, who are accepting and have made some, by virtue of reaching out, have made efforts to be good to me when I became known. But as far as a face to face relationship I don't know another trans person anywhere around me. Aaand, I know they're there, but clearly they're closeted or something, and so I – in terms of face to face interaction, I'm basically a unicorn in this town.

<u>Lack of legal protections</u>: Multiple participants cited the lack of legal protections from gender-based discrimination as a reason for concern when attempting to access health care in Mississippi. Angie expressed her frustration with the only place in Mississippi that advertises their willingness to provide HRT, and extended those frustrations to the state of care for transgender persons across the state. She said,

> It's just stressful. Going to the doctor is already scary because – I don't know, it's just stressful. Then not knowing – like if a supposedly LGBTQ-friendly place like Open

Arms can fuck up, obviously a place that doesn't specifically deal with trans people's needs, like who fucking knows what could happen. I don't want to possibly go through being denied like – I don't want to be embarrassed or asked to leave – like, I don't know if that would actually happen, but I'm sure it has. Especially with that fucking law where you can legally do that for [mocking voice] 'religious reasons.'

She recalled how she approached accessing healthcare in Mississippi before moving to a large, socially liberal city on the West Coast, particularly as it related to House Bill 1523 and financial barriers. She said,

I guess until I got here, I just mostly avoided dealing with it completely. But it's also easier to find places where they don't charge you so much here, too. So it's that and knowing like, they're probably not gonna turn me away because I'm trans like they – like they could legally do that in Mississippi, and it's just a different culture here, like especially politically – like I'm protected here. Like I almost wish someone would deny me service here because I could sue them and pay off my student loans [laughs]. But like there, there's really no protection – there's protections for bigots, but not me as a trans-female.

Witnessing discrimination against other LGBT people in your community can add to fears of being personally discriminated against, which may increase anxiety and care-delaying behaviors. Angie recounts hearing how her friends, a lesbian couple, encountered discrimination when looking to have their anniversary dinner at a local restaurant, and extends that cultural attitude to her potential of experiencing discrimination in healthcare settings. She said,

If people will turn down business to gay people – like I'm not saying being gay is easy but like being trans – it's definitely – like it's definitely something people seem to be less accepting of than even being gay. So if they're willing to do that at a restaurant, like losing money for the sake of just not wanting to serve a female-female couple, like, of course they would tell me they won't treat me in like – like if I see a doctor. So like for a lot of reasons it just didn't seem worth it to risk it cause it's not like I was ever super sick, like near death or anything.

It's not just Mississippi: When asked how they felt living in Mississippi had affected their transition processes, many participants made sure to emphasize to me that Mississippi, while having its challenges, is not the only place where transgender patients experience discrimination and substandard care. Caleb, a trans man in his mid 20s who has not yet begun medically-assisted transition due to concerns about his family, told me that he feels other places would have many of the same issues as Mississippi, and connected providers' willingness to the general political climate, as well as the effects of rurality. He said,

> I'm sure that there are a lot of other places that are just as bad as we are. Like, I don't know, Montana, or like, Wyoming, some of the fly-over states, I'm sure those are pretty bad too. But it seems to be better in bigger cities and people seem to be more – I don't know, open to changes. I mean, the election was really good proof of that. I mean, all of the rural areas voted for Trump and all of the cities voted for Hillary. And so, I mean it was a really good example of cities wanting change and to move forward and progression, and understanding that people are people. And rural areas are like – if you're not me, fuck you.

Eric told me how, even if people in other states are more accepting of transgender people, they may still be uneducated on trans medicine and hesitant to prescribe hormone replacement therapy. He said,

> I had trouble in [Midwestern state], too, finding a consistent doctor. It's not that there aren't people – like people are more accepting of it – but then finding physicians who are comfortable prescribing it is really difficult.

Resource limitations: One barrier to care that was frequently cited across participants was the lack of resources and providers who were willing to provide trans-specific healthcare. Tamera, who lives in North Mississippi and began living as a woman over 10 years ago but only recently accessed supervised hormone replacement therapy,

discussed what her options for transition were when she began her social transition. She said,

[scoffs] I didn't have any. Other than the reading that I did online. I did it wrong, as opposed to the advice that people give, if you go and you ask 'what should I do? I need to come out.' What I did wasn't anything like that. Um, because the things that they would advise me to do weren't available for me to do.

She continued later by describing the time after she reached her transitional 'breaking point' and began living as a woman in her daily life. She said,

I went 24/7, and I had not been to a counselor, I had not been to a doctor – like it would do me any good at all – that's another, just another thing that, like I said, people would say 'you ought to do this first' – it simply wasn't available. Other than talking to people on forums online, I didn't have a resource.

April expressed her exasperation regarding the limited number of providers who will prescribe and monitor hormone levels for transgender patients. She, as well as all of the other participants who shared their experiences, described travelling long distances to access care. She said,

You know, if there was somebody closer to home, you know, it would be better. It would be better if someone would work with the LGBT community closer to home. But you can't find anybody ... I wish there was one in [hometown] where I didn't have to go travel basically 2 hours away or 3 hours away or somethin' just to see a doctor about bein' trans and getting hormones. It's – it's.. [sighs] so I wish there were more people that dealt with it.

<u>There's only one place for us: Open Arms</u>: At the time of data collection for this study, it appeared that only one healthcare center in the state of Mississippi advertised their willingness to work with the LGBT community: Open Arms Healthcare Center, located in the capitol city of Jackson, the most populated city in the state. Their website

heralds their accomplishment of being "Mississippi's first LGBTI healthcare center." The majority of the participants in the study mentioned accessing, or attempting to access, care from Open Arms at some point. Some people reported having negative experiences, some reported having positive experiences, but most people reported a mix of both – a gratefulness for the ability to access care in the state they live, but frustrations with lack of gender sensitivity training for much of the staff and some gatekeeping by providers. Having a provider located in her community that explicitly works with the transgender community and provides prescriptions for HRT was incredibly exciting for Ashley, who described it this way:

> When my friends took me to the group study [at Open Arms] I found out a couple days later like I could get my hormones, like once they told me I was so excited. I was just so excited, once they told me I could go and get my hormones. I just really didn't care about anything else. Like 'Wait, what? You're telling me that I can transition here? In the Bible belt state?' [laughs] And they were just like 'yeah, that's what this clinic is open for, it's to help everyone in the community.'

Despite providing the much-needed resource of HRT access, Open Arms was not without issues. Jensen reports having a positive experience seeking care at Open Arms, but acknowledges that he has heard negative reports from other people who went there. He said,

> [I] finally got to the point where [my therapist] wrote me a letter for hormone replacement therapy, or HRT, or in my case testosterone, right? Brought me the letter and I took that letter to the Open Arms health care clinic in Jackson. And they were great to me. They - and now, I've heard about other people's experiences there. I know a lot of people that still use their services there. I've heard of not so great stories.

When I asked why she left Open Arms and began seeing a provider in the neighboring state of Alabama, April replied with critiques of their lack of transparency regarding her bloodwork results and the long wait times for appointments. She said,

> Well, Open Arms, I would always – like when I had to get my blood drawn – they would never tell me about my blood tests. They would never let me know anything and it was just.. it was awful. And then goin' down there, I mean like, everybody.. [sighs] It would take like a week and a year to even get an appointment there [scoffs] and I was like 'oh my god are you serious?' Like get with the program people.

When I asked her if she could think of any particularly negative experiences related to seeking healthcare, Kate replied that she felt some of her providers, including Open Arms, had taken advantage of her financially because they knew transgender people were vulnerable. She said, "I felt like both my endocrinologist at UMMC (University of Mississippi Medical Center) and Open Arms kinda pulled me around to get more money out of me, because they knew I *needed* it." Later, when I asked what advice she would give to providers serving transgender patients in Mississippi, Kate reiterated her point: "Don't try and siphon money out of us, just because we need this service." Three different individuals in the study reported being misgendered by front office staff and/or the phlebotomists drawing their bloodwork. In addition to high costs and staff insensitivity, Angie told me the effect this misgendering had on her experience at Open Arms, and offered advice to the clinic. She said,

> [The price of healthcare she receives in another state is] still better than the $300 for labs they expected me to pay every 3, 6 months at Open Arms, plus a $60 copay, and that was with student insurance and supposedly being on a sliding scale. Like the billing was through Labcorp, but it was just way too much, which is why a lot of people – and like I did it too – like a lot of people just got their meds offline and looked up standard doses to start off with and just tried that, because Open Arms did not make it easy. Like they gave

me a script right away and that's not even normal for them because like – so from what I hear from just about everyone who has gone to them is that they give you the runaround and either won't give you a script for some stupid reason or they like are rude or don't actually seem to have your lab results and just go off whatever – I don't know. Like they didn't seem really that competent and they did misgender me even though I went in there in a fucking skirt. Like how stupid can you be? So I know like – like okay trans stuff isn't their primary thing, everyone knows that AIDS treatment and management is like their main thing but like, don't offer those services unless you're going to make sure your staff isn't being rude to trans patients, like okay? Not that hard. So yeah, it wasn't the best experience for me – like the counselor they had there was great, I really liked her and she obviously knew what she was talking about but no one else seemed to and I only got to talk to her once for like 30 minutes before she turned me over to the nurse who did the informed consent and showed me how to do my shots.

While Jensen has a positive view of Open Arms, he understands that one clinic cannot effectively serve the needs of the entire transgender population in the state of Mississippi, and had this to say:

One place cannot be cannot be assisting or all of the trans community or gender nonconforming community in the state of Mississippi - it just can't be like that - it can't. There are so many people here that are now going to extremes - going to certain lengths to get their hands on hormones illegally online. I mean they're – they're risking their own safety and they're risking certain consequences for the sake of feeling comfortable in their own skin. Because we do not have significant resources here in Mississippi. We need more trained therapists, counselors. We need more trained nurses and doctors that work with the trans community specifically, or LGBT maybe specifically. We need we need more education. We need more education. We need to open up more non-profit organizations that help cater to these needs. We really truly do at this point. It's like we're running a daycare center. I mean I use this as an example, but imagine imagine a day care center where you have 20 to 50 young children being watched per every adult, right? Like every one of those adults watching 20 to 50 children. I mean you can't do it. You cannot do it.

Provider limitations: When looking to access care, the primary barrier participants identified when it came to their providers was the lack of education regarding transgender health that they possessed. Each participant in the study reported, to varying degrees,

their frustration with providers' lack of education on transgender health care. Even when providers did not discriminate against trans patients, and genuinely wanted to help, their lack of training often caused issues that could manifest in several ways. After describing a situation in which his doctor learned he was transgender and, despite his efforts to help, provided subpar care, Eric, a doctor, discussed some of the ways in which a provider's lack of education on trans health can manifest in interactions with trans patients. He said,

> It was just very clear that they didn't have a backup plan. They had no way to deal with the situation. Like the guy had no idea. No one had any idea how to deal with the situation. So, I think that's mostly what we run into. The system doesn't account for trans people. So when doctors run into trans people, they either like have to improvise, which like, a lot of them are not very good at doing, and they do really poorly, which then upsets the patient. Or, they become belligerent because they just don't know what to do and they don't like feeling like they don't know what to do. Or, like the good ones say they just don't know what to do, but then they expect the trans person to educate them on what they're supposed to do. Which is really awkward. Like if you didn't have diabetes and had someone come in and they were diabetic, you can't like ask them 'Oh, well what kind of insulin should you be on? What kind of dose should you be on?' Like, that's not appropriate.

Stacy, who is well-networked in her community, spoke to several affirming providers but was still unable to access care due to their limited knowledge of trans healthcare and subsequent unwillingness to prescribe and monitor her HRT. She discussed the importance of education in tandem with sensitivity and willingness to help. She said,

> I think a lot of [providers] probably would not anticipate having a transgender patient. And so they're not prepared. Even those that are accepting, maybe want to be affirming, don't have the right tools to handle things. Like I said, with Dr. J and with Dr. A, I mean, they were both very nice, but neither one of them was comfortable doing anything. So I would say, educate yourself, learn what you need to learn, work with other appropriate professionals like an endocrinologist or something. Study. Understand. Because it's

important – I mean you may not have that many patients, but if you've got one patient with an obscure disease, do you just let that go because you don't have experience in that area? No, you're going to try to help them.

Several participants mentioned that while they were frequently able to access general care without discrimination, even when their providers knew their transgender status, that finding providers to prescribe and monitor HRT was exceedingly difficult. Brandon, who lived out of the state for some years, described the difficulty of finding a provider who would refill his prescription for testosterone upon returning to live in Mississippi. He said, "Trying to find a doctor to write me my prescription was like trying to find a needle in a haystack."

Not all providers let their lack of education stop them from helping their transgender patients. While recovering from a life-threatening injury, Tamera reported that her rehabilitation doctors went above and beyond to provide her with access to medically supervised HRT. However, despite their desire to help, they had significant difficulties locating a provider who would do the necessary bloodwork. Tamera described the situation this way:

Both my spine surgeon and my rehab doctor turned over every rock in North Mississippi to try to find an endocrinologist who would do bloodwork and – you know because my insurance was paying for all this at the time – and they couldn't find anybody in North Mississippi within range, that they had a working relationship with, that would do the bloodwork necessary to properly administer the hormones. All she could do was just continue what I'd been doing. And so, you know, that tells you something about the medical environment up here, when no endo will even run a simple blood test and report back hormone levels. They didn't want to get their hands dirty with it.

Later, Tamera reported being pleased, and very surprised, that during her extensive contact with medical providers while addressing her serious injury, she

experienced no transphobic discrimination. However, she also clarified that she believes this is because the procedures were not specifically to treat her gender dysphoria. She said,

> To go through something of that significance, and to contact that many people in two different major locations in this state, and not be able to report any transphobia, I found remarkable. So my report to you is basically that if you're receiving generic care for various conditions in North Mississippi, you have a pretty good chance that you're gonna have a positive experience. If you're looking for anybody to support you in the medical aspects of transition, you're probably completely out of luck.

Brad, white trans man in his mid 20s, conveyed a similar message when I asked him how he would feel if he needed to see a provider he did not know. He said,

> For regular stuff I think I'd be fine. But if I had to go to a doctor here for trans-specific things, you know like hormones, I would have to bring in my own literature to make sure the doctor was on the same page as my doctor in Chicago was. Because I've heard of like, some doctors around here just have like really different protocols.

Theme 2: Strategies for Navigating & Accessing Care

When considering how transgender Mississippians navigate the challenges they face when seeking healthcare, four primary themes were identified: Support systems, Internet as a resource, confidence/standing up for self, and DIY HRT/Making do medically.

Support systems: Existing literature on transgender health shows that having family support, support from friends, and support from/connection to the LGBT community can increase health-seeking behaviors and boost mental health outcomes, partially offsetting the negative effects of discrimination (Bockting 2013, Testa et al.

2014, Bariola et al., 2015). Brandon described his fear of proceeding with surgery and how the support of his wife, a nurse, made all the difference in his sense of safety. He also acknowledged that many transgender people do not have that support system, and questioned what happens to them, if they are even able to access surgery. He said,

> When we got up to the surgical waiting area, I kept telling my wife that I was questioning doing this. She was like "you have *got* to have it done, we've come this far now, I'm not gonna let them mistreat you. We're not backing out now. I'm not gonna let them mistreat you." Cause I – I was scared. I was like "you know, what kinda jokes are they gonna be saying back in the OR room." You could tell that [the nurse] – that they were just not comfortable with me being there, or treating me, uh, as a patient. And I was being discharged the next day. And I told [my wife] "just get me out of here. Take me home." If I did not have a wife that was a nurse, I would not have felt safe. She was the one that was checking my bleeding. She was the one to make sure there was nothing going on. And I can't imagine – and you know, I'm fortunate in the fact that I do have that knowledge and I do have that support system. A lot of people don't and they never even make it to where they can have surgery, get different things taken care of that they need to take care of. But in the moment they have to go in there in an acute situation, to where it's a life-threatening emergency, who's gonna be their advocate? I did not feel safe.

Brad also acknowledged the positive effect the support of his partner has had on his transition process. He credited his partner for pushing him to ask the questions he needed to ask to confront his identity. He said,

> My partner, we've been together going on eight years now. And we had both identified as lesbians before and um, she was actually one of the people – or *the* person, that started asking me the questions that I really needed to be asked to like you know, kind of break through it and get to this point. So, I don't know, she's been my number one support person.

Ashley's friends, some of whom are also transgender women, are the ones who initially brought her to Open Arms, where she was excited to learn she could access transitional healthcare. She described the support she receives from her friends this way:

> They were very supportive. A lot of them were very, very supportive. They were just like, if there's anything you need, we'll do what we can to help you, because we know how your family is.

Internet as a resource: Every individual who participated in this study reported using the Internet in some way to aid their transition. The ways in which it was utilized were fairly broad, but most frequently it was used to connect to other transgender people, do research on transgender people in an effort to help themselves define their identities, discover options for treatment, locate/vet providers, and access Telemedicine.

As mentioned previously, being connected to the LGBT community, and having connections to other transgender people, has shown to boost mental health outcomes. Often, meeting other transgender people is incredibly difficult, particularly if an individual lives in a rural area without organizational resources. It is a relatively small population, and many individuals within that population choose not to share that personal information broadly. The Internet is a convenient way to meet people with shared experiences. Kate described the importance of the Internet to her as a teenager. She said, "Because I was on the Internet a lot, I found about the trans community pretty easy and I really identified with it. And when you're talking in text, no one can tell if you're passing or not, so it made me feel really comfortable with myself." Juno also described the Internet as a place they found community, and a starting place for exploring their gender presentation and subsequently understanding themself to be gender nonbinary. They said,

> I probably started thinking about things when I was around 15. Like I cut my hair short and I was heavily – like my only really source of interaction with people, because I was so isolated and just like a weird kid that no one liked, is like the Internet. And like me and my friends – like my Internet friends would tell me I looked androgynous, which I didn't

know what that meant, but I looked into it and I really liked that. The first word I saw was like androgynous, and I would take my step-brother's clothes and dress up in them,

When patients can safely bet that their providers' knowledge about their health needs is limited to non-existent, they may navigate this by doing health research themselves. Brandon described how the depth of the research he did on the Internet made him significantly more educated on the topic than the majority of providers. He said,

I did a lot of research from the first time that I discovered what gender identity disorder was and what my options were I just – did a lot of reading a research about it and it was 2 years before I took that first shot. Like I became so educated on the variances of what could cause this, how did this happen, uhm, I was probably more educated than endocrinologists, the therapists, and probably even the majority of the doctors out there.

Jensen, like Brandon, also did a significant amount of research online. When I asked him if he believes transgender Mississippians generally trust doctors, he gave a resounding 'no' and described how, given the lack of education providers tend to have, self-care may be preferable. He said, "No. No. I didn't even trust finding a therapist here because I - I don't think that people are educated enough here. And I feel like I know more about helping myself than professionals - quote unquote professionals - in their fields know about what's going on with me. So I almost feel like self-help is better help."

In addition to substituting for the lack of knowledge of local providers by self-educating using the Internet, 4 of the 16 participants described accessing Telemedicine. Each individual who accessed Telemedicine reported that the person they were being treated by was an expert and/or specialist in trans medicine. This also allowed them to access care from providers in another state without incurring travel expenses.

DIY HRT & Making do medically: When the barriers to accessing medically supervised HRT seemed insurmountable, or were particularly inconvenient, some

participants reported accessing hormones illicitly, primarily by purchasing hormones online and following recommended regimens. The primary reported reasons for DIY HRT were difficulties of accessing HRT through a provider, financial reasons, and avoiding providers. After unsuccessfully trying to access medically-supervised HRT from multiple providers, including Open Arms, Stacy describes why she returned to purchasing hormones online. She said "It was headache after headache for a while. And that's kinda why I got hormones online, is because I just kept getting a major headaches of trying to do this the right way." Lisa described the insurance billing factors she encountered when trying to access her hormones from the VA Hospital in Jackson, MS, and how that led her to purchasing hormones online. She said,

> They can only prescribe up to the limit for treating like a post-menopausal cis woman with low estrogen levels, which is much lower than the levels that you want to give a trans woman to, you know, accelerate that process. So they basically cut my dose in half. I told them where to stick it and started ordering it from India. So, the estrogen portion is self-med. Blood levels are okay, they still fund that testing, so every 3 months I adjust my dose as needed.

To clarify, I asked her if ordering hormones online is easier than accessing them through a provider. She said, "Yeah, easier and cheaper than even the copay on the prescription was. And yeah, it's – if it wasn't actually medicine that it says on the label, I'd have known about it by now." April, who began her medical transition at the age of 15 (the youngest age of all participants), reported that the first hormones she took were her mother's birth control pills. She said,

> I couldn't live my life as a boy anymore. I could not do it. And I wasn't going to do it. So, my mom basically put me on her, uhm, birth control. And that's where it all started. That's where April came from [laughs] birth control. I do not recommend – if you're an

M to F – I do not recommend taking birth control 'cause it can mess up your liver real bad. Even though the hormones I'm taking now *can* mess up your liver, it's from a doctor so I get my blood drawn and stuff to make sure my hormone levels are okay. But yeah [laughs] that's how life was.

Again, she reiterates the she does not recommend transitioning without medical supervision, but at the time she began her process, she felt there was no way around it given Mississippi's cultural context. She said, "I didn't go to a therapist. I did this all on my own. I basically, you know, did it without a doctor's permission or a therapist's permission. I don't… *recommend* it…doin' it that way. But sometimes you gotta do what you gotta do. And especially bein' here in Mississippi. I transitioned during a time where it was *not* okay to be trans. People would look at you and say 'What the hell? You're what? No.'"

In addition to financial reasons and lack of options, fear of provider discrimination caused many participants to delay accessing general care. Juno described why they have not been to the doctor, even though they have needed to go to the doctor for over a month, and mentioned documentation as another reason for delaying care-seeking. They said, "I recently had a thing I needed to go to the doctor for, and I haven't really – I just didn't go because I can't really just go to a clinic because it just seems like...stressful, and you have to get like – you know, I definitely look like a guy to them and um, but you know, my name and my biological sex on paper is still female, and so I haven't really wanted to get into that because I don't know who I'm going to end up with – and like the receptionist and it just seems like too much to go through." Similarly, Angie reported a time where she was very sick and, instead of going to the doctor and risking encountering mistreatment, she asked for antibiotics from her roommates and

treated the illness herself. She also mentioned that she saved money by doing so. She said,

> There were a few times I had like – so I'm pretty sure I had strep throat – like it was bad, I couldn't eat and I could seriously barely fucking talk but I didn't go to the doctor. I asked my roommates to see if anybody had extra like – like leftover antibiotics they hadn't finished or used or whatever, and two of them did so I just combined – like I looked it up a little bit – but I just used their antibiotics and eventually it went away. But yeah, I saved money and didn't have to go through whatever questions or however they might have treated me.

Confidence & Interactional Privilege: Some participants cited their self-confidence in interactions with providers as a reason for their ability to be treated respectfully and be taken seriously. Confidence in interactions seemed to be a way of navigating around negative perceptions of transgender people. Eric, who has an MD, cited his educational and status privilege as a benefit in his interactions with providers, while acknowledging that other trans patients do not have that privilege. He said, "I talk to doctors as a doctor, and so I can kind of get what I want because I think there's a certain acceptance that I'm probably not asking for anything terrible or dangerous.. but other people don't have that ability." Jensen cited his self-confidence and presentation of self as a benefit in interactions with healthcare providers, and called upon other trans people to do the same. He said,

> I think that the way that my behavior is, in the way I present myself and interact and communicate with other people has led me to advantages. That's what I think. There are too many people that are of the trans community or LGBT community in general, that, for whatever reason, fear. They fear standing up for themselves. They fear interacting with other people, conversing with other people on topics related to their gender or sexuality. They fear not being accepted. They fear being discriminated against. They fear the confrontation all together. They just don't - they want to keep quiet and keep private. So when they're put in situations where they have to - I mean, if want to move forward

with transitioning for whatever reason, they have to interact with certain people and complete certain things right? And in order to get to where they need to be and they are forced to be put in positions that they're not accustomed to, not used to. So they are very shy. You know during those interactions and they don't really stand up for themselves and speak out and speak proud and speak loud the way maybe they should if they want to be treated a certain way, which is why I feel as though I should be proactive.

Mike, a mental healthcare provider with a Master's degree who lived in Mississippi but moved to a left-leaning state in the Northwest, also detailed the benefits that come along with presenting one's self as confident. He said, "And especially being in the mental health field myself, you know, I think that that is definitely something that – that works to your favor. People don't question you when you walk around with confidence. Uhm, but if you constantly question yourself and, you know, and I'm not necessarily saying walk in like you own the place. But if you uh, act like something's wrong, then people might think that something's wrong." It is worth nothing that each of the 5 participants who reported using confidence in interactions with providers were white trans men with passing privilege. Three of those men had advanced degrees. This is important because they had gender, racial, and educational privilege – something that many individuals living in the racially diverse, and often impoverished, areas of Mississippi do not have.

CHAPTER VII

RECOMMENDATIONS FOR PROVIDERS

To know how to better serve transgender patients and give them good healthcare experiences, which will promote care-seeking behaviors, providers must know what makes these patients uncomfortable and how they can improve their services and interactions. The four primary suggestions that came from participants were: stating they will work with trans patients, taking the time to self-educate, having a backup plan, and treating trans patients like a people. As discovered in previous research with transgender individuals living in rural areas, having a provider that explicitly states they work with trans people is a priority when deciding who to see (Whitehead, 2016). April echoed this when I asked her what she looked for in providers. She said,

> They basically need to say that they deal with trans patients. They need to know – transgender people need to know that they will work with them. Because like a lot of doctors that I grew up going to, they're like Christian bigots. Like if I go to see them now, they're like 'you're what?'

Another thing that trans patients want from their providers is them to put in the effort to self-educate about trans care, not ask patients to educate them, and have a backup plan if they do not feel comfortable providing trans-specific care. When I asked what she wanted providers in Mississippi to know about treating trans patients, Tamera first described a really good interaction with a provider who previously had no experience treating trans patients with hormones. She said,

There was not any moment where I thought 'these people don't take me seriously, they're just humoring me.' They treated me like a woman at every turn. Like I said, that certain rehab doctor – when I initially told her about the hormones, she said 'I don't know about that, I don't know anything about how that works or what would be the proper dosage or anything, but I'll think about it' and the next day, she came back when they brought the medicine around, and she said 'this is estrogen and Spiro, I went home last night and found out what I needed to know to do this right and I'm fine with prescribing this for you.' And, you know, the notion that she was conscientious enough to say 'I don't know but I am willing to go find out,' I just considered above and beyond. Because she just as easily could've said 'I don't know' like my local doctor did, and left it at that.

She later goes on to advise providers that trans-specific healthcare is not a daunting, complicated thing to learn, and that it would make a big difference in the lives of a lot of clients if they took even minimal time to learn about it. She said,

There's a learning curve that's not that steep. [If] a layperson, just by doing their research on the Internet, like myself, can in the course of less than a week, familiarize themselves with the basic parameters of the subject then there's really no reason way somebody like my rehab doctor can't put in just a minimal amount of time to acquaint themselves with the nature of the condition, why it exists, how it happens, and the legitimacy of it and the recommended regimes to medically support it. I mean it's the kind of thing that they could take a weekend and make themselves knowledgeable about.

Adding even more good advice to the discussion, Tamera discusses the importance of training office staff on sensitivity to preferred names and pronouns, which can make a big difference in the experience of a trans patient. She said,

It costs them nothing for their staff and support team to 100% respect the gender identity profession of people that come through the door. Doesn't matter what they look like, doesn't matter if they've got it figured out or if their paperwork says male and they're presenting as female.

Because many providers do not self-educate like Tamera suggested, they often ask the patients to train them on their specific health concerns. James described coming

out to his therapist as trans and receiving her support, but also being asked to educate her on trans issues. He said,

> I actually talked to, uh, the therapist I was seeing at that moment about it. We had, uh, good rapport. And her response to me was actually very good. She was more than willing to continue to see me, but she said that I would have to teach her. Alright, now look. Here I am, 53, 54 years old. And I have *just* figured out the damn question and the answer myself. Okay? I really didn't even have time to educate her too.

Luckily, James's therapist had someone well-versed in trans issues to refer him to, and he went on to enjoy working with the new provider. This referral made a big difference for James, and other participants reported wanting their providers to have a backup plan, someone to refer them to if they were unable to provide care for whatever reason. Eric talked about his desire for providers to have a backup plan. He said,

> If someone's coming to you for a prescription and you're not comfortable writing it, just tell them you're not comfortable writing it. And probably have a backup plan and know someone who might be comfortable writing it, you know? I'm sure there are plenty of doctors in Mississippi who aren't comfortable prescribing Plan B but you should, at least, be a decent person, and tell someone where they can go and get it, you know?

The majority of participants alluded to or explicitly said that when they are seeking healthcare, they just want to be treated like a person. They want to be treated with respect, and for providers to acknowledge medically-assisted transition as a legitimate treatment for gender dysphoria, like they would any other hormone imbalance. James talked about the othering and objectification that often occurs when trans people seek care. He said, "I think that – it's easy to objectify people. Perhaps that's the best term. Rather than seeing the person before you. 'Oh nooo, it's an object - you're an 'it' thing' No, no. It's a person. A person. A human being." Existing qualitative research with

transgender patients indicates that one of the things they frequently encounter is experiencing interactions in which their provider is visibly uncomfortable with interacting with them and treating them as a patient (Kosenko et al., 2013). Ashley described the effect of providers acting uncomfortable with trans patients, causing them to feel uncomfortable seeking care. She said,

> You went into this field to protect and save lives, and even though you're not going to save every life, I feel like if that's what you signed up to do, that's what you need to do, no matter if the patient's gay, lesbian, transgender, it doesn't matter because that is still a person, and act and treat with respect. Treat people as how they would like to be treated. Be more self-aware of their actions. Even just not knowing how to act, it makes people very leery of even just coming in and seeing [a provider].

Multiple participants reported wanting their providers to approach their trans-specific care like they would any other hormonal imbalance or health issue. After asking what advise she would give to providers in Mississippi, Angie explicitly addresses this. She said,

> I feel like it's crazy to me that people go into the medical profession and then treat people who are seeking treatment like shit. Like this is in the DSM, this is a condition that causes certain symptoms, so like dysphoria, and it is treatable. So just treat it like any other hormone imbalance issue and treat your patients.

Several participants reported wishing that providers would not make assumptions about them, but found that they were likely to do so. Participants reported wishing their providers would stop making routine healthcare encounters about them being trans and expressed frustration that they frequently conflated gender and sexuality. Levi talked about his desire for providers to stop making assumptions about trans patients. He said,

A lot of doctors make a lot of assumptions. And most of the time, almost every time I go to the doctor, it has nothing to do with getting a prescription [for testosterone], you know what I mean? That's only one of the reasons I got to the doctor. They do whatever they need to, take my bloodwork or whatever to make sure it's not ruining my liver, so it's not a big deal. So I guess if a doctor had never seen a trans patient before I would just say to not make assumptions and most of the time, the trans details don't even matter.

James expressed a similar sentiment when I asked what he would tell healthcare providers working in Mississippi. He said,

Sometimes.. it really is sinus, you know. Or a broken foot. I hear lots of stories that – all kinds of judgmental things, where people go in for emergency care and – and it's like 'Oh my god you're what?' And automatically that has everything to do with, you were just in a car wreck. No, it doesn't. Totally unrelated. What you have in front of you is a *person* that was in a car wreck and is in need of emergency care. They have a broken leg, can't you see the bone sticking out? This has absolutely nothing to do with HRT. Nothing. Didn't – that one didn't cause this other one. I – I have trouble with that.

When I asked her if she would feel comfortable going to a doctor she did not know, Ashley directly connects this unnecessary focus on her transgender status to her avoidance of care. She said,

Normally, I try not to go to the hospital or go to the doctor or anything like that because, like you said, I'm more so concerned that they're not gonna be concerned about what's actually wrong with me, they're just gonna focus on 'oh my god, there's a trans woman here, we don't see this too often' and it becomes one of those things like, 'I'm gonna question her, let me ask her about this,' like noooo. I just want my cold prescription! Why don't y'all just write me a little prescription for something generic, not that hard.

Several participants reported feeling frustrated by providers who conflated gender and sexuality, and appearing to over-sexualize trans patients. Ashley reported feeling insulted by several nurses when they interacted with her in an exaggerated way that is typically associated with 'flamboyant' gay men. She said,

I just feel like a lot of the healthcare physicians should be more well-equipped and I wish that every trans person that went in there wasn't treated like, gay. Because trans women go in and they'll be like 'Hey giiirl! Oh, yes bitch!' and I'm like, 'Well wait a minute. Would you talk to another woman like that?' And they kinda looked at me like 'Ashley that's not offensive' and I'm like 'Yes, it is.' Like I'm just a person, I'm not asking for all this extra.

The influence of religion on Mississippi's cultural climate is significant, and every participant, even those that were Christian themselves, brought up Christianity as it related to historically condemning transgender people. Brandon, who believes in a higher power but does not go to church, told me how he responds to people who tell him he is 'going against God,' and gave a creative analogy for understanding how his experience feels. He said,

People look at me and say 'Well God made you the way you are – made you a girl and you're going against God.' And I'm like 'you do realize that God made everybody. If that's the case, God makes people that are intersex all the time.' So that makes no sense. To me being transgender is just like level 1 of being intersex. It affects our brains and uh, how we interpret things, and – it's kinda like being stuck with the wrong software and hardware. It's kinda like trying to play a PS4 game on an Xbox. It's just not gonna work. You're not gonna be able to play the same with that hardware. It's just not going to happen. And being transgendered, you have a brain, but then you have all this… hardware that you can't do anything with. It's – it's just a constant state of going back and forth. You gotta find a way to make it work.

Stacy advised healthcare providers in Mississippi to first educate themselves and second to disconnect their professional behavior from their personal beliefs, particularly religiously-informed beliefs. She said,

I just think maybe for healthcare professionals and Mississippi: Number one, educating themselves. Number two, disconnecting themselves from any type of preconceived notions, religious beliefs that could potentially keep them from doing their job. I think sometimes people, not just in healthcare profession, but people will allow their religious beliefs to cloud, their judgment on what they should be doing. Especially if you're a

public role in public sector, taxpayer dollars are paid for you to do your job as it's defined, not for you to bring in something like your religious beliefs and say I can't do that. Well, it's in your job description, if you don't want to do that, maybe you need to go into private practice or something. So I think you know, educating themselves and disconnecting themselves from things that could prevent them from doing their job and doing it effectively. Like a preconceived notion or religious beliefs.

CHAPTER VIII

DISCUSSION

Summary of Findings: Through the use of interview data with transgender adults who have lived in Mississippi and subsequent thematic analysis, this research project has attempted to understand what barriers transgender Mississippians face when accessing healthcare, how they navigate those barriers, and what recommendations they have for providers.

The results indicate that transgender Mississippians face a plethora of barriers to accessing quality healthcare, including limited representation, financial barriers, insurance barriers, barriers related to legal documentation, employment discrimination, and visual stigma. They also face limited access to resources, lack of provider education, and lack of provider willingness to prescribe transgender-specific care.

The way these individuals navigate these barriers includes leaning on support systems, using the Internet to do research, accessing HRT illicitly and making do medically, and behaving confidently in interactions with medical providers. They recommended that providers explicitly state they will work with the transgender population, take time to self-educate about trans-specific health needs, and treat them like human beings.

Limitations and future research: The primary limitation of this study was the lack of Black and/or African American participants in the study. Mississippi has a large Black

population and the fact that recruitment of that population was limited to one out of 16 participants is unfortunate, and leaves many questions about the effect of race unanswered. An additional limitation is that this study included primarily well-off individuals – individuals with advanced degrees and lucrative jobs. Though some struggled in the face of employment discrimination, no participant reported being homeless at any point in their lives.

Future research with Mississippi's transgender population would be well-served by recruiting Black transgender participants, as well as other transgender people of color, including those individuals who are not English-speaking, or fluent in English. Future research should also include a more socioeconomically diverse sample to try to gauge the needs of the most underserved and resource-poor individuals in the state.

Conclusion: In conclusion, using thematic analysis of interview data, this thesis identified the primary barriers that transgender Mississippians face when attempting to access quality healthcare, identified ways in which they navigate those barriers, and identified suggestions they have for providers. Despite the incredible potential for/realized experiences of transphobic discrimination, these individuals pushed through the seemingly insurmountable barriers that stood in the way of their access to transitional care, and the goal of achieving a gendered embodiment that aligns with their gender identity. These individuals were an inspiration to me, and I hope the stories they shared with me, as well as their recommendations to providers, make a positive difference in the experiences of transgender people who will need to access this care in the future.

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APPENDIX A

DEFINITIONS

Cisgender: Cisgender individuals are those whose sex and gender align in normative ways. Men assigned male at birth and women assigned female at birth are cisgender.

Transgender (formerly transsexual): "By definition, a transsexual [transgender] is a person whose physical sex is unambiguous, and whose gender identity is unambiguous, but whose sex and gender do not concur" (Devor 1989, p.20). Transgender is an umbrella term that can include transgender women (also referred to as MtF, transfemales), transgender men (FtM, transmales), nonbinary, genderqueer, and other gender nonconforming individuals.

Cisnormativity: Bauer et al. (2009, p. 356), defines cisnormativity as the "expectation that all people are cissexual, that those assigned male at birth will always grow up to be men and those assigned female at birth will always grow up to be women...cisnormativity disallows the possibility of trans existence or trans visibility."

Gender-affirming surgeries: Some transgender people undergo gender-affirming surgeries to bring their gendered embodiment more into line with their gender identity. There are a variety of these procedures including, but not limited to, SRS (sex-reassignment surgery, or the restructuring of natal genitalia), top surgery (the masculinization or feminization of the chest), and FFS (facial feminization surgery).

Gender identity: "Gender identity refers to the inner psychological conviction of an individual that he or she is a man or a woman. The concept of gender identity allows transsexuals to maintain that, in spite of a male body, they are and always have been women" (Nanda 1990, p.137). Gender identity may also be experienced outside of the male/female, man/woman binary to include individuals who experience themselves as neither men nor women.

Genderqueer: Richards et al. (2015) refer to those individuals who fall under the umbrella term "genderqueer" as "people have a gender which is neither male nor female and may identify as both male and female at one time, as different genders at different times, as no gender at all, or dispute the very idea of only two genders." These individuals may alternatively be referred to as having "non-binary" genders.

HRT: HRT, or hormone replacement therapy, in the case of transgender individuals, is the administration of cross-sex hormones to masculinize or feminize the body to be more in line with one's gender identity.

Transition: Social transition is a movement away from self-identifying with and/or being identified by others with one's sex assigned at birth, toward identification and alignment with one's experienced gender identity. This can be done through gender presentation (haircut, clothing choices), name change, and other facets of self-presentation. Medical transition, most often achieved through HRT and gender-affirming surgeries, aids in the process realizing a physical gendered embodiment that is more in line with one's gender identity. Not all transgender individuals pursue medical transition or may pursue some aspects and not others.

APPENDIX B

INTERIEW SCHEDULE

INTERVIEW SCHEDULE

I. Background: Can you tell me a little bit about yourself?
   a. How old are you?
   b. How would you describe your race/ethnicity?
   c. How would you describe your gender?
   d. How would you describe your sexuality?
   e. Are you currently married/otherwise partnered?
      - If not, have you had significant romantic relationships in the past?
        - How would you describe those?
        - (or) Why do you feel you haven't?
      - If you are currently partnered, how would you describe your relationship?
      - Were you partnered during your transition? Did this present any specific benefits or challenges?
   f. Are you a parent, biologically/via adoption/otherwise?
      - If so, how would you describe your relationship(s) with your child(ren)?
      - Does being a trans parent present any unique benefits or challenges? What are they?
   g. Do you have a personal religious/spiritual affiliation?
      - If so, are you involved with a religious/spiritual community?
   h. Are there any other groups or organizations you are involved in?
   i. What's the highest level of education you've received?
   j. Are you currently employed?
      - If so, what is your occupation?
      - If not, how long have you been unemployed?
      - If not, what is the last job you held before becoming unemployed?
      - If not, how did you become unemployed?
   k. Tell me about the place(s) you grew up.
      - Where all have you lived?
      - What were the reasons for your moves?
      - Was there ever a time you/your family had a difficult time making ends meet?
      - How would you describe the place you live now?
   l. Tell me about your family. What are they like?
      - Are they religious?

- What is the highest level of education your parent(s)/guardian(s) have received?
- What did/do your parent(s)/guardian(s) do for work?
- How is your relationship with them? Has it changed over time?

II. General

a. Where did you grow up? What was growing up in X like?
b. When did you know you were trans? How did you know?
c. How did you make sense of your gender as a child?
d. Have you "come out" as trans to your family? Friends?
    - If so, who did you tell first? Why?
    - How did they react?
    - How did you feel?
    - Are there people you haven't come out to? Why or why not?
    - Are you active on social media? If so, which social media sites do you have accounts on?
    - Have you "come out" on social media?
e. There's some debate about why people are trans. What is your perspective?
    - How do you explain being transgender to others?
    - Does your explanation depend on the person you're talking to?
    - Do some explanations seem to make more sense to you than others?
f. When, if ever, did you decide to go through your medical transition process?
    - How old were you at that time?
g. If you have not gone through a medical transition, please elaborate on why.
    - Are there other "transitional" steps that you took?
    - Do you think being trans without medically transitioning creates a different lived experience? If so, how? Can you give some examples from your own experience?
h. What were some of the first social changes you noticed after beginning your (physical and/or social) transition?
    - Have you ever been treated negatively because of your gender identity?
    - By whom?
    - Did you feel like people treated you differently? Better? Worse? In what ways?
    - Has that changed over the course of your transition process?
i. A lot of the national attention to trans people has been centered around public bathroom use. What do you make of this debate?

- How do you navigate public bathroom use? (e.g. avoid all together, find gender neutral restrooms, use bathroom corresponding to gender identity regardless any law/perceived threat)
- How, if at all, has that changed over time?
- Have concerns about using public restrooms ever caused any health problems for you? (e.g. kidney infection, anxiety, etc.)
- Have you ever had problems related to your gender identity in public restrooms? (e.g. harassment, angry looks)

j. Do you think living in Mississippi has shaped your transition process? If so, how? If not, why not?
- How would it have been different if you transitioned elsewhere?

III. Health care

a. What were your experiences with healthcare providers like during childhood/adolescence/teenage years?
- Do you know if your parents were ever without health insurance coverage for you or themselves?
- How far did your family have to travel to get to the doctor?
- How often did you go?
- Were you ever really sick or injured as a child/adolescent/young adult?
- Did your gender identity ever come up with medical providers during this time?

b. Did you request/did your parents ever involve you in any type of mental health services during childhood/adolescence/young adulthood?
- What was the reason for you/them seeking mental health care at that time?
- Can you describe your interactions with mental health providers?
- Was that/Where those mental health provider(s) supportive?

c. What, if any, trans-related medical services have you received?
- Are there additional medical services you hope to receive in the future?
- Are there barriers that have kept/currently keep you from accessing those desired services?

d. What was your first step in the medical transition process?
- How did you find a provider for that health care service?
- Where there any particularly helpful resources for you during that time?

e. How did you find the providers for the other trans health-specific services you've received?

f. How much do you think doctors know about trans-specific health care needs?
   - Why do you think they don't know more?
g. Have you faced any particular challenges getting health care?
   - Have you had to travel long distances to access health care?
   - Have you ever put off seeking health care when you needed it? If so, why?
h. Can you tell me about some specific health care interactions that stand out to you?
i. Are there any particular *positive* experiences with health care providers that stand out to you?
   - Why do you think that happened?
   - Why does that stand out to you?
j. Are there any particular *negative* experiences with health care providers that stand out to you?
   - Why do you think that happened?
   - Why does that stand out to you?
k. Why do you think trans people tend to have worse health outcomes than cis people?
l. Do you think certain trans people may have a harder time in interactions with health care providers than others? Why?
m. Do you think the new Presidential administration will have any influence on how trans people are treated in medical settings or by insurance providers? What about local governments?
n. What advice would you give to health care providers in Mississippi?
o. Is there anything we haven't covered that you would like to discuss?

APPENDIX C

RECRUITMENT FLYER

RECRUITMENT FLYER

We'd like to hear about the experiences of trans Mississippians seeking and receiving health care services for a study at Mississippi State University.

We are interested to hear your thoughts & experiences to understand the state of health care for Mississippi's transgender population.

We want to speak with individuals who identify anywhere along the trans spectrum (MtF, FtM, genderqueer, & others), are 18 years of age or older and live in Mississippi.

As a study participant, you would complete a 60-90 minute interview. Interviews will be audio-recorded and take place at a time and accessible location of your choosing.

In appreciation of your time and sharing your experience, you will receive a $10 gift card.

Interested in participating?
Want more information?

Please contact Micah King at 601-462-8951 or mdk106@msstate.edu

All correspondence will be treated as confidential.

Micah King is a graduate student at Mississippi State University, Department of Sociology.

This study has been reviewed and approved by Mississippi State University's Internal Review Board.